

Background Information Regarding the Legal Basis for  
Special CMS Provisions for American Indians and Alaska Natives

**I. Introduction**

There is a special relationship between the United States and Indian tribes that creates a trust responsibility toward Indian people regarding health care. The existence of this truly unique obligation supplies the legal justification and moral foundation for health policy making specific to American Indians and Alaska Natives (AI/AN) -- with the objectives of enhancing their access to health care and overcoming the chronic health status disparities of this segment of the American population.

It is beyond question that 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) -- as evidenced by Presidential Executive Orders and Special Memoranda.<sup>1</sup> Furthermore, with regard to health care for AI/ANs, 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 trust responsibility, and laws enacted pursuant thereto, provides ample authority for the Secretary -- whether acting through the Indian Health Service (IHS), CMS, or other agency of HHS -- to take pro-active efforts to achieve the Indian health objectives Congress has articulated.

HHS and CMS both recognize this authority in their tribal consultation policy:

"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 and 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 ..."<sup>2</sup>

While CMS often looks to the Social Security Act for authority, the historic and complex body of federal Indian law and case law applies throughout the federal government to all agencies,

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<sup>1</sup> See, e.g., Exec. Order No. 13175, 65 Fed. Reg. 67249 (Nov. 6, 2000) *reprinted in* 2000 U.S.C.C.A.N. at B77; White House Memorandum for Heads of Executive Departments and Agencies, Nov. 5, 2009; Dep't of Health and Human Services Tribal Consultation Policy (Dec. 14, 2010); Centers for Medicare and Medicaid Services Tribal Consultation Policy (Nov. 17, 2011); *Cramer v. United States*, 261 U.S. 219 (1923).

<sup>2</sup> Dep't of Health and Human Services Tribal Consultation Policy (Dec. 14, 2010), at 1; Centers for Medicare and Medicaid Services Tribal Consultation Policy (Nov. 17, 2011), at 1.

including CMS. The intent of this paper is to provide a brief summary of federal Indian law that is most relevant to current and future regulations and guidance 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.<sup>3</sup> The Constitution contains no explicit language that defines the trust relationship. Rather, 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 dealings between the federal government and Indian tribal governments.

The earliest formal dealings between the federal government and Indian tribes were undertaken through treaty-making. From the United States' perspective, treaty objectives were essentially two-fold: cessation of hostilities to achieve and maintain public peace, and acquisition of land occupied by tribal members. Tribes doubtless had a peace-making 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. These treaties/promises were the first expression of the federal government's obligation to Indian tribes.

The initial express recognition that a trust responsibility existed came from the courts. 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. That theme -- and the duty of the federal sovereign to Indian tribes -- carried forward some 50 years later when, in *United States v. Kagama*, 118 U.S. 375, 384 (1886), the Supreme Court acknowledged that tribes are under the protection and care of the United States:

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<sup>3</sup> *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. Arizona State Tax Comm'n*, 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).

"From their very weakness and helplessness, so largely due to the course of dealing of the federal government with them, and the treaties in which it has been promised, there arises the duty of protection, and with it the power [of protection]."<sup>4</sup>

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 plenary 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. This is not to say, however, that the United States has always acted honorably toward Indians throughout its history.<sup>5</sup> Nonetheless, the fact that our government has failed in some instances to act in an honorable manner toward Indians does not and should not absolve the more powerful sovereign from its responsibility to carry out its obligations honorably.

**B. "Indian" as a *political* rather than a *racial* classification: Indian-specific lawmaking and the "rationally related" standard of review**

In pursuit of its authority under the Constitution and the trust responsibility, Congress has enacted Indian-specific laws on a wide variety of topics<sup>6</sup> as well as included Indian-specific provisions in general laws to address Indian participation in federal programs.<sup>7</sup> In the landmark

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<sup>4</sup> See also *Board of County Commissioners of Creek County v. Seber*, 318 U.S. 705, 715 (1943) ("Of necessity the United States assumed the duty of furnishing . . . protection [to Indian tribes] and with it the authority to do all that was required to perform that obligation . . .").

<sup>5</sup> An example is unilateral abrogation of Indian treaties by Congress. See, e.g., *Lone Wolf v. Hitchcock*, 187 U.S. 553 (1903).

<sup>6</sup> 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. §450, *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 College or University 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.*

<sup>7</sup> 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 and 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(c) (funding set-aside for Bureau of Indian Affairs schools); Head

case of *Morton v. Mancari*, 417 U.S. 535 (1974), the Supreme Court set out the standard of review for such laws -- the "rational basis" test. In *Mancari*, the Court reviewed an assertion by non-Indians that the application of Indian preference in employment at the Bureau of Indian Affairs (as ordered in the Indian Reorganization Act<sup>8</sup>) was racially discriminatory under the then-recently amended civil rights law which prohibited racial discrimination in most areas of federal employment.

