Centers for Medicare & Medicaid Services

American Indian and Alaska Native Strategic Plan

2010 - 2015

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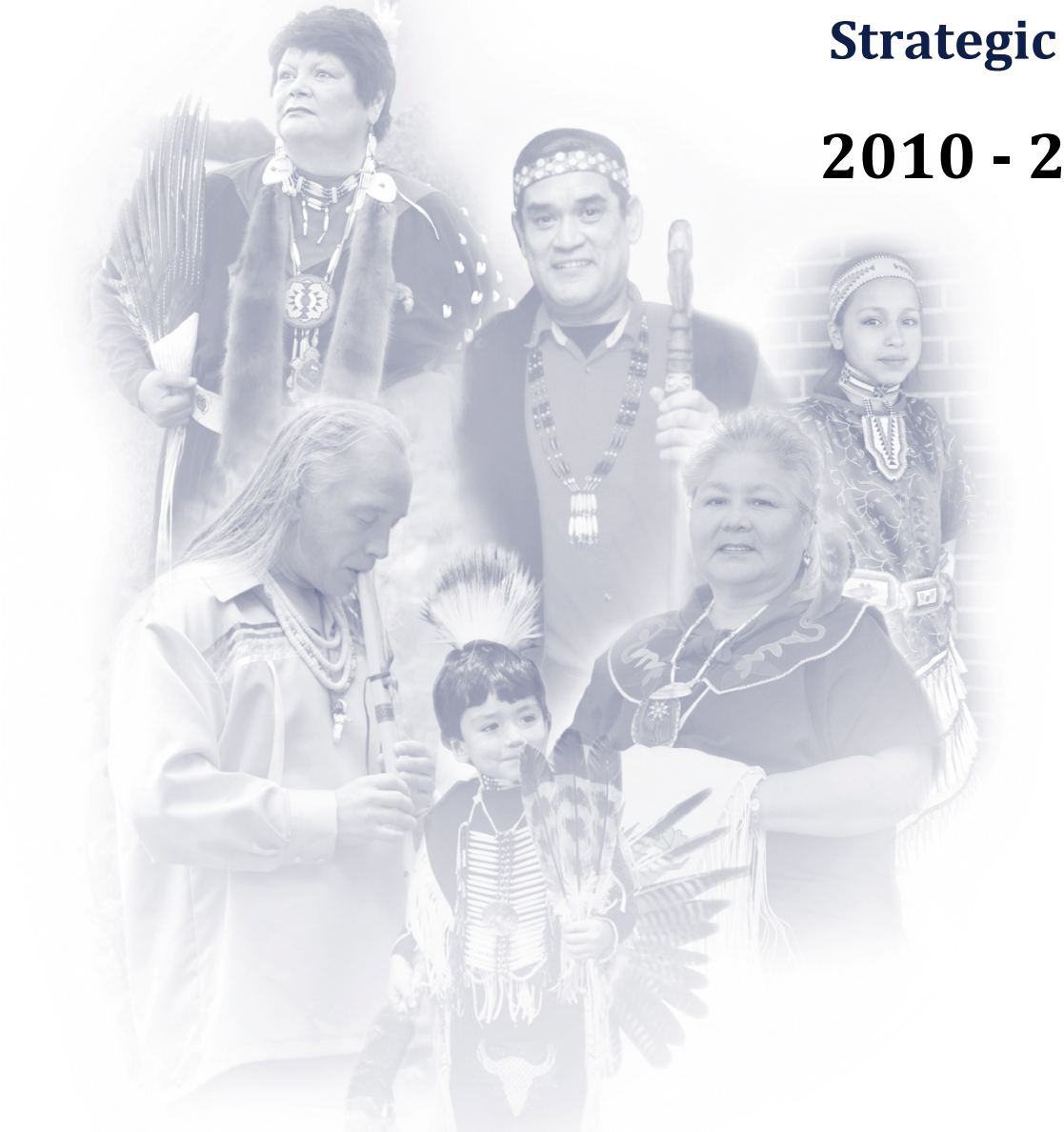

The 2010-2015 CMS AI/AN Strategic Plan covers the time period from Fiscal Year 2010 to Fiscal Year 2014 (FY2010-FY2014), which spans from October 1, 2010 to September 30, 2015. Recommendations contained in the plan will also be used to inform budget requests for Fiscal Year 2009.

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2010-2015 Strategic Plan

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The 2010-2015 CMS AI/AN Strategic Plan was developed over a period of nine months, beginning in April 2008. The TTAG Strategic Plan subcommittee met frequently in-person and by conference call to review the 2005-2010 AI/AN Strategic Plan and develop new goals, objectives, and tasks for the 2010-2015 AI/AN Strategic Plan. TTAG's subcommittees for Long Term Care, Data Advisory, and Outreach & Education also provided essential input related to their visions for future activities and outcomes. TTAG reviewed the final draft of the Strategic Plan in July 2008. The plan was approved and released for nationwide tribal comment and review in August 2008.

