Tribal Technical Advisory Group
To the Centers for Medicare & Medicaid Services
c/o National Indian Health Board 910 Pennsylvania Avenue, SE Washington, DC 20003 (202) 507-4070 (202) 507-4071 fax

February 14, 2018

Administrator Seema Verma
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: <u>Exemption of Indian Health Service (IHS) Beneficiaries from Medicaid Work and Community Engagement Requirements</u>

Dear Administrator Verma:

On behalf of the CMS Tribal Technical Advisory Group (TTAG)[1] to the Centers for Medicare and Medicaid Services (CMS), I write to you in response to the January 17, 2018 Dear Tribal Leader Letter (DTLL) on the recently released Dear State Medicaid Director (SMD: 18-002) letter, entitled *RE: Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries.* In the DTLL, CMS Director Brian Neale stated that CMS could not approve exempting IHS beneficiaries from Section 1115 Demonstration waivers that impose mandatory Medicaid work and community engagement requirements because of civil rights concerns. In addition, on that same day on January 17th, in a meeting with the Department of Health and Human Services' Secretary's Tribal Advisory Committee (STAC), you indicated that the Office of Civil Rights objected to such an exemption because of their interpretation that an exemption could not be given on the basis of "race."

As you know, Tribes have been universally opposed to such requirements[2] and strongly disagree with the interpretation by the Office of Civil Rights. In order to better illustrate this point, the attached memo was created at the request of Tribes to illustrate why CMS has the authority to issue an exemption for IHS beneficiaries that does not raise Civil Rights concerns and is required to do so.

We remind you that American Indians and Alaska Natives (AI/AN) are among the nation's most vulnerable populations, and rely heavily on the IHS for health care. However, the IHS is currently funded at around 60% of need,[3] and average per capita spending for IHS patients is only $3,688

[1] The TTAG advises CMS on Indian health policy issues involving Medicare, Medicaid, the Children's Health Insurance Program, and any other health care programs funded (in whole or part) by CMS. In particular, TTAG focuses on providing policy advice to CMS regarding improving the availability of health care services to American Indians and Alaska Natives (AI/AN) under these federal health care programs, including through providers operating under the health programs of the Indian Health Service (IHS), Tribes, Tribal organizations, and Urban Indian organizations (I/T/Us or Indian health care providers).
[2] See CMS-TTAG Letter to Seema Verma, *RE: Medicaid Work Requirements in Indian Country*, May 2, 2017
[3] See Indian Health Service, Frequently Asked Questions, https://www.ihs.gov/forpatients/faq/.

compared with $9,523 nationally.[4] Most of AI/AN's live in areas of chronic unemployment, which leaves many of them without any form of coverage other than Medicare and Medicaid. Without supplemental Medicaid resources, the Indian health system will not survive. It is critically important that CMS and HHS work with Tribes to provide a blanket exemption for IHS beneficiaries from any Section 1115 Demonstration waivers that impose mandatory Medicaid work and community engagement requirements.

Thank you for considering the unique circumstances of Tribes as you evaluate State demonstration waivers that contain work requirements. We look forward to consulting with you further on this issue.

Sincerely,

W. Ron Allen, Chair,
Tribal Technical Advisory Group

cc:

Roger Severino, Director, Office of Civil Rights, Department of Health and Human Services

Calder Lynch, Senior Counselor to the Administrator, Centers for Medicare and Medicaid Services

Stacey L. Ecoffey, Principal Advisor for Tribal Affairs, Office of Intergovernmental Affairs, Immediate Office of the Secretary, Department of Health and Human Services

Kitty Marx, Director, CMCS Division of Tribal Affairs, Centers for Medicare and Medicaid Services

Attachments:

1. Memo on the Constitutionality of the Indian Health Care System
2. Appendix A: Indian-Specific Exemptions in Approved Section 1115 Waivers
3. Appendix B: CMS Administration of the Trust Responsibility

[4] Indian Health Service, IHS 2016 Profile, https://www.ihs.gov/newsroom/factsheets/ihsprofile/.

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MEMORANDUM

February 12, 2018

To: Centers for Medicare and Medicaid Services

From: Hobbs, Straus, Dean & Walker LLP

Re: *Constitutionality of Indian Health Care System*

Over the past several years, the Centers for Medicare and Medicaid Services (CMS) has declined to approve State Medicaid Demonstration Waivers and Medicaid State Plan Amendments that make necessary accommodations for beneficiaries of the Indian Health Service, citing "civil rights concerns." Most recently, on January 17, 2018, CMS Director Brian Neale provided Tribes with a Dear Tribal Leader's Letter that stated that CMS could not approve exempting IHS beneficiaries from Section 1115 Demonstration Waivers that impose mandatory Medicaid work and community engagement requirements. In his letter, Director Neale recognized that Tribes have requested exemptions from such requirements, but stated that CMS could not approve them because CMS is "constrained by statute" and because CMS is "concerned that requiring states to exempt AI/ANs could raise civil rights concerns." No explanation or analysis was provided to support this far reaching conclusion. On an All Tribes' Call held on February 1, 2018, CMS took the position that it may only make such an accommodation for IHS beneficiaries when Congress has enacted a statute authorizing it.

CMS is incorrect. To begin with, Congress has already enacted a statute requiring CMS to support the Indian health system through the Medicaid program. Enacted over 40 years ago, Section 1911 of the Social Security Act authorizes IHS and tribally operated programs to bill the Medicaid program. Section 1911 was enacted provide supplemental federal funding to the Indian health system and designed to ensure that Medicaid funds would "flow into IHS institutions."

CMS has ample legal authority to single out IHS beneficiaries for special treatment in administering the statutes under its jurisdiction if doing so is rationally related to its unique trust responsibility to Indians. Under familiar principles of Indian law, such actions are political in nature, and as a result do not constitute prohibited race based classifications. This principle has been recognized and repeatedly reaffirmed by the Supreme Court and every Circuit Court of Appeals that has considered it, and has been extended to the actions of Administrative Agencies like the Department of Health and Human Services (HHS) even in the absence of a specific statute. In fact, HHS regulations implementing Title VI of the Civil Rights Act recognize and implement this

principle with respect to the Indian health system.[1]

Mandatory work and community engagement requirements will create a barrier to access to Medicaid that is unique to IHS beneficiaries. Unlike other Medicaid enrollees, IHS beneficiaries have access to the IHS system at no cost to them. Faced with mandatory work and community engagement requirements that do not accommodate or account for Tribal programs, American Indian and Alaska Native Medicaid enrollees can and will simply choose to no longer participate in the Medicaid program. That, in turn, will deprive the Indian health system of Medicaid resources in a manner that is contrary to Congressional intent in Section 1911 of the Social Security Act and which will thwart, rather than advance, the objectives of the Medicaid statute for Indian health.

Congress has declared that "it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians … to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy."[2] While Medicaid is a statute of general applicability, CMS has a duty to implement the law in a manner that accommodates the unique needs of the Indian health system and the beneficiaries it serves. Doing so is consonant with CMS's general obligations to advance Indian health, is not "constrained by statute," and does not raise any "civil rights concerns." CMS has ample legal authority to make accommodations to ensure that work and community engagement requirements do not pose a barrier to access to Medicaid for IHS beneficiaries when exercising administrative discretion in reviewing pending State Section 1115 Demonstration applications. CMS has made such accommodations in the past when exercising administrative discretion in the absence of a statute, and should do so once again.

I. Indian Tribes are political, sovereign entities to which the federal government owes a trust responsibility

Indian tribes are political, sovereign entities whose status stems from the inherent sovereignty they possess as self-governing people predating the founding of the United States,[3] and since its founding the United States has recognized them as such.[4] As the Supreme Court explained in 1876, "from the commencement of its existence [and following the practice of Great Britain before the revolution], the United States has negotiated with the Indians in their tribal condition as nations."[5] The United States entered into the first treaty with an Indian tribe in 1778. Once the Constitution was ratified, President George Washington worked with the Senate to ratify treaties in the late 1780s, thereby establishing that treaties with Indian tribes would utilize the same political

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[1] 45 C.F.R. § 80.3(d).
[2] 25 U.S.C. § 1602(a)(1).
[3] *See Worcester v. State of Ga.*, 31 U.S. 515 (1832).
[4] *See Morton v. Mancari*, 417 U.S. 535 (1974).
[5] *United States v. Forty-Three Gallons of Whiskey*, 93 U.S. 188, 196 (1876).

process that treaties with foreign nations must go through.[6] Although treaty making with Indian tribes formally ended in 1871, the federal government has continued to interact with Indian tribes as political entities through statutes and administrative actions. Early Supreme Court decisions also confirmed the status of Tribes as political entities operating within the confines of the United States.[7]

Through treaty making and its general course of dealings, the United States took on a special and unique trust responsibility for Indians and Indian tribes.[8] In entering into those treaties, Indian tribes as political entities had exercised their sovereignty by bargaining for what they could in exchange for portions of their land or other concessions—all with the goal of providing for their people under the circumstances they faced. In turn, treaty promises made by the federal government helped to shape the young country's view of its responsibilities to Indians and Indian tribes. As the Supreme Court recently noted, although the federal trust responsibility to Indian tribes is not the same as a private trust enforceable under common law, "[t]he Government, following a humane and self imposed policy . . . has charged itself with moral obligations of the highest responsibility and trust."[9]