While the Supreme Court's civil rights jurisprudence has generally applied strict scrutiny when reviewing classifications based on race, color, or national origin,<sup>9</sup> in *Mancari* the Court determined that this test was not appropriate when reviewing an Indian employment preference law. Indeed, the Court declared that the practice under review was not even a "racial" preference. Rather, in view of the unique historic and political relationship between the United States and Indian tribes, the Court characterized the preference law as *political* rather than *racial*, and said 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." *Id.* at 555. The Court found that hiring preferences in the federal government's Indian service were intended "*to further the Government's trust obligation toward the Indian tribes,*" to provide greater participation in their own self-government, and "to reduce the negative effect of having non-Indians administer matters that affect Indian tribal life" in agencies such as the BIA which administer federal programs for Indians. *Id.* at 541-542 (emphasis added).<sup>10</sup>

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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, P.L. 111-5 (Feb. 17, 2009) (§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, P.L. 111-148 (Mar. 23, 2010) (various Indian specific provisions, discussed below).

<sup>8</sup> 25 U.S.C. §461, *et seq.* The Indian hiring preference appears at 25 U.S.C. §472.

<sup>9</sup> The Supreme Court has interpreted Title VI to allow racial and ethnic classifications only if those classifications are permissible under the Equal Protection Clause. *Regents of Univ. of Cal. v. Bakke*, 438 U.S. 265, 287 (1978). In this regard, the Court has also 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).

<sup>10</sup> Indian Preference provisions are not limited to the BIA, and have been applied in a variety of federal programs for the benefit of Indians. Section 7 of the Indian Self Determination Act, for example, establishes a broad federal policy of providing hiring, training, and contracting preferences for Indians in contracts or grants with Indian organizations across all federal agencies. 25 U.S.C. § 450e(b). Indian preference provisions are also found in other statutes. *See, e.g.*, 42 U.S.C. § 9839(h) (establishing an Indian hiring preference at American Indian Programs Branch of Head Start Bureau); 20 U.S.C. § 3423c(c) (establishing an Indian employment preference in the Office of Indian Education in the Department of Education). *See also Preston v. Heckler*, 734 F.2d 1359 (9th Cir. 1984)

Once the link between special treatment for Indians as a political class and the federal government's unique obligation to Indians is established, "ordinary rational basis scrutiny applies to Indian classifications just as it does to other non-suspect classifications under equal protection analysis." *Narragansett Indian Tribe v. National Indian Gaming Comm'n.*, 158 F.3d 1335, 1340 (D.C. Cir. 1998).

The Indian hiring preference sanctioned by the Court in *Mancari* is only one of the many activities the Court has held are rationally related to the United States' unique obligation toward Indians. The Court has upheld a number of other activities singling out Indians for special or preferential treatment, *e.g.*, the right of for-profit Indian businesses to be exempt from state taxation, *Moe v. Confederated Salish & Kootenai Tribes*, 425 U.S. 463, 479-80 (1976); fishing rights, *Washington v. Washington State Commercial Passenger Fishing Vessel Ass'n*, 443 U.S. 658, 673 n.20 (1979); and the authority to apply federal law instead of state law to Indians charged with on-reservation crimes, *United States v. Antelope*, 430 U.S. 641, 645-47 (1977). The Court in *Antelope* explained its decisions in the following way:

"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 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."

*Antelope*, 430 U.S. at 645 (emphasis added).

The courts continue to acknowledge the special political status of Indians and to uphold legislation singling out Indians on that basis. *See, e.g., Am. Fed'n of Gov't Employees, AFL-CIO v. United States*, 330 F.3d 513, 522-23 (D.C. Cir. 2003) (finding outsourcing preference for Indian-owned firms was rationally related to the legitimate legislative purpose of promoting the economic development of federally recognized tribes and their members); *United States v. Wilgus*, 638 F.3d 1274, 1287-88 (10th Cir. 2011) (upholding exception to the Bald Eagle Protection Act for Indian tribal members to possess eagle feathers).

### **III. Congress's Recognition of the Federal Trust Responsibility in Health Laws**

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(Indian Preference Act requires Secretary of HHS to adopt standards for evaluating qualifications of Indians for employment in the Indian Health Service that are separate and independent from general civil service standards).

