

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

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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 and Medicaid Services (CMS) -- as evidenced by Presidential Executive Orders and Special Memoranda.¹ 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 IHS, CMS, or other agency of DHHS -- to take pro-active efforts to achieve the Indian health objectives Congress has articulated.

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.² 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.

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¹ See, e.g., Exec. Order No. 13,175, 65 Fed. Reg. 67,249 (Nov. 9, 2000), *reprinted in* 2000 U.S.C.C.A.N. at B77; Dept. of Health and Human Services Tribal Consultation Policy (Jan. 14, 2005); *Cramer v. United States*, 261 U.S. 219 (1923).

² *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 220-225 (1982); Reid Payton Chambers, *Judicial Enforcement of the Federal Trust Responsibility to Indians*, 27 STAN. L. REV. 1213, 1215-1220 (1975).

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/maintain public peace, and acquisition of land occupied by tribal inhabitants. 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:

"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]."³

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 should require 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.⁴ 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 superior sovereign from its responsibility to carry out its obligations honorably. As noted by the preeminent Indian law scholar, Felix S. Cohen --

"[W]here Congress is exercising its authority over Indians rather than some other distinctive power, the trust obligation apparently requires that its statutes be based on a determination that *the Indians will be protected*. Otherwise, such statutes would not be rationally related to the trustee obligation."⁵

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

³ 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 . . .").

⁴ An example is unilateral abrogation of Indian treaties by Congress. See, e.g., *Lone Wolf v. Hitchcock*, 187 U.S. 553 (1903).

⁵ FELIX S. COHEN, *HANDBOOK OF FEDERAL INDIAN LAW* 221 (1982) (emphasis added).

In pursuit of its authority under the Constitution and the trust responsibility, Congress has enacted Indian-specific laws on a wide variety of topics⁶ as well as included Indian-specific provisions in general laws to address Indian participation in federal programs.⁷ In the landmark 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 Act⁸) 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,⁹ 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. Here, 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

⁶ See, e.g., 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.*

⁷ 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 SCHIP 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 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 and 2005 amendments include funding set-asides for Indian reservation roads programs and direct development of regulations through Negotiated Rulemaking with tribes).

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

⁹ 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).

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).¹⁰

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).

Recognition of the federal trust responsibility in health laws

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.¹¹ Here, however, we focus on only one of those laws: the Indian Health Care Improvement Act (IHCIA).¹²

Enacted in 1976 as Public Law 94-437, the IHCIA 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;

¹⁰ 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) (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).

¹¹ *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.

¹² 25 U.S.C. §1601, *et seq.*

inadequate funding;¹³ 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.¹⁴

Eligibility for Medicare and Medicaid. It was in the 1976 IHCA that Congress, through amendments to the Social Security Act, extended to Indian health facilities the authority to collect Medicare and Medicaid reimbursements:

- Sec. 1880 made IHS hospitals (including those operated by Indian tribes¹⁵) eligible to collect Medicare reimbursement
- Sec. 1911 made IHS and tribal facilities eligible to collect reimbursements from Medicaid
- An amendment to Sec. 1905(b) applied a 100 percent 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% 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*.¹⁶ This action is consistent with the status of AI/ANs as a *political* designation.

Through amendments to Sec. 1880 made in 2000 and 2003, IHS and tribal hospitals and clinics are now 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.¹⁷

¹³ 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.

¹⁴ The IHCA 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.

¹⁵ 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.*

¹⁶ H.R. REP. NO. 94-1026, pt. III, at 21 (1976), *as reprinted in* 1976 U.S.C.C.A.N. 2782, 2796.

¹⁷ 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 new Medicare 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).

IHCIA findings and declaration of policy. The IHCIA law recognizes the United States' responsibility to provide "federal health services" to Indians in unequivocal terms:

"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."¹⁸

"The Congress hereby declares that it is the policy of this Nation, in fulfillment of its special responsibilities and legal obligation to the American Indian people, to assure *the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy.*"¹⁹

In 1992, Congress amended the IHCIA to enumerate 61 health status objectives for Indians that were to be met by the year 2000.²⁰

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 DHHS 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 also extend to the Centers for Medicare & Medicaid Services, as an agency of DHHS.

Federal trust responsibility and the Executive Branch

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.²¹ Courts have generally been reluctant to impose liability for the federal government's failure to provide social services under the general trust relationship.²² One notable exception is the case of *Morton v. Ruiz*²³ 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

¹⁸ Pub. L. No. 94-437, § 2(a) (Sept. 30, 1976); *codified at* 25 U.S.C. §1601(a).

¹⁹ Pub. L. No. 94-437, § 3(a) (Sept. 30, 1976); *codified at* 25 U.S.C. §1602(a) (emphasis added).

²⁰ Pub. L. No. 102-573 (1992). These objectives are codified at 25 U.S.C. §1602(b).

²¹ *Seminole Nation v. United States*, 316 U.S. 286, 297 (1942).

²² 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).