II. The Federal Government May Lawfully Carry Out Its Trust Responsibility By Singling Out Indians and Indian Tribes for Special Treatment

The Constitution recognizes that Indian tribes have a unique political status within our federal system. The federal government is said to have broad "plenary" power over Indian affairs drawn explicitly and implicitly from the Constitution, including the Indian commerce clause,[10] the treaty clause,[11] and other provisions, as well as "the Constitution's adoption of preconstitutional powers necessarily inherent in any Federal Government" and the general relationship between the United States and Indian tribes.[12]

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[6] COHEN'S HANDBOOK OF FEDERAL INDIAN LAW 31–32 (Nell Jessup Newton et al. eds., 2012 ed.); *see also Marks v. United States*, 161 U.S. 297, 302 (1896).
[7] *Worcester v. State of Ga*, 31 U.S. 515 (1832); *Cherokee Nation v. State of Ga.*, 30 U.S. 1 (1831); *Johnson v. McIntosh*, 21 U.S. 543 (1823).
[8] *See Morton v. Mancari*, 417 U.S. at 552; *United States v. Kagama*, 118 U.S. 375, 384 (1886); *Cherokee Nation v. State of Ga*, 30 U.S. 1.
[9] *United States v. Jicarilla Apache Nation*, 564 U.S. 162, 176 (2011) (omitting internal quotations) (*quoting Seminole Nation v. United States*, 316 U.S. 286, 296–97 (1942)).
[10] U.S. CONST., art. I, § 8, cl. 3.
[11] U.S. CONST., art. II, § 2, cl. 2.
[12] *United States v. Lara*, 541 U.S. 193, 200–01 (2004); *see also Morton v. Mancari*, 417 U.S. at 551–52; *McClanahan v. State Tax Comm'n of Arizona,* 411 U.S. 164, 172 n.7 (1973); *United States v. Holliday*, 70 U.S. 407, 418 (1865); H.R. CON. RES. 331, 100th Cong. (1988) (reaffirming government-to-government relationship with Indian tribes recognized in Constitution).

In 1974, the Supreme Court in *Morton v. Mancari* held that the federal government could lawfully treat Indians and Indian tribes differently from other groups in carrying out the trust responsibility without running afoul of United States Constitution's equal protection clause.[13] The Court explained that such treatment is not directed at a suspect racial classification but rather at a unique and non-suspect class that is based on a political relationship with tribal entities recognized as separate sovereigns in the Constitution.[14] The Court noted that "there is no other group of people favored in this manner."[15] Thus, while the Supreme Court's civil rights jurisprudence has generally applied strict scrutiny when reviewing classifications based on race, color, or national origin,[16] the Court in *Mancari* held that the strict scrutiny test was not appropriate when reviewing the Indian employment preference law at issue in that case.[17] The Court explained that the analysis instead "turns on the unique legal status of Indian tribes under federal law and upon the plenary power of Congress [drawn from the Constitution], based on a history of treaties and the assumption of a 'guardian-ward' status, to legislate on behalf of federally recognized Indian tribes."[18] The Court went on to mandate that, "[a]s long as the special treatment [for Indians] can be tied rationally to the fulfillment of Congress' unique obligation toward the Indians, such legislative judgments will not be disturbed."[19]

The Supreme Court's conclusion that the federal government can treat Indians and Indian tribes differently from other citizens based on a political rather than racial status acknowledges that Indian tribes are political sovereigns (and Indians are members of those political sovereigns). Following *Morton v. Mancari*, the Supreme Court has explained that the federal government is not acting on behalf of a "racial group consisting of Indians," but instead the different treatment is "rooted in the unique status of Indians as a separate people with their own political institutions" and in Indian tribes' status as "quasi-sovereign tribal entities."[20]

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[13] 417 U.S. 535 (1974). This memorandum focuses on the federal government's different treatment of Indians and Indian tribes. However, courts have made clear that state action implementing federal law aimed at furthering the federal government's trust responsibility is subject to the same rational basis equal protection test. *See, e.g., Washington v. Confederated Bands and Tribes of the Yakima Indian Nation*, 439 U.S. 463 (1979).
[14] *Id.* at 553–55.
[15] *Id.* at 554.
[16] The Supreme Court has interpreted Title VI of the Civil Rights Act, 42 U.S.C. §§2000d et seq., to allow racial and ethnic classifications only if those classifications are permissible under the equal protection clause. *Regents of Univ. of Cal. v. Bakke*, 438 U.S. 265, 287 (1978). The Court has stated that "all racial classifications, imposed by whatever federal, state, or local governmental actor, must be analyzed by a reviewing court under strict scrutiny. In other words, such classifications are constitutional only if they are narrowly tailored measures that further compelling governmental interests." *Adarand Constructors, Inc. v. Pena*, 515 U.S. 200, 227 (1995).
[17] 417 U.S. at 553–55.
[18] *Id.* at 551.
[19] *Id.* at 555.
[20] *United States v. Antelope*, 430 U.S. 641, 645–46 (1977) (omitting internal quotations).

As former Supreme Court Justice Antonin Scalia acknowledged in an opinion he authored for the United States Court of Appeals for the D.C. Circuit, Indians and Indian tribes do not qualify as a suspect classification for purposes of an equal protection analysis because the "Constitution itself establishes the rationality of the present classification" through its "provi[sion of] a separate federal power which reaches only the present group."[21] In its decision in *United States v. Antelope*, the Supreme Court explained:

> 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.[22]

Since *Mancari*, Courts have continuously upheld the principle that federal actions that single Indians and Indian tribes out do not unconstitutionally target a racial classification, including actions other than the Indian hiring preference at issue in *Mancari*. The Supreme Court has done so many times,[23] every United States Circuit Court of Appeals that has discussed the issue has affirmed this principle,[24] courts continue to employ it today,[25] and courts have confirmed that applies equally in the context of agency action.[26]

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

[22] 430 U.S. at 645.

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

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

[25] Even within this decade, many courts have applied the principle. *See, e.g.*, *E.E.O.C. v. Peabody W. Coal Co.*, 773 F.3d 977, 987–88 (9th Cir. 2014); *KG Urban Enterprises, LLC v. Patrick*, 693 F.3d at 17–20; *United States v. Wilgus*, 638 F.3d at 1286–87.

[26] *See, e.g.*, *EEOC v. Peabody W. Coal Co.*, 773 F.3d 977, 982–89 (9th Cir. 2014) (upholding federal agency approval of company's lease to mine coal on Indian tribes' reservations that included hiring preference for tribal members); *United States v. Decker*, 600 F.2d 733, 740–41 (9th Cir.1979) (upholding

The United States Department of Justice has routinely and successfully defended the principle that the federal government's treatment of Indians and Indian tribes differently from other citizens does not unconstitutionally involve a prohibited racial classification.[27] For example, in a 2006 Supreme Court brief, the Department stated the Supreme Court has "consistently rejected equal protection challenges to Acts of Congress that treat tribally-affiliated Indians differently from other persons" on the basis "that such laws are based not on impermissible racial classifications, but on the unique status of Indians as a separate people with their own political institutions" as recognized in the Constitution.[28]

To find that federal actions targeted at Indians and Indian tribes violate the Constitution's equal protection clause would have drastic impacts on the federal government's ability to carry out its trust responsibilities to Indians and Indian tribes, and would be entirely inconsistent with well-settled law. As the Supreme Court recognized, if the United States' different treatment of Indians and Indian tribes "were deemed invidious racial discrimination, an entire Title of the United States Code (25 U.S.C. [containing Indian laws]) would be effectively erased and the solemn commitment of the Government toward the Indians would be jeopardized."[29]

III. The Civil Rights Act and the Affordable Care Act do not prohibit the federal government from carrying out its trust responsibility to provide Indians and Indian tribes with healthcare

The Civil Rights Act and the Affordable Care Act prohibit discrimination based on race in the healthcare context. The Civil Rights Act of 1964 broadly prohibits race-based discrimination, stating:

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federal agency regulation enacted to implement tribes' treaty fishing rights and international treaty); *Parravano v. Babbit*, 861 F.Supp. 914, 926–28 (N.D. Cal. 1994) (upholding federal agency authorization via regulation of fish harvest for tribal members); *see also United States v. Michigan*, 471 F.Supp. 192, 270–71 (W.D. Mich. 1979) (finding state compliance with federal agency regulation protecting Indians' treaty rights would not violate equal protection clause).

[27] *See, e.g.*, Brief for Federal Respondents in Opposition to Petition for Writ of Certiorari, *AirStar Helicopters, Inc. v. F.A.A.*, 538 U.S. 977 (2003) (No. 02-931), 2003 WL 21698173; Brief for the United States as Amicus Curiae Supporting Respondents on Writ of Certiorari, *Duro v. Reina*, 495 U.S. 676 (1990) (No. 88-6546), 1989 WL 1126957; Brief for the Secretary of Interior, *Delaware Tribal Bus. Comm. v. Weeks*, 430 U.S. 73 (1977) (No. 75-1301), 1976 WL 194271.