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.<sup>11</sup> 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 Indian Health Service and tribal programs that serve the Indian population.

### **A. The Indian Health Care Improvement Act**

The Indian Health Care Improvement Act (IHCIA)<sup>12</sup> 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;<sup>13</sup> 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.<sup>14</sup>

The IHCIA has been periodically reauthorized and amended since 1976. In 2010, the law was comprehensively amended and authorized as a permanent law of the United States.<sup>15</sup> 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:

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<sup>11</sup> See, e.g., Snyder Act, 25 U.S.C. § 13; Johnson-O'Malley Act, 25 U.S.C. § 452; Transfer Act, 42 U.S.C. § 2001, *et seq.* (transferred responsibility for Indian health to Public Health Service); annual appropriations to the Indian Health Service included in the Interior and Related Agencies Appropriations Acts.

<sup>12</sup> 25 U.S.C. §1601, *et seq.* 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).

<sup>13</sup> 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, pt. 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. Commission on Civil Rights, *Broken Promises: Evaluating the Native American Health Care System* (Sept. 2004), at 98.

<sup>14</sup> The IHCIA was later amended to include formal establishment of the Indian Health Service as an agency of DHHS. Pub. L. No. 100-713 (1988). The IHS establishment is codified at 25 U.S.C. § 1661.

<sup>15</sup> Sec. 10221 of the Patient Protection and Affordable Care Act, P.L. 111-148 (Mar. 23, 2010).

### **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 of the Indians is far below that of the general population of the United States.<sup>16</sup>

### **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 professions in each Service are 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.<sup>17</sup>

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 Indian Health Service 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

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<sup>16</sup> 25 U.S.C. §1601.

<sup>17</sup> 25 U.S.C. §1602.

responsibility for Indian health, to implement the expressed policies, and to achieve the stated goals extend to the Centers for Medicare & Medicaid Services, as an agency of HHS.

## **B. 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. 1880<sup>18</sup> made IHS hospitals (including those operated by Indian tribes<sup>19</sup>) eligible to collect Medicare reimbursement.
- Sec. 1911<sup>20</sup> made IHS and tribal facilities eligible to collect reimbursements from Medicaid
- An amendment to Sec. 1905(b)<sup>21</sup> 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 application of a 100 percent 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*.<sup>22</sup> 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.<sup>23</sup>

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<sup>18</sup> 42 U.S.C. §1395qq.

<sup>19</sup> Tribes and tribal organizations are authorized to operate IHS-funded hospitals and clinics through contracts and compacts issued pursuant to the Indian Self-Determination and Education Assistance Act, 25 U.S.C. § 450, *et seq.*

<sup>20</sup> 42 U.S.C. §1396j.

<sup>21</sup> 42 U.S.C. §1396d(b).

<sup>22</sup> H.R. REP. No. 94-1026, pt. III, at 21 (1976), as reprinted in 1976 U.S.C.C.A.N. 2782, 2796.

<sup>23</sup> In fact, Congress expressly authorized the Secretary of HHS to issue standards to assure access by pharmacies operated by the IHS, tribes and urban Indian organizations 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

### C. 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).<sup>24</sup> 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.<sup>25</sup>

### D. Indian-Specific Provisions Designed to Ensure Indian Access to Medicaid, Medicare 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.<sup>26</sup> Significantly, Congress gave tribal documentation “tier I” status – the same as a U.S. passport. Individuals presenting tribal affiliation documentation would not be required to present any additional identity documentation.

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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 Affordable Care Act 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).

<sup>24</sup> 42 U.S.C. §2105(c)(6)(B); *see also* 25 U.S.C. §1647a.

<sup>25</sup> 42 U.S.C. §2103(a)(3)(D).

<sup>26</sup> 42 U.S.C. §1396b(x)(3)(B), as added by Sec. 211 of the Children’s Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3) (Feb. 4, 2009).

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.<sup>27</sup>
- *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.<sup>28</sup>
- *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.<sup>29</sup> 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 gave an Indian Medicaid enrollee the option to select an Indian health program as his/her primary care provider, and directed that Indian health providers (IHS, tribal and urban Indian organization programs) be paid at a rate not less than that of the managed care entity's

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<sup>27</sup> 42 U.S.C. §§1396o(j) and 1396o-1(b)(3)(vii), as added by Sec. 5006(a) of the American Recovery and Reinvestment Act of 2009 (P.L. 111-5) (Feb. 17, 2009). 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.

<sup>28</sup> 42 U.S.C. §§1396a(ff) and 1397gg(e)(1)(H), as added by Sec. 5006(b) of the American Recovery and Reinvestment Act of 2009 (P.L. 111-5) (Feb. 17, 2009).