²³ 415 U.S. 199 (1974).

not consistent with the "distinctive obligation of trust incumbent upon the Government in its dealings" with Indians.²⁴

The IHCIA provisions 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 there may be no currently-available mechanism to judicially enforce these policies, 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 this federal law. In fact, they justify -- indeed, require -- the Executive Branch to act in a pro-active manner to use its resources "to assure the highest possible health status for Indians." 25 U.S.C. §1602(a). 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 of 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."²⁵

As part of DHHS, and as an agency required to implement statutory provisions intended to benefit Indian health, CMS should affirmatively advance the IHCIA objectives when making Indian health-related decisions in the Medicare and Medicaid programs. The trust responsibility and the federal law 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 has taken actions based on the trust responsibility. In recent years, HCFA/CMS has taken some steps to carry out the trust responsibility to Indians in its administration of the Medicare, Medicaid, and SCHIP programs. Each was a rational exercise of the agency's authority and justified by the United States' special obligations to Indian tribes.

A summary of these actions follows:

- In 1996, through a Memorandum of Agreement with IHS, HCFA re-interpreted the term "facility of the Indian Health Service" in Section 1911 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. <<http://www.cms.hhs.gov/aian/moafinal.pdf>>.
- The 1996 IHS/HCFA MOA incorporated the regulatory policy that states must accept as Medicaid providers IHS facilities who meet state requirements, but these facilities are not required to obtain a state license. 42 C.F.R. §431.110.

²⁴ *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).

²⁵ *Federal Power Comm'n v. Tuscarora Indian Nation*, 362 U.S. 99, 142 (1960) (Black, J., dissenting).

- In 1999, HCFA issued a guidance, followed by a proposed rule, to prohibit states from imposing any cost sharing on AI/AN children under SCHIP, 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 SCHIP 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 SCHIP 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. <<http://www.cms.hhs.gov/aian/11-07-00.asp>>.
- In January, 2001, the HCFA State Medicaid Manual was revised to protect from estate recovery certain Indian-specific property held by a deceased Indian Medicaid beneficiary. See Part 3 - Eligibility, 01-01 General Financial Eligibility Requirements and Options, Sec. 3810.A.7.
- 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. <<http://www.cms.hhs.gov/aian/081701a.pdf>>.
- 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. <http://www.cms.hhs.gov/aian/tl02-003_opps_120602.pdf>.
- In 2003, CMS chartered a Tribal Technical Advisory Group comprised of tribal leaders to advise the agency on Medicare, Medicaid, and SCHIP issues that impact Indian health programs.

Carrying out the trust responsibility to Indians in these and other ways coincides with and compliments CMS's stated program objectives, particularly the goal of improving "access to services for underserved and vulnerable beneficiary populations, including eliminating health disparities." <<http://www.cms.hhs.gov/about/mission.asp>>.

The uniqueness 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. 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 SCHIP 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 only American Indian/Alaska Native beneficiaries who fall within the eligibility criteria

established by the IHS. *See* 42 C.F.R. §136.12.²⁶ The IHS estimates the service population served by IHS and tribally-operated programs in more than 30 states is approximately 1.8 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.²⁷ IHS services at no cost to the Indian patient remains IHS policy today.
- Indian preference. Indian preference in hiring applies to the Indian Health Service. 42 C.F.R. §136.41-.43.²⁸ 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 get 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.
- Use of HHS personnel. To help staff their programs, tribes and tribal organizations are authorized by law to utilize employees of DHHS under Intergovernmental Personnel Act assignments and commissioned officers of DHHS 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 for Alaska, 25 U.S.C. §1616l. The Alaska Medicaid Plan reimburses Indian health programs for covered services provided by CHAPs in Alaska.
- Federal Tort Claims Act coverage. Pursuant to federal law, tribal health programs and their employees are covered by the FTCA. 25 U.S.C. §450f, note.
- IHS as payor of last resort. IHS is payor of last resort for eligible Indian beneficiaries, notwithstanding any state or local law to the contrary. 42 C.F.R. §136.61.
- 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.,* 70 Fed. Reg. 30,764 (May 27, 2005) (establishing reimbursement rates for calendar year 2005).
- 100% FMAP. Medicaid-covered services provided to AI/ANs in IHS and tribal facilities are reimbursed at 100% FMAP in recognition that the responsibility for Indian health care is a totally federal obligation. Sec. 1905(b) of SSA.

²⁶ 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.

²⁷ *See, e.g.,* Pub. L. No. 104-134, 110 Stat. 1321-190 (April 26, 1996).

²⁸ *See also* *Preston v. Heckler*, 734 F.2d 1359 (9th Cir. 1984) (upholding the Indian Health Service's Indian employment preference).

- 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. 25 U.S.C. §1621e(f).
- 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.²⁹ 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.³⁰ 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. 164 (1973). Indian tribal governments are not political subdivisions of states.
- 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 payors); as administrator of a health program with responsibilities for advising its patients about eligibility for Medicare, Medicaid, and SCHIP; 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 SCHIP in Indian Country in ways that assure full access by Indian beneficiaries and IHS/tribal providers.

²⁹ *See, e.g.,* Exec. Order No. 13,175, "Consultation and Coordination with Indian Tribal Governments (Nov. 9, 2000) (issued by President Clinton and subsequently endorsed by President George W. Bush); Dept. of Health and Human Services Tribal Consultation Policy (Jan. 14, 2005); CMS Consultation Strategy, <<http://www.cms.hhs.gov/aian/conpl2.asp>>.

³⁰ For example, CMS regulations provide that IHS facilities who meet state requirements for Medicaid participation must be accepted as a Medicaid provider but are not required to obtain a state license. 42 C.F.R. §431.110.