[28] Brief for United States in Opposition to Writ of Certiorari, *Means v. Navajo Nation*, 549 U.S. 952 (2006) (No. 05-1614), 2006 WL 2453502, at *7 (quoting *United States v. Antelope*, 430 U.S. at 646-647) (omitting internal quotations). The United States Court of Appeals for the Ninth Circuit had upheld the statute at issue as complying with the equal protection clause based on the principle in *Morton v. Mancari*. *Means v. Navajo Nation*, 432 F.3d at 932–933. The Supreme Court denied a petition for certiorari. *Means v. Navajo Nation*, 549 U.S. 952 (2006).

[29] *Morton v. Mancari*, 417 U.S. at 552. The same would be true of Title 25 and portions of Title 42 of the Code of Federal Regulations.

> No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.[30]

The Affordable Care Act incorporates this prohibition from the Civil Rights Act into the healthcare context, stating:

> Except as otherwise provided for in this title (or an amendment made by this title), an individual shall not, on the ground prohibited under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), the Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.), or section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title (or amendments). The enforcement mechanisms provided for and available under such title VI, title IX, section 504, or such Age Discrimination Act shall apply for purposes of violations of this subsection.[31]

HHS has promulgated a regulation carrying out the statutory prohibition against race-based discrimination, stating "[n]o person in the United States shall, on the ground of race, color, or national origin be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program to which this part applies."[32] However, it recognizes that individuals may not be deemed to be subject to racial discrimination because they are excluded from participating in programs limited to individuals of a different race or national origin such as those operated by the Indian Health Service.[33]

Neither the Civil Rights Act's nor the Affordable Care Act's provisions prohibiting racial discrimination apply on their face to federal actions singling out Indians and the Indian health care system for different treatment. This is because federal actions that carry out the federal trust responsibility do not constitute racial discrimination. As outlined above, such actions are not directed at a suspect racial classification for purposes

[30] 42 U.S.C. § 2000d.
[31] 42 U.S.C. § 18116(a).
[32] 45 C.F.R. § 80.3(a).
[33] 45 C.F.R. § 80.3(d).

of an equal protection analysis. Although the Supreme Court has interpreted the Civil Rights Act as incorporating equal protection jurisprudence regarding suspect classifications,[34] federal actions directed at Indians and Indian tribes that carry out the federal trust responsibility to Indians do not identify a suspect class and do not constitute race-based discrimination pursuant to the Civil Rights Act.[35]

The Supreme Court in *Morton v. Mancari* addressed the issue of whether the Indian hiring preference violated the prohibitions against race-based discrimination found in the Civil Rights Act and then in the 1972 amendments of the Equal Employment Opportunity Act, although it did so in the context of discrimination in employment.[36] It determined that the later-enacted statutory prohibitions against race-based discrimination in hiring did not repeal the earlier-enacted Indian hiring preference.[37] It found that the hiring preference at issue "did not constitute racial discrimination of the type otherwise proscribed."[38] According to the Court, to categorize the Indian hiring preference as violating the statutory prohibition against race-based discrimination would be "formalistic reasoning that ignores both the history and purposes of the preference and the unique legal relationship between the Federal Government and tribal Indians."[39] Therefore, neither the Civil Rights Act nor the Affordable Care Act prohibit special accommodations for Indians or Indian tribes in the healthcare context.

IV. Congress and the Department of Health and Human Services May Lawfully Create Indian Specific Programs to Help Fulfill the United States' Trust Responsibility to Provide for the Health Care of Indians

Congress has authorized appropriations and enacted numerous Indian specific laws to fulfill its trust responsibility to provide for the health care of Indian people. Congress has also enacted numerous Indian-specific provisions in laws of general applicability to accommodate the unique aspects of the Indian health system and the Indian people it serves. Federal agencies, including HHS, have taken action to accommodate the Indian health system and individual Indians in laws of general applicability. Such accommodations are political rather than racially-based and are rationally tied to the United States' trust responsibility to provide for the health care of

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[34] *See Regents of Univ. of California v. Bakke*, 438 U.S. at 287.
[35] *See EOC v. Peabody W. Coal Co.*, 773 F.3d 977, 989 (9th Cir. 2014) (examining Civil Rights Act's prohibition against discrimination in employment).
[36] *Morton v. Mancari*, 417 U.S. at 545–551 (holding Equal Employment Opportunity Act did not repeal Indian hiring preference, and citing as one reason that Congress included exemption for certain Indian hiring preferences in Civil Rights Act, which was made applicable to federal government through Equal Employment Opportunity Act did).
[37] *Id.*
[38] *Id.* at 548.
[39] *Id.* at 550.

Indians. As a result, they are lawful under rational basis review, and pose no implications with regard to federal civil rights laws.

Following is a brief summary of the types of Indian-specific legislation and administrative actions undertaken by Congress and the Department of Health and Human Services and its agencies.[40]

Congressional Action – Indian specific legislation

Since its inception, Congress has enacted Indian specific legislation on a wide variety of topics.[41] Congress initially provided for the health care of Indians through the ratification of treaties that specifically obligated the United States to provide care for Indians, including health care, and through discretionary appropriations. By 1871, when Congress ceased treaty making and instead dealt with Tribes through statute, at least 22 treaties had obligated the United States to provide for some type of medical service.[42] Congress continued to address Indian health through a patchwork of appropriations and statutory authority, and in 1921 enacted the Snyder Act, which authorized the Bureau of Indian Affairs to carry out programs "[f]or relief of distress and conservation of health" among Indians.[43] In 1954, Congress enacted legislation that transferred responsibility for Indian health to the Public Health Service.[44]

In 1976, Congress enacted the Indian Health Care Improvement Act (IHCIA) to bring statutory order and direction to the delivery of health services to Indians, stating that "[f]ederal 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 trust responsibility to, the American Indian people."[45] The law provided significant new Indian health care delivery authorities to the Indian health service, authorized grants and scholarship programs for Indians to enter the health professions, authorized appropriations for the construction of new facilities, and authorized the Urban Indian Health program, among other things.[46]

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[40] A more detailed summary is also provided in Appendix B of the CMS TTAG Strategic Plan, attached hereto.
[41] *See, e.g.,* Indian Health Care Improvement Act, 25 U.S.C. § 1601, *et seq*.; Indian Self-Determination and Education Assistance Act, 25 U.S.C. §§ 5301, *et seq*. (formerly 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.*
[42] U.S. Pub. Health Serv., Health Services for American Indians 86 (1957).
[43] 25 U.S.C. § 13.
[44] Pub. L. No. 83-568, c. 658, §1, 68 Stat. 674 (codified as amended at 42 U.S.C. § 2001).
[45] 25 U.S.C. § 1601(1). The IHCIA has been periodically reauthorized and amended since 1976, and was comprehensively amended and authorized as a permanent law of the United States in 2010. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 10221 (Mar. 23, 2010).
[46] 25 U.S.C. §§ 1601, *et seq*.

That same year, Congress enacted the Indian Self-Determination and Education Assistance Act (ISDEAA), which authorizes Tribes to take over federal programs for Indians, including health programs, by contracting with the federal government.[47] In 1988, Congress expanded the program by enacting the Tribal Self-Governance Demonstration Project, which provided tribes greater flexibility in the administration of programs under the Act.[48] That authority was made permanent as to the Indian Health Service in 2000.[49]

Congress has also authorized health care delivery providers found only in the Indian health care system,[50] provided for Indian hiring preference,[51] and authorized Indian tribes and tribal organizations to use HHS employees in their facilities.[52]

Congressional Action – Laws of General Applicability

Congress has also enacted Indian-specific provisions in laws of general applicability to ensure Indian participation in federal programs.[53] In 1976 Congress amended the Social Security Act to authorize Indian health facilities operated by either IHS or Indian tribes that have contracted under the Indian Self-Determination and Education Assistance Act to collect Medicaid and Medicare reimbursements.[54] At the

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[47] 25 U.S.C. §§ 5301, *et seq*. (formerly 25 U.S.C. §§ 450, *et seq*.)
[48] Pub. L. No.100-472 § 209, 102 Stat. 2285.
[49] Pub. L. 106-260 § 4, 114 Stat. 713 (codified at 25 U.S.C. §§ 5381, *et seq.*).
[50] *See* 25 U.S.C. §§ 1616, 1616*l*.
[51] 25 U.S.C. § 5307(b) (formerly 25 U.S.C. § 450e(b)); 42 C.F.R. §§ 136.41-136.43,
[52] 25 U.S.C. § 5323 (formerly cited as 25 U.S.C. § 450i)
[53] *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 Start Act, 42 U.S.C. § 9801, *et seq.* (includes funding allocation for Indian tribal programs and special criteria for program eligibility); Federal Highway Act, 23 U.S.C. § 101, *et seq.* (1998, 2005, 2008 and 2012 amendments include funding set-asides for Indian reservation roads programs and direct development of regulations through Negotiated Rulemaking with tribes); American Recovery and Reinvestment Act of 2009, Pub. L. No. 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, Pub. L. No. 111-148 (Mar. 23, 2010) (various Indian specific provisions, discussed below).
[54] 42 U.S.C. §§ 1395qq, 1396j.