<sup>29</sup> 42 U.S.C. §1396p(b)(3)(B), as added by Sec. 5006(c) of the American Recovery and Reinvestment Act of 2009 (P.L. 111-5) (Feb. 17, 2009).

network provider.<sup>30</sup> These changes were needed to overcome the reluctance of managed care entities to admit Indian health providers to their networks and to reimburse them for services provided to Indian Medicaid enrollees.

#### **E. Solicitation of Input from 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 to and solicitation of input from IHS, tribal health programs and urban Indian organizations. On the federal level, this requirement is to be carried out by CMS through maintenance of the Tribal Technical Advisory Group originally chartered by the agency in 2003.<sup>31</sup>

States are required 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.<sup>32</sup>

#### **F. Cap on Rates Charged for Contract Health 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.<sup>33</sup> 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.<sup>34</sup>

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<sup>30</sup> 42 U.S.C. §1396u-2(h), as added by Sec. 5006(d) of the American Recovery and Reinvestment Act (P.L. 111-5) (Feb. 17, 2009).

<sup>31</sup> 42 U.S.C. §1320b-24, as added by Sec. 5006(e)(1) of the American Recovery and Reinvestment Act (P.L. 111-5) (Feb. 17, 2009). The maintenance of the Tribal Technical Advisory Group does not substitute for government-to-government consultation with tribes.

<sup>32</sup> 42 U.S.C. §§1396a(a)(73) and 1397gg(e)(1)(C), as added by Sec. 5006(e)(2) of the American Recovery and Reinvestment Act (P.L. 111-5) (Feb. 17, 2009).

<sup>33</sup> 42 U.S.C. §1395cc(a)(1)(U), as added by the Medicare Modernization Act of 2003 (P.L. 108-173).

<sup>34</sup> 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.

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.

### **G. Indian-Specific Provisions Designed to Ensure Indian Access to the Health Insurance Exchanges**

The Patient Protection and Affordable Care Act (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 law 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.<sup>35</sup> 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 Indian Health Service. 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.
- Cost-Sharing Protections for Indians Enrolled in a Health Insurance Exchange Plan. The Affordable Care Act 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.<sup>36</sup>

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<sup>35</sup> 26 U.S.C. §5000A(e)(3).

<sup>36</sup> 42 U.S.C. §18071(d).

- 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.

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.<sup>37</sup> Courts have generally been reluctant to impose liability for the federal government's failure to provide social services under the general trust relationship.<sup>38</sup> One notable exception is the case of *Morton v. Ruiz*<sup>39</sup> where the Supreme Court said the Bureau of Indian Affairs 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.<sup>40</sup>

The IHCIA policy statements quoted above expressly recognize a trust responsibility to maintain and improve the health of Indians, and establish a national policy to assure the highest possible health status to Indians, as well as to provide all resources necessary to effect that policy. While currently there may be no available mechanism to enforce these policies judicially, this does not make them meaningless. They establish the goals which the Executive Branch -- particularly the Department of Health and Human Services -- must strive to achieve as it implements federal law. In fact, they justify -- indeed, require -- the Executive Branch to be proactive and use its

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<sup>37</sup> *Seminole Nation v. United States*, 316 U.S. 286, 297 (1942).

<sup>38</sup> *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).

<sup>39</sup> 415 U.S. 199 (1974).

<sup>40</sup> *Id.* at 236. *See also* Chambers, note 2, *supra*, at 1245-46 (arguing that courts should apply the trust responsibility as a "fairness doctrine" in suits against the United States for breach of a duty to provide social services).

resources "to assure 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 IHCIA, 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."<sup>41</sup>

## **B. CMS Administration of the Trust Responsibility**

As part of DHHS, and as an agency required to implement statutory provisions intended to benefit Indian health, CMS should affirmatively advance policy objectives as set out by Congress in the IHCIA 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 IHCIA. 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."<sup>42</sup> 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."<sup>43</sup> Though its consultation policy, CMS has committed to consulting with Indian tribes when developing policy that may affect Indians.

CMS has exercised its authority to administer federal health care programs and interpret the statutes within its jurisdiction in a manner that assures access by Indian people and participation by the unique Indian health delivery system. In recent decades, CMS (previously HCFA) has taken steps to carry out the trust responsibility to Indians in its administration of the Medicare,

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<sup>41</sup> *Federal Power Comm'n v. Tuscarora Indian Nation*, 362 U.S. 99, 142 (1960) (Black, J., dissenting),

<sup>42</sup> Centers for Medicare & Medicaid Services Tribal Consultation Policy (Nov. 17, 2011), at 1; U.S. Dep't of Health and Human Services Tribal Consultation Policy (Dec. 14, 2010), at 1.