same time, Congress amended Sec. 1905(b)[55] of the Social Security Act to ensure States would not bear the burden of costs associated with doing so by applying a 100 percent federal medical assistance percentage (FMAP) to Medicaid services provided to an Indian by an IHS or tribally-operated facility. These actions were undertaken with the understanding that, since the United States has a trust obligation to provide health care services to Indians, it was appropriate for the United States to provide Indians health care services as Medicaid beneficiaries.[56]

Similarly, in 1997 Congress included provisions in the Children's Health Insurance Program (CHIP) to authorize IHS and tribal health providers to collect payments[57] and require states to describe in their state plans the procedures they will use to ensure access for low income Indian children[58]. In 2009, Congress acted to remove several barriers to full and fair participation by Indians and Indian health providers in the Medicaid program by enacting several Indian specific provisions.[59]

In 2009, Congress codified an existing regulatory requirement that CMS provide prior notice to and solicit input from IHS, tribal health programs and urban Indian health programs on any proposed changes to Medicare, Medicaid and CHIP. On the federal level, this requirement is carried out by CMS through the Tribal Technical Advisory Group originally chartered by the agency in 2003.[60] In addition, Congress imposed an obligation on the States to solicit advice from IHS and tribal health programs and urban Indian organizations within their borders prior to submission of any state plan amendments, waiver requests and demonstration projects to CMS.[61]

Congress has also enacted Indian specific provisions designed to maximize the resources of the Indian health system. In 2003, Congress enacted a limitation on the

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[55] 42 U.S.C. § 1396d(b).
[56] See H.R. REP. No. 94-1026, pt. III, at 21 (1976), as reprinted in 1976 U.S.C.C.A.N. 2782, 2796.
[57] 42 U.S.C. § 1397ee(c)(6)(B); see also 25 U.S.C. § 1647a,
[58] 42 U.S.C. § 2103(a)(3)(D).
[59] *See, e.g.,* 42 U.S.C. § 1396u-2(h) (giving Indian Medicaid enrollee option to select Indian health program as primary care provider and mandating that IHS, tribal, and urban Indian organization programs be paid at rate not less than that of managed care entity's network provider); 42 U.S.C. § 1396b(x)(3)(B) (permitting documents issued by federally recognized Indian tribe evidencing individual's membership, enrollment in, or affiliation with tribe as satisfactory documentation of United States citizenship for purposes of enrollment in Medicaid or CHIP); 42 U.S.C. §§ 1396o(j), 1396o-1(b)(3)(vii) (prohibiting states from imposing any premium or cost-sharing on Indian for covered service provided by IHS, health program operated by Indian tribe, tribal organization, or urban Indian organization, or through referral under contract health services); 42 U.S.C. §§ 1396a(ff);1397gg(e)(1)(H) (exempting from resources calculation certain enumerated types of Indian property); 42 U.S.C. §1396p(b)(3)(B).(exempting certain Indian-related income, resources, and property held by deceased Indian from Medicaid estate recovery requirement).
[60] 42 U.S.C. §1320b-24, as added by Sec. 5006(e)(1) of the American Recovery and Reinvestment Act (Pub. L. No. 111-5) (Feb. 17, 2009). The maintenance of the Tribal Technical Advisory Group does not substitute for government-to-government consultation with tribes.
[61] 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).

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.[62]

V. CMS and HHS Have A Duty to Accommodate Indian Interests in Administering Federal Statutes

It has long been established that the Executive Branch is responsible for carrying out the federal trust responsibility to provide health care to Indians. While courts have generally been reluctant to impose liability on the United States for failing to provide social services under the general trust relationship, Congress has set goals for the Executive Branch it is the duty of its agencies to uphold. For example, the Indian Health Care Improvement Act provides that the United States is "to ensure the highest possible health status for Indians and urban Indians and to provide all resources to effect that policy."[63]

HHS and CMS have a duty to advance those broad Congressional objectives when administering the federal healthcare programs they oversee. The trust responsibility and the federal laws enacted to carry it out not only permit CMS to treat Indians served by the Indian health system as unique Medicare, CHIP and Medicaid enrollees entitled to special accommodation and treatment, they require it. Both the CMS and HHS Tribal Consultation policies recognize this trust responsibility:

> 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 …[64]

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[62] 42 U.S.C. §1395cc(a)(1)(U), as added by the Medicare Modernization Act of 2003 (P.L. 108-173).
[63] 25 U.S.C. § 1602(1).
[64] DEP'T OF HEALTH AND HUMAN SERVICES, TRIBAL CONSULTATION POLICY (2010) at 1–2, www.hhs.gov /sites/default/files/iea/tribal/tribalconsultation/hhs-consultation-policy.pdf; CENTERS FOR MEDICARE AND MEDICAID SERVICES, TRIBAL CONSULTATION POLICY (2011) at 1; www.cms.gov/ Outreach-and-Education/American-Indian-Alaska-Native/AIAN/Downloads/CMSTribalConsultation Policy2015 .pdf.

In carrying out that responsibility, CMS has an ongoing duty to ensure that Indians have maximum access to the major programs it oversees; "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."[65]

Over the years, CMS has taken numerous executive actions to administer federal health care programs and interpret statutes and regulations within its jurisdiction in a manner that ensures access by Indian people and full participation by the Indian health system. In recent years, CMS (previously HCFA) has taken concrete steps to carry out the federal trust responsibility in administering Medicare, Medicaid and CHIP. CMS has accommodated the unique needs of the Indian health system, through numerous regulations, guidance, policy, State Medicaid Director Letters, and its consideration of State Plan Amendments and Section 1915 and 1115 Demonstration Waivers.[66]

Each one of these actions was targeted to Indians as a political class and rationally related to the administration of federal health care programs in a manner consistent with the federal trust responsibility. As such, they do not violate the Civil Rights Act of 1964, the non-discrimination provisions of the Affordable Care Act, or any other civil rights statute, nor do they raise any "civil rights concerns."

VI. Exempting Indians from Work and Community Engagement Requirements is Lawful and Necessary

At least four States (Arizona, Utah, Arkansas and Indiana) have recognized that mandatory community engagement and work requirements would create a unique barrier to access to Medicaid enrollment for Indian Medicaid enrollees. As a result, they have proposed exempting AI/AN from such requirements in pending State Demonstration Waivers (Arizona, Utah and Arkansas), or have deemed tribal programs to meet such requirements (Indiana). As previously noted, the January 17, 2018 Dear Tribal Letter from CMS Director Brian Neale states that CMS cannot approve a waiver that exempts American Indians and Alaska Natives because CMS is "constrained by statute" and that CMS is "concerned that requiring states to exempt AI/ANs could raise civil rights concerns."

As discussed above, there is no federal statute that "constrains" the authority of CMS to administer the Medicaid program in a manner that ensures that American Indians and Alaska Natives can maintain access to it. Nor does administering the Medicaid program to account for the unique needs of AI/ANs raise any civil rights concerns. Rather, as the courts have repeatedly confirmed, CMS is well within its authority to make

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[65] CENTERS FOR MEDICARE & MEDICAID SERVICES, TRIBAL CONSULTATION POLICY at 2.
[66] Appendix A "Examples of Indian-Specific Standard Terms and Conditions;" Appendix B "Examples of Indian-specific CMS regulations"

such accommodations, and has an obligation to do so under the trust responsibility. CMS has taken comparable action in the past, and it has an obligation to do so in this instance as well.

CMS may not lawfully approve any Demonstration Waiver if it fails to take steps to ensure that it does not result in a barrier to access for Indians and the Indian health system. Section 1115 of the Social Security Act authorizes the CMS to waive application of certain enumerated provisions in the Social Security Act only if doing so is "likely to assist in promoting the objectives" of the Medicaid statute.[67] Mandatory community engagement and work requirements may not be lawfully imposed on AI/AN as a condition of Medicaid eligibility pursuant to this authority.

The Medicaid statute sets out unique objectives that are specific to the Indian health system. Mandatory community engagement and work requirements will not "assist in promoting the objectives" of the Medicaid statute with regard to the Indian health system. Instead, they directly conflict with those objectives.

While the Medicaid statute has several general objectives,[68] it also sets out specific objectives for Indian health. In 1976, Congress amended the Medicaid statute to authorize IHS and tribally operated facilities to bill the Medicaid program in order to make Medicaid resources available to supplement funding for the chronically underfunded Indian health system.[69] Section 1911[70] of the Act made IHS and tribal facilities eligible to collect reimbursements from Medicaid, and an amendment to Section 1905(b)[71] ensured States would not bear the burden of costs associated with doing so by applying a 100 percent FMAP to Medicaid services provided to an Indian by an IHS or tribally-operated facility.

Congress enacted Section 1911 to ensure that federal Medicaid funding would flow freely to the Indian health system. Section 1911 was enacted "as a much-needed supplement to a health care program which for too long has been insufficient to provide quality health care to the American Indian."[72] It was intended "to enable Medicaid funds to flow into IHS institutions."[73] Congress intended these resources be available to enable

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[67] 42 U.S.C. § 1315.
[68] 42 U.S.C. § 1396.
[69] 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 (2004) at 98, http://www.usccr.gov/pubs/nahealth/nabroken.pdf.
[70] 42 U.S.C. § 1396j.
[71] 42 U.S.C. § 1396d(b).
[72] H.R. REP. NO. 94-1026, pt. III at 21 (1976), *reprinted in* 1976 U.S.C.C.A.N. 2782, 2796.
[73] *Id*. at 20.