<sup>43</sup> Centers for Medicare & Medicaid Services Tribal Consultation Policy (Nov. 17, 2011), at 2.

Medicaid, and CHIP programs. Each was a rational exercise of the agency's authority and fully justified by the United States' special obligations to Indian tribes.

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 percent 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 Medicare Modernization Act 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/AN in the 2010 amendments to the Indian Health Care Improvement Act.<sup>44</sup>
- *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

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<sup>44</sup> 25 U.S.C. §1647a.

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.<sup>45</sup> Congress subsequently made this consultation requirement statutory, adding State Plan Amendments and demonstration projects as requisite subjects of tribal consultation.<sup>46</sup> CMS informed the States of this consultation requirement on several occasions and codified the 2001 policy statement.<sup>47</sup> 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 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 IHS, tribal and urban Indian organization 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

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<sup>45</sup> Letter from Health Care Fin. Admin. To State Medicaid Directors (July 17, 2001) <http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/smd071701.pdf>.

<sup>46</sup> 42 U.S.C. §§1396a(a)(73) and 1397gg(e)(1)(C), as added by Sec. 5006(e)(2) of the American Recovery and Reinvestment Act (P.L. 111-5) (Feb. 17, 2009).

<sup>47</sup> CMS SMD #09-003 (June 17, 2009); CMS SMDL #10-001 (Jan. 22, 2010); 77 Fed. Reg. 11678 (Feb. 27, 2012).

pharmacies, such as Federal Tort Claims Act coverage (obviating the need for privately-purchased professional liability insurance).<sup>48</sup>

- Approval of Indian-specific State Medicaid Plan Provision. 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 percent 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.

Carrying out the trust responsibility to Indians in these and other ways coincides with and compliments 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.<sup>49</sup> 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.

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<sup>48</sup> 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.

<sup>49</sup> 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.

- 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.<sup>50</sup> 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 Indian Health Service. 42 C.F.R. §136.41-43.<sup>51</sup> 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. §450e(b).
- 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 Indian Health Service issued pursuant to the Indian Self-Determination and Education Assistance Act (ISDEAA). 25 U.S.C. §450 *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 Federal Tort Claims Act (FTCA). 25 U.S.C. §450f, note. 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. §450i.
- 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. §1616l. The Alaska Medicaid Plan reimburses Indian health programs

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<sup>50</sup> *See, e.g.,* Pub. L. No. 104-134, 110 Stat. 1321-190 (April 26, 1996).

<sup>51</sup> *See also* *Preston v. Heckler*, 734 F.2d 1359 (9th Cir. 1984) (upholding the Indian Health Service's Indian employment preference).

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 IHS, tribal and urban Indian organization programs.<sup>52</sup>
- *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 percent FMAP in recognition that the responsibility for Indian health care is a federal obligation. Sec. 1905(b) of SSA; 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.<sup>53</sup> Indian tribes determine their own governmental structure. They are not required to follow the U.S. model of separate legislative, executive, and judicial branches.

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<sup>52</sup> 25 U.S.C. §1623(b), as added by Sec. 2901(b) of the Affordable Care Act (P.L. 111-148) (Mar. 23, 2010).

<sup>53</sup> *See, e.g.*, Exec. Order No. 13175, "Consultation and Coordination with Indian Tribal Governments (Nov. 9, 2000) (issued by President Clinton and subsequently endorsed by Presidents George W. Bush and Barack Obama); White House Memorandum for Heads of Executive Departments and Agencies, Nov. 5, 2009 (President Obama endorsement); Dep't of Health and Human Services Tribal Consultation Policy (Dec. 14, 2010); Centers for Medicare and Medicaid Services Tribal Consultation Policy (Nov. 17, 2011).

- State law does not apply. By virtue of the Supremacy Clause, state laws generally do not apply to the IHS system.<sup>54</sup> 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. Arizona State Tax Comm'n*, 411 U.S. 1641 (1973). Indian tribal governments are not political subdivisions of states. Tribal facilities and their employees may not be required to have state licensure to perform their duties.
- 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 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, 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.

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<sup>54</sup> For example, Section 408 of the IHClA provides that an entity operated by IHS, an Indian tribe, tribal organization or urban Indian organization that meets state requirements for licensure must be accepted as a provider but is not required to obtain a state license. 25 U.S.C. §1647a.