IHS facilities to meet the conditions of participation in the Medicare and Medicaid programs.[74]

But Medicaid funds will cease to flow into IHS institutions if CMS approves Medicaid conditions of eligibility that will have unique adverse effects on American Indian and Alaska Native Medicaid enrollment. Should that occur, the objectives of the Medicaid statute with regard to AI/ANs and the Indian health system will be thwarted, not advanced.

In order to access Medicaid resources, the Indian health system must be able to enroll its patients in State Medicaid plans. If it cannot do so because the barriers to access are too high, AI/ANs will simply elect not to enroll in Medicaid. Unlike every other Medicaid enrollee, AI/ANs have a federal right to access Indian health services at no cost to them. As a result, they can access health services without having to maintain Medicaid eligibility. This means that if the State imposes general conditions of eligibility that are impossible for our citizens to meet, they will simply elect not to enroll in Medicaid. That, in turn, will deprive the Indian health system of a stream of supplemental funding it desperately needs to survive, and that Congress intended it receive.

Nor are work requirements practical in a tribal setting. Many AI/ANs live in areas of high employment, including reservations and remote Indian villages where there simply are no jobs. And many participate in non-traditional employment in subsistence economies that does not generate the type of documentation required to demonstrate compliance with a work requirement, yet are vital to their survival.

Meeting these proposed work requirements through participation in Community Engagement activities will also be difficult, if not impossible, for AI/ANs unless special accommodations are made. Unlike other Medicaid enrollees, AI/ANs do not as a general matter seek State assistance through State work programs. Instead, they seek and receive assistance through Tribal programs. It is unrealistic to think that a tribal member participating in a tribal employment or assistance program will also participate in a State program simply to qualify for Medicaid when they can access care at IHS without doing so. Such requirements would just add to the bureaucracy surrounding AI/AN access to a federal program, and many AI/ANs would dis-enroll from Medicaid.

In addition, imposing these requirements on AI/ANs would be contrary to congressional intent. Congress has already declined the opportunity to authorize States to dis-enroll Tribal members from Medicaid who fail to meet work requirements. In 1996, Congress amended the Medicaid statute to authorize States in limited circumstances to dis-enroll certain individuals enrolled in Medicaid if they failed to comply with State-

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[74] *Id.*

imposed work requirements required under the Temporary Assistance for Needy Families (TANF) program.[75] That authority, however, only applies to individuals receiving cash assistance under a State program funded under part A of subchapter IV of Chapter 7 of the Social Security Act. It does not extend to Indians who receive cash assistance under a Tribal TANF program. As a result, a State may not terminate Medicaid eligibility for Indians receiving assistance under a Tribal TANF program if they fail to meet Tribal work requirements under the program. Congress could easily have extended that authority to Indians when it amended the Medicaid statute in 1996, but declined to do so. This was consistent with Congress' overarching goal of maintaining access to Medicaid for Indian people and access to Medicaid resources by the Indian health system.

The recently issued State Medicaid Directors' Letter #18-002, "Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries" encourages States considering work and community engagement requirements to consider aligning those requirements with TANF and SNAP program requirements, such as creating exceptions for "individuals participating in [T]ribal work programs." The regulations implementing the TANF program have different provisions for enforcement of the work participation requirements under a State TANF program and a Tribal TANF program, and allow Tribes in the first instance to enforce those provisions on their members. If an individual in a family receiving assistance under the State program refuses to engage in work required under section 607, the State must reduce or terminate the assistance payable to the family, subject to any good cause or other exceptions.[76] On the other hand, the PROWORA provides that a Tribe TFAP must have provisions comparable to section 607(e) and include the Tribe's proposal for penalties against individuals who refuse to engage in work activities.[77] Thus, a State must enforce the work participation requirements against families receiving assistance through the State TANF program, but it is Tribes that enforce a different set of work requirements pursuant to a different set of rules against families receiving assistance through their Tribal TANF program. This treatment respects Tribal sovereignty, and reflects the fact that it is Tribes, and not the States that can and should determine compliance with these requirements. If a State's proposed Medicaid work and community engagement requirements are to be aligned with the process Congress authorized for Indians, it must respect and acknowledge the right of Tribes and Indian health programs to certify compliance with work and tribal community engagement activities.

CMS has a duty not to approve a waiver if it would have the effect – intended or not – of defeating Congress' intent that the Medicaid program provide supplemental resources to the Indian health system. Unless exceptions or accommodations are made, mandatory community engagement and work requirements would have the unintended

[75] 42 U.S.C. § 1396u-1(b)(3)(A).
[76] *See* 42 U.S.C. § 607(e); 45 CFR § 261.14.
[77] *See* 42 U.S.C. § 612(c); 45 CFR § 286.135.

and perverse effect of encouraging AI/ANs to disenroll from Medicaid. As a result, unless AI/ANs are exempted from these requirements, the proposed Demonstration Waivers will not be likely to assist in promoting the objectives of the Medicaid program with regard to Indian health.

CMS has ample legal authority to provide an exemption (such as those proposed by Arizona, Utah and Arkansas) or accommodation (such as that proposed by Indiana) for AI/ANs from work requirements. Doing so is consistent with the federal trust responsibility and required to ensure AI/ANs maintain access to the Medicaid program in a manner consistent with Congress' intent in enacting Section 1911 of the Social Security Act. Without an exemption or accommodation, the proposed waiver will not be "likely to assist in advancing the objectives" the Medicaid statute sets out for Indian health, and cannot be approved under the authority set out in Section 1115 of the Social Security Act.

CONCLUSION

CMS has a duty to ensure that AI/ANs are not subjected to State-imposed work requirements that would present a barrier to their participation in the Medicaid program. CMS should withdraw those provisions in Director Neale's January 17, 2018 letter that assert that CMS lacks the authority to make such accommodations for IHS beneficiaries. CMS not only has ample legal authority to make such accommodations, it has a duty to require them.

APPENDIX A: Indian-specific Exemptions in Approved Section 1115 Waivers

CMS has approved a number of Indian-specific provisions and special terms and conditions (STCs) in State Plan Amendments and Section 1115 demonstration waivers. They are needed to accommodate the unique status of AI/AN Medicaid enrollees and maintain continued access to Medicaid resources by the Indian health system. Examples include exempting American Indians and Alaska Natives (AI/ANs) from mandatory enrollment in Medicaid managed care; providing supplemental payments to IHS/tribal facilities for AI/AN Medicaid beneficiaries; and a variety of other Indian-specific provisions. Some of these examples are listed in the following three tables.

These Indian-specific provisions are consistent with CMS's obligations to carry out federal law applicable to AI/ANs, to fulfill the federal trust responsibility to provide for Indian health care, and to comply with its own tribal consultation policy.

Table 1: AI/AN Exemption from Mandatory Managed Care	
Alabama	STCs provide AI/ANs are not required to enroll in managed care but may opt in: **VI.23. Individuals who may opt-in to [Regional Care Organization] enrollment – American Indians/Alaska Natives.** Individuals identified as American Indian or Alaska Native (AI/AN) will continue to access Medicaid services as they do now through the fee for service system unless an individual AI/AN chooses to opt into the demonstration and access coverage pursuant to all the terms and conditions of this demonstration. a. **Access to I/T/Us.** An eligible AI/AN individual, whether enrolled in this demonstration or not, will be able to access covered benefits through any Indian Health Service (IHS), Tribal or urban Indian organization (collectively, I/T/U) facilities funded through the IHS. b. **Payments to I/T/Us.** Payments to an I/T/U or a health care provider through referral under purchased/referred care services provided to an eligible AI/AN shall not be reduced by the amount of any enrollment fee, premium, or similar charge, or in amount of any deduction, copayment, cost sharing or similar charges. I/T/U facilities are entitled to payment notwithstanding network restrictions pursuant to section 2016 of the Indian Health Care improvement Act (IHCIA). c. **Notices to AI/ANs.** As part of the application process, applicants will have an opportunity to verify AI/AN status using appropriate verification documents.
Arkansas	STCs provide AI/ANs are not required to enroll in managed care but may opt in: **17. Populations Affected by the Arkansas Works Demonstration.** Except as described in STCs 18 [which addresses Medically Frail Individuals] and 19 [which applies to American Indians and Alaska Natives], the Arkansas Works Demonstration affects the delivery of benefits, as set forth in section 1905(y)(2)(B) of the Act and codified at 42 CFR Section 433.204(a)(2), to adults aged 19 through 64 eligible under the state plan….

	19. American Indian/Alaska Native Individuals. Individuals identified as American Indian or Alaskan Native (AI/ AN) will not be required to enroll in QHPs or [employer sponsored insurance (ESI)] in this demonstration, but can choose to opt into the demonstration and access coverage pursuant to all the terms and conditions of this demonstration. Individuals who are AI/AN and who have not opted into the Arkansas Works will receive the [alternative benefit plan (ABP)] available to the new adult group and operated through a fee for service (FFS) system. An AI/AN individual will be able to access covered benefits through Indian Health Service (IHS), Tribal or Urban Indian Organization (collectively, 1/T/U) facilities funded through the IHS. Under the Indian Health Care Improvement Act (IHCIA), I/T/U facilities are entitled to payment notwithstanding network restrictions.
Arizona	An AI/AN-only, fee-for-service delivery system exists, the Arizona Health Care Cost Containment System (AHCCS) American Indian Health Program. Alternatively, STCs provide that although AI/ANs are not required to enroll in managed care, they may opt in and may also opt in to programs targeted toward expansion adults: **20. Participation in AHCCCS CARE**. a) **Mandatory Participation**. Expansion Adults – beneficiaries enrolled in the new adult group with incomes that exceed 100 percent of the FPL – are required to participate in AHCCCS [Choice Accountability Responsibility Engagement] (hereinafter "AHCCCS CARE member(s)"). The following Expansion Adults are exempted from AHCCCS CARE participation: i. Persons with serious mental illness; ii. American Indian/Alaska Natives; and iii. Persons considered "medically frail" …. … c) **Voluntary Participation.** Nothing in this demonstration shall preclude the state from permitting all Expansion Adults exempted from AHCCCS CARE participation … to choose to opt in …. [M]embers who opt in will not be: i. Required to pay premiums or Strategic Coinsurance based on Medicaid enrollment; ii. Disenrolled for failure to pay into the AHCCCS CARE Account; or iii. Required to participate in the Healthy Arizona or AHCCCS Works program. **38. American Indians/Alaska Natives (AI/AN).** Medicaid-eligible AI/AN may opt in to AHCCCS and receive Medicaid benefits through managed care. They are otherwise provided benefits through Medicaid fee-for-service.
Kansas	STCs provide AI/ANs are not required to enroll in managed care and may opt out: **18. Exemption.** The following population is exempt from mandatory enrollment in mandatory managed care and is not affected by this demonstration except to the extent that individuals elect to enroll in managed care.

	a. American Indians/Alaska Natives (AI/AN): The AI/AN population will be automatically enrolled in managed care under the demonstration. This population will have the ability to opt out of managed care at the beneficiary's discretion. The state will use the definition of Indian provided at 42 CFR 447.50.
Michigan	STC provides that AI/ANs are not required to enroll in managed care but may opt in: **20. Delivery System Options.** Beginning April 1, 2018, after the Healthy Michigan Plan has been in operation for 48 months, non-medically frail Healthy Michigan Plan enrollees with incomes at or above 100 percent of the FPL will choose between two delivery system programs based on their health plan eligibility status. The two delivery systems, which will have a separate cost sharing structure, include the Healthy Michigan Plan, available with the completion of a healthy behavior, and a Marketplace Option. Both programs will provide alternative benefit plan (ABP) benefits. Information about the delivery system, benefits and cost sharing applicable in each of these components are described in Section VII (Delivery System), Section VI (Cost Sharing, Contributions, and Healthy Behaviors), and Section V (Benefits). Individuals who have not yet chosen a Medicaid Health Plan or QHP, and those who are considered members of an exempt or voluntary population (including, but not limited to American Indians/Alaska Natives) for managed care enrollment under the state's approved 1915(b) Comprehensive Health Care Program Waiver (as of December 17, 2015), Michigan state plan, or federal regulations, may receive services through a fee-for-service (FFS) delivery system. Additionally, Attachment E notes: For those populations who are currently voluntary or exempt from enrollment into a Medicaid Health Plan (e.g., Native Americans, …), they will remain a voluntary or exempt population from managed care under this demonstration.
Montana	AI/ANs are excluded from mandatory managed care: **IV.2.** The following populations are excluded from all portions of the demonstration other than continuous eligibility provisions in Section VIII. a. Individuals who are medically frail; b. Individuals who the state determines have exceptional health care needs….; c. Individuals who live in a region (that may include all or part of an Indian reservation), where the State is unable to contract with sufficient providers[]; d. Individuals exempted by federal law from premium or cost sharing obligations [such as AI/ANs], whose exemption is not waived by CMS….
Nevada	STC provides AI/ANs are not required to enroll in managed care but may opt in: **18. Exemption.** The following population is exempt from mandatory enrollment in a [Care Management Organization (CMO)] and is not affected by this demonstration except to the extent that individuals elect to enroll in a CMO.

	a. American Indians/Alaska Natives (AI/AN): The AI/AN population will be allowed to voluntarily enroll in a CMO at the discretion of the individual beneficiary (subject to the individual having a demonstration-qualifying diagnosis as specified in STC 20). The individual may disenroll from the CMO at any time by notifying the state either verbally or in writing. The state will use the definition of Indian provided at 42 CFR 447.50. [Note that no other populations are listed]
New Mexico	Prior waiver (updated waiver still pending) provided that AI/ANs are exempt from mandatory enrollment, but may opt in,and provided numerous AI/AN protections. These provisions were drafted prior to CMS's most recent managed care regulations. Waiver Authority: **2. Freedom of Choice, Section 1902(a)(23)(A)** … Mandatory enrollment of American Indians/ Alaskan Natives (AI/ANs) is only permitted as specified in paragraph 24 of the STCs. STCs: **V. NATIVE AMERICAN PARTICIPATION AND PROTECTIONS** **22. General.** Recognizing the federal government's historic and unique relationship with Indian tribes as well as the special protections and provisions that Indian tribes are entitled to under federal law, this section describes additional protections for Native Americans enrolled in Centennial Care. … **24. Maintenance of opt-in for AI/AN beneficiaries.** AI/AN beneficiaries shall maintain a choice to opt-in to Centennial Care or to access care through a fee-for-service delivery system. AI/AN beneficiaries who are dual eligible or who have a nursing facility level of care, however, will continue to be required to enroll in managed care. **25. Requirements for Modification of AI/AN Opt-In Provision.** After thorough evaluation of the experience AI/AN beneficiaries who opt-in to Centennial Care and consultation with tribes and soliciting advice from I/T/Us in accordance with the requirements in STC 15, the state may propose to modify STC 24 to include an opt-out of Centennial Care for AI/AN beneficiaries without submitting an amendment pursuant to STC 7 if it can demonstrate to CMS' satisfaction that it has met the below conditions and the results of the evaluation indicate that AI/AN beneficiaries will receive improved quality of care under Centennial Care.

a. Outreach and Education Strategy. The state will develop for CMS review and approval a beneficiary outreach and education strategy for AI/ANs that will include culturally appropriate notices and program materials that are accessible to individuals with limited English proficiency;
b. Care Coordination**.** The state will develop for CMS's review and approval a care coordination strategy that encourages the use of AI/AN care coordinators and limits duplication of services between I/T/U and non-I/T/U providers;
c. Model Indian Health Care Provider Contract Addendum. The state will develop for CMS's review and approval a standard I/T/U contract addendum for all MCOs to assure that MCOs comply with key federal laws that apply when contracting with I/T/U providers, minimize potential disputes, and lower the perceived barriers to contracting with I/T/Us. This model should be similar to the model QHP contract addendum for Indian Health Care Providers published by CMS on April 3, 2013;
d. Timely Claims Payment. The state will submit for CMS review and approval a plan for paying claims in a timely manner that reduces administrative burdens on tribal health programs either operated by the IHS or operated under the authority of P.L. 93-638; and
e. Network Adequacy. The state will submit for CMS review and approval documentation establishing that there are sufficient Indian Health Care Providers in the network to ensure timely access to services available under the contract for AI/AN enrollees who are eligible to receive services from such providers, consistent with 1932(h)(2)(A)(i) of the Act.
f. Requirements for Modification of Section V. After consultation with tribes and soliciting advice from I/T/Us in accordance with the requirements in STC 15, the state may propose changes to other requirements of Section V without submitting an amendment pursuant to STC 7 if it can demonstrate to CMS' satisfaction that the change is supported by the results of the ongoing evaluation and continuous improvement set forth in STC 28.

27. Minimum Managed Care Guarantees. Each MCO must, at a minimum provide the following contractual delivery service protections for AI/ANs:

a. MCOs will have to offer contracts to all Indian Health Service (IHS), tribes and tribal organizations operating health programs under the Indian Self-Determination and Education Assistance Act; and urban Indian organizations operating health programs under title V of the Indian Health Care Improvement Act; hereinafter referred to as I/T/Us. I/T/Us will not be required to contract with the plans, and all of the I/T/Us, contracted or not with an MCO, will be reimbursed, at a minimum, at the OMB rates (in accordance with 1932(h) of the Act); and as applicable up to three (3) encounters per day or the number of encounters approved in the Medicaid state plan;
b. Services provided within I/T/Us are not subject to prior authorization requirements and MCOs will provide education and training to I/T/Us on steps needed to ensure appropriate referrals to non-IHS providers in and outside of the MCO network;
c. MCOs will be required to offer contracts to other Tribal health care delivery enterprises which are properly licensed and/or credentialed, like care coordinators, transportation vendors, behavioral health providers and LTC providers;
d. Native Americans will be permitted to select an I/T/U to be their primary care physician (PCP) and/or to access care at an I/T/U whether or not that facility is contracted with the member's MCO.

	e. MCOs will be required to offer technical assistance to Tribes that seek to become certified and accredited Patient-Centered Medical Homes and/or Health Home providers; and f. MCOs will be required to work directly with I/T/Us on billing and provider issues. **28. Ongoing evaluation and continuous improvement.** The state shall closely monitor and evaluate the experience of AI/AN who are enrolled in Centennial Care as part of the demonstration evaluation and demonstration annual reports, described in STCs 117 and 118.
Oregon	STC provides AI/ANs are exempt from managed care enrollment: 16. The 1115 demonstration will have no impact on American Indian and Alaska Natives (AI/AN) rights to exemption from enrollment in managed care organizations, or the requirements for [Coordinated Care Organizations (CCOs)] and other managed care entities to come into compliance with the CMS 2390-F, regulations regarding Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability published April 26, 2016, including the AI/AN specific provisions at 42 CFR section 438.14 23.a.ii. Tribal members must make an affirmative voluntary choice for COO enrollment (i.e., cannot be auto-enrolled).

Table 2: Supplemental Payments to IHS/Tribal Facilities	
Arizona	Waiver expenditure authority provides: **3.** Expenditures under contracts with managed care entities that do not provide for payment for Indian health care providers as specified in section 1932(h) of the Act, when such services are not included within the scope of the managed care contract. Expenditures for direct payments made to IHS or Tribal 638 providers by the state, which are offset from the managed care capitation rate. **18.** Expenditures for payments to participating IHS and tribal 638 facilities for categories of care that were previously covered under the State Medicaid plan, furnished in or by such facilities. The STCs program description provides: In addition, the demonstration will provide for payments to IHS and tribal 638 facilities to address the fiscal burden for certain services not covered under the state plan and provided in or by such facilities. This authority will enable the state to evaluate how this approach impacts the financial viability of IHS and 638 facilities and ensures the continued availability of a robust health care delivery network for current and future Medicaid beneficiaries. As part of the extension of the demonstration in 2016, based on CMS clarifying its policy for claiming 100 percent federal matching for services received through IHS and 638 facilities, the state can transition from the current uncompensated care reimbursement methodology to service-based claiming. STC number 33 states: **33. Payments to IHS and 638 Facilities.** The state is authorized through to make payments to IHS and tribal 638 facilities that take in to account furnishing specified types of care furnished by IHS and tribal 638 facilities to Medicaid-eligible individuals. Facilities must use the methodology discussed in Attachment F.
California	Waiver expenditure authority provides: **III. Uncompensated Care for Indian Health Service (IHS) and Tribal Facilities.** Expenditures for supplemental payments to support participating IHS and tribal facilities that incur uncompensated care costs associated with services for which Medi-Cal coverage was eliminated by SPA 09-001 that are furnished by these providers to individuals enrolled in the Medi-Cal program.

	STCs provide: **32. Supplemental Payments to IHS and 638 Facilities.** The state shall make supplemental payments to Indian Health Service (IHS) and tribal 638 facilities to take into account their responsibility to provide uncompensated care and support the IHS and tribal 638 service delivery network. Supplemental payments shall be computed based on the uncompensated cost for services that were eliminated from Medi-Cal coverage in July 2009 pursuant to state plan amendment 09-001, furnished by such facilities to individuals enrolled in the Medi-Cal program. Participating tribal facilities shall maintain policies for furnishing services to non- IHS beneficiaries that are in place as of January 1, 2013. Payments shall be based on the approved methodology set forth in Attachment F. The annual limit for the IHS uncompensated care cost shall be $ 1,550,000 total computable per year (DY 11 – 15).
Oregon	Waiver provides for payment for services at Indian Health Care Providers not covered under State Plan. Expenditure authority: **5.** Expenditures for primary care services furnished to eligible individuals by Indian Health Service (IHS) and tribal health facilities operating under the Indian Self Determination and Education Assistance Act (ISDEAA) 638 authority that were restricted or eliminated from coverage effective January 1, 2010 for non-pregnant adults enrolled in [Oregon Health Plan (OHP)].” STCs provide: **19. c. Summary of OHP Benefit Structure.** … [T]he OHP Plus benefit … consists of: v. Primary care services furnished to eligible individuals by Indian Health Service (IHS) and tribal health facilities operating under the Indian Self Determination and Education Assistance Act (ISDEAA) 638 authority, that were restricted or eliminated from coverage subject to the Prioritized List effective January 1, 2010 for non-pregnant adults enrolled in OHP.

Table 3: Special Delivery System Provisions	
Arizona	Arizona also has an AI/AN-only State Plan Amendment (SPA), approved June 2017. The SPA provides for American Indian medical homes. As mentioned above, Arizona also has an AI/AN-only delivery system, the American Indian Health Program (AIHP), as part of its demonstration.
California	California has an AI/AN-specific SUD delivery system: **132. Drug Medi-Cal Definitions** … c. Tribal and Indian Health Providers A description of how the Tribal operated and Indian health providers, as well as American Indians and Alaska Natives Medi-Cal beneficiaries, will participate in the program through a Tribal Delivery System will be outlined in Attachment BB following approval of this amendment. The provisions in attachment BB will be consistent with the authorities in the Indian Health Care Improvement Act (including the statutory exemption from state or local licensure or recognition requirements at Section 1621(t) of the Indian Health Care Improvement Act) and will be developed in consultation with the California tribes, and Tribal and Urban Indian health programs located in the state, consistent with the Tribal Consultation SPA and the CMS Tribal Consultation Policy.
Washington	STCs authorize a Tribal Delivery System Reform Incentive Payment Program: **V. DELIVERY SYSTEM REFORM INCENTIVE PAYMENT PROGRAM** **24. Tribal Engagement and Collaboration Protocol**. The state, with tribes, IHS facilities, and urban Indian Health Programs, must develop and submit to CMS for approval a Tribal Engagement and Collaboration Protocol (Attachment H) no later than 60 calendar days after demonstration approval date. Once approved by CMS, this document will be incorporated as Attachment H of these STCs, and once incorporated may be altered only with CMS approval, and only to the extent consistent with the approved expenditure and waiver authorities and STCs. ACHs will be required to adopt either the State's Model ACH Tribal Collaboration or Communication Policy or a policy agreed upon in writing by the ACH and every tribe and Indian Health Care Provider (IHCP) in the ACH's region. The model policy establishes minimum requirements and protocols for the ACH to collaborate and communicate in a timely and equitable manner with tribes and Indian healthcare providers.

In addition to adopting the Model ACH Tribal Collaboration and Communication Policy, ACH governing boards must make reasonable efforts to receive ongoing training on the Indian health care delivery system with a focus on their local tribes and IHCPs and on the needs of both tribal and urban Indian populations.

Further specifications for engagement and collaboration in Medicaid transformation between tribes, IHS facilities, and urban Indian health programs and (b) ACHs and the state, will be described by the Tribal Engagement and Collaboration Protocol (Attachment H). At a minimum, the Tribal Engagement and Collaboration Protocol must include the elements listed below:

a. Outline the objectives that the state and tribes seek to achieve tribal specific interests in Medicaid transformation; and
b. Specify the process, timeline and funding mechanics for any tribal specific activities that will be included as part of this demonstration, including the potential for financing the tribal specific activities through alternative sources of non-federal share.

25. Tribal Coordinating Entity. The federal government and the State have federal trust responsibility to support tribal sovereignty and to provide health care to tribal members and their descendants. Part of this trust responsibility involves assessing this demonstration for impacts, including unintended consequences, on affected IHCPs and AI/AN. The state will facilitate a tribal coordinating entity (TCE) controlled by tribes and Urban Indian Organizations (as defined in 25 U.S.C. § 1603(29)) for purposes of facilitating appropriate engagement and coordination with tribal governments and communicating advice and feedback from Indian Health Care Providers (IHCPs) (as defined in 42 C.F.R. § 438.14(a)) to the state on matters related to this demonstration. The state will work with the TCE:

a. To provide opportunity to review programs and projects implemented through delivery system reform efforts within this demonstration;
b. For the TCE to coordinate with affected tribes and IHCPs to provide an assessment of potential impacts as a result of delivery system reform activities within this demonstration on affected IHCPs and AI/AN populations and report these assessments to CMS, the ACHs, and the State;
c. To coordinate with tribes and IHCPs to establish a cross-walk of statewide common performance measures to the GPRA measures used by tribes and IHCPs; and
d. To support other tribal-specific projects implemented through this demonstration to the extent appropriate.

26. Tribal Specific Projects. Consistent with the government-to-government relationship between the tribes and the State, tribes, IHCPs, or consortia of tribes and IHCPs can apply directly through the State to receive funding for eligible tribal specific projects. Tribes and IHCPs will not be required to apply for tribal specific projects through ACHs or the TCE, and the TCE and ACHs will not participate in the approval process for tribal specific projects.

	a. Indian Health Care Provider Health Information Technology Infrastructure. The state will work with the tribes and IHCPs to develop a tribal specific project, subject to CMS approval, that will enhance capacity to: (i) effectively coordinate care between IHCPs and non-IHCPs, (ii) support interoperability with relevant State data systems, and (iii) support tribal patient-centered medical home models (e.g., IHS IPC, NCQA PCMH, etc.). b. Other Tribal Specific Projects. The state will work with tribes on tribal specific projects, subject to CMS approval, that align with the objectives of this demonstration, including requirements that projects reflect a priority for financial sustainability beyond the demonstration period. c. The Tribal Engagement and Collaboration Protocol (Attachment H) will provide further specifications for process, timeline and funding mechanics for any tribal specific projects that will be included as part of this demonstration. To the extent applicable, the Tribal Engagement and Collaboration Protocol must align with project requirements set forth in these STCs.

Table 4: Additional Indian-specific Provisions	
Indiana	Participation in tribal program satisfies work and community engagement requirements: **IV.4. Qualifying Activities.** HIP beneficiaries may satisfy their community engagement requirements through a variety of activities, including but not limited to: ... • Members of the Pokagon Band of Potawatomi who are participating in the tribe's comprehensive Pathways program, or any other beneficiary participating in a workforce participation program that the state has determined will promote full employment and meets the goals of Indiana's community engagement initiative. Exemption from requirement to pay into health savings account: **V.1. HIP Benefits.** HIP beneficiaries, other than section 1931 parents and caretaker relatives and pregnant women, will receive benefits available in one of the state's approved [alternative benefit plans (ABPs)]. These beneficiaries will have access to the HIP Plus plan containing an enhanced benefit package that includes adult chiropractic, vision, and dental as additional state plan services. Such beneficiaries with income at or below 100 percent of the FPL (other than AI/AN individuals) who do not make their required monthly [Personal Wellness and Responsibility (POWER)] account contributions within the 60-day payment period, will be defaulted to the HIP Basic benefit plan. … **VII.2.a. All HIP eligible beneficiaries** will be eligible for HIP Plus. HIP Plus requires beneficiaries to make a monthly contribution to their POWER Accounts based upon their FPL, except for populations that are otherwise excluded from cost sharing requirements.
Oregon	Tribal Engagement and Collaboration Protocol 35. **Tribal Engagement and Collaboration Protocol**. The state, with tribes, Indian Health Service facilities, and urban Indian Health Programs, must develop and submit to CMS for approval of a Model Tribal Engagement and Collaboration Protocol (Attachment I) no later than 90 calendar days after the demonstration approval date. Once approved by CMS, this document will be incorporated as Attachment I of these STCs, and once incorporated may be altered only with CMS approval, and only to the extent consistent with the approved expenditure and waiver authorities and STCs.

	CCOs will be required to adopt either the state's Model CCO Tribal Engagement or Collaboration Protocol or a policy agreed upon in writing by the CCO and every tribe and Indian Health Care Provider (IHCP) in the CCO's region. The model protocol establishes minimum requirements, such as inclusion of the Model Medicaid and CHIP Managed Care Addendum for IHCPs, and protocols for the CCOs to collaborate and communicate in a timely and equitable manner with tribes and IHCP. In addition to adopting the Model CCO Tribal Engagement and Collaboration Protocol, CCO governing boards must make reasonable efforts to receive ongoing training on the Indian health care delivery system with a focus on tribes in their region and IHCPs and on the needs of both tribal and urban Indian populations. Further specifications for engagement and collaboration among (a) tribes, IHS facilities, and urban Indian health programs and (b) CCOs and the state, will be described by the Model CCO Tribal Engagement and Collaboration Protocol (Attachment I).

APPENDIX B: CMS Administration of the Trust Responsibility

CMS has consistently acted to fulfill the Executive Branch's trust responsibility to AI/ANs. CMS affirmatively advances policy objectives set out by Congress in the IHCIA, which calls on the United States to assure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy. Often these policies have subsequently been codified by Congress after CMS has led the way.

One of the ways CMS has acted to fulfill this trust responsibility has been the passage of numerous Indian-specific regulations and guidance. The following table contains key examples from the last 20+ years.

Indian-specific CMS Regulations and Guidance	
Authority for tribal facilities to bill Medicaid at the same rate as IHS.	In 1996, the HCFA (CMS's predecessor agency) entered a Memorandum of Agreement (MOA) with IHS in which HCFA reinterpreted the term "facility of the Indian Health Service" in Section 1911 of the Social Security Act. This reinterpretation allowed a tribally owned facility operated under an ISDEAA agreement to elect designation as a "facility of the Indian Health Service." Previously, the term was interpreted to include only facilities actually owned or leased by IHS. The MOA allowed tribal facilities to bill Medicaid at the annually established Medicaid billing rates for IHS facilities, and it applied the 100% federal medical assistance percentage (FMAP) to Medicaid services provided by such facilities.
Tribal facilities as state Medicaid providers.	The 1996 MOA also extended to tribal facilities the regulatory policy at 42 C.F.R. § 431.110 that states must accept IHS facilities meeting state requirements as Medicaid providers but that these facilities are not required to obtain a state license. Congress enshrined this policy in law for all federally funded health programs serving AI/ANs in the 2010 amendments to the IHCIA.
Cost-sharing protections for AI/ANs in CHIP.	In 1999, the HCFA issued guidance that prohibited states from imposing any cost-sharing on AI/AN children under the Children's Health Insurance Program (CHIP), citing the unique federal relationship with tribes. The policy was subsequently codified as a regulation at 42 C.F.R. § 457.535. This HCFA regulation reflected the agency's interpretation of how best to carry out the statutory provision requiring states to demonstrate how they would assure CHIP access for eligible AI/AN children. 42 U.S.C. § 1397bb(b)(3)(D).

Cost-sharing protections for AI/AN children in Section 1115 demonstrations.	In 2000, HCFA announced that the policy prohibiting cost-sharing for Indian children under CHIP would be extended to Section 1115 Medicaid demonstration projects. The agency said it would no longer approve Section 1115 applications that imposed 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 renewals prior to submitting them to CMS.[1] Congress subsequently made this consultation requirement statutory in the 2009 American Recovery and Reinvestment Act, adding State Plan Amendments and demonstration projects to the list of proposals requiring tribal consultation. 42 U.S.C. §§ 1396a(a)(73), 1397gg(e)(1)(C). CMS has refused to accept waiver applications on this basis.
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. This allowed IHS and tribal clinics to continue billing at the higher Medicaid billing rate for IHS facilities.
Broadly defining hospital services subject to Medicare-like rates.	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.
Formation of CMS Tribal Technical Advisory Group.	In 2003, CMS chartered a Tribal Technical Advisory Group (TTAG) comprised of tribal officials and employees to advise on Medicare, Medicaid, and CHIP issues impacting Indian health care programs. CMS's foresight was met with approval by Congress, which granted TTAG explicit statutory status in 2009 and added representatives of the IHS and urban Indian organizations. 42 U.S.C. § 1320b-24.

[1] For the initial policy, see Letter from HCFA to State Medicaid Directors (July 17, 2001). CMS subsequently informed states of this requirement on several occasions and codified the policy statement. See SMD #09-003 (June 17, 2009); SMD #10-001 (Jan. 22, 2010); 77 Fed. Reg. 11678 (Feb. 27, 2012).

Indian Health Addendum required for Medicare Part D pharmacy contracts.	In 2005, CMS passed a final rule stating that it would require Medicare Part D plans to include a "special addendum" to their standard contracting terms to assure I/T/U pharmacies would be able to participate in the program. 42 C.F.R. § 423.120(a)(6); 70 Fed. Reg. 4252 (Jan. 28, 2005). The addendum addresses several aspects of federal law and regulations applicable to those pharmacies, such as Federal Tort Claims Act coverage obviating the need for privately purchased professional liability insurance.
CMS issues and updates Tribal Consultation Policy	In 2011, CMS finalized an agency-specific Tribal Consultation Policy. The policy was updated in 2015, adding a new section that incorporated state–tribal consultation requirements for state Medicaid agencies to obtain advice and input from tribes prior to seeking changes in Medicaid programs when those changes would have tribal implications.
Approval of Indian-specific Medicaid State Plan provision.	In April 2012, CMS approved an Arizona Medicaid waiver request through which several optional Medicaid services can continue to be covered at IHS and tribal facilities even though they are otherwise discontinued from coverage in the state plan. When these services are provided to AI/AN patients at IHS and tribal facilities, 100% FMAP applies. This action was a significant acknowledgement by CMS that it had the authority and obligation to carry out the trust responsibility for Indian health.
CMS requires contracts using special terms and conditions to be offered to ITUs by health insurance issuers	In its 2014 Letter to Issuers, CMS said that qualified health plans (QHPs) should, as part of meeting requirements to include a sufficient number and distribution of essential community providers, offer contracts to all Indian health providers in their service area. No similar requirement was made for non-Indian essential community providers. CMS also provided a model contract addendum with special terms and conditions for contracts with ITUs. The following year CMS stated that it expected issuers to offer contracts to all available ITUs and to use the model addendum.
Indian-specific provisions must be implemented by Medicaid managed care plans.	In 2016, CMS published a final rule on managed care in Medicaid and CHIP, codifying a range of Indian managed care protections. The rule includes required standards for contracting with Indians, Indian health care providers, and Indian managed care entities. 42 C.F.R. §§438.14, 457.1209. CMS subsequently issued, after tribal consultation, a model Medicaid and CHIP managed care addendum.