Significant tribal resources were used throughout the process of the developing this document. Additional funding was provided by CMS to the Indian Health Service and the National Indian Health Board.

This is the second AI/AN Strategic Plan developed by TTAG. The first plan – for the period 2005-2010 – was developed under the Chairmanship of Margaret Terrance, Nashville Area Representative to TTAG, and was staffed by Mim Dixon, consultant.

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Executive Summary

The Tribal Technical Advisory Group (TTAG) prepared the Centers for Medicare & Medicaid Services' *2010-2015 American Indian and Alaska Native Strategic Plan* (CMS AI/AN Strategic Plan) with the fundamental goals of improving AI/AN access to Medicare, Medicaid, and State Children's Health Insurance Programs (SCHIP), while supporting the vital role Indian health programs in their delivery of health services. The 2010-2015 CMS AI/AN Strategic Plan covers the time period from Fiscal Year 2010 to Fiscal Year 2014 (FY 2010 – FY 2014), which spans from October 1, 2010 to September 30, 2015. Recommendations contained in the plan will also be used to inform budget requests for FY 2009.

The provision of health services to American Indians and Alaska Natives (AI/ANs) stems from a unique trust relationship between the United States and Indian Tribes. The Federal government's trust responsibility provides the legal justification and moral foundation for health policymaking specific to AI/ANs (For detail on the legal basis for CMS provisions for AI/ANs, see Appendix D, p. 62).

The purpose of the CMS AI/AN Strategic Plan is to outline a path for CMS to partner with tribal governments in order to achieve mutually beneficial goals and objectives. These goals and objectives serve to improve AI/AN access to CMS administered programs. The plan also supports the core values of CMS to promote quality services and responsiveness to beneficiaries, health care professionals, and CMS partners. The proposed goals and objectives include specific task recommendations that span a five year period, and include an evaluation process to regularly assess and update the Strategic Plan as needed. The plan's goals, objectives, and tasks include funding recommendations for the CMS Administrator to consider during budget formulation processes and while writing CMS work plans.

This plan was prepared under the guidance of TTAG's Strategic Plan subcommittee and went through a rigorous review by Tribes, TTAG, and the CMS Tribal Affairs Group. A draft of the plan was completed and presented at the 2008 National Indian Health Board and National Congress of American Indians' annual conferences. A draft of the plan was also sent to the highest elected official and tribal health director at each federally recognized Tribe. Recommendations received from the two conferences and from elected tribal leaders and health directors were incorporated into this final document.

Goals, Objectives, and Tasks

The intent of this Strategic Plan is to present goals, objectives, and tasks that will provide direction to CMS personnel and TTAG members who will ultimately be responsible for their execution. For this plan to be focused and useful, complex issues are presented in a brief and simplified manner. It is anticipated that CMS will work closely with TTAG to more fully develop individual concepts and tasks, and implement them over the next five years. Some of the objectives can be accomplished with

effective leadership and communication, without requiring additional funding. Others will need additional resources. The Plan is consistent with the Mission, Vision, Goals, and Objectives of CMS. Thus, this document provides a blueprint to accomplish five mutual goals of CMS and Tribes:

Goal 1: Execute CMS's legal and political obligation to engage in meaningful consultation with Tribes and work closely with the Tribal Technical Advisory Group (TTAG).

Following the directive of Presidential Executive Order No. 13175 (Nov. 6, 2000) and the Sept. 23, 2004, *Presidential Memorandum on the Government-to-Government Relationship with Tribal Governments*, the Department of Health and Human Services (HHS) adopted a Tribal Consultation Policy on January 14, 2005. The HHS policy requires that its operating units, including CMS, share in the responsibility of coordinating, communicating, and consulting with Indian Tribes on issues that impact them. Shortly after TTAG was established in 2004, it began collaborating with CMS personnel to develop a CMS Tribal Consultation Policy. The draft CMS policy has undergone substantial review and revision to reflect input from Tribes, TTAG, CMS, and HHS personnel; as of August 2008, it has not been finalized or approved by CMS. Tribes anticipate that, when complete, the CMS Consultation Policy will establish workable mechanisms for obtaining policy input from Tribes and Indian health policy experts when the agency is considering new policies, changing existing policies, or implementing new programs. Tribal consultation provides stakeholders the opportunity to engage in collaborative policymaking, which in turn increases the efficiency of the decision-making process and improves the quality of policy outcomes. This goal encourages CMS to approve and fully implement a Tribal Consultation Policy that is acceptable to Tribes, and to develop a set of values and principles to guide decision-making processes. Supporting this undertaking, Goal 1 requests that CMS provide financial support for tribal consultation activities and encourages key CMS decision-makers to participate in consultation meetings.

Goal 2: Identify current and future administrative, regulatory, and legislative policies that impact AI/AN beneficiaries and I/T/U[1] providers. Consult with Tribes and work closely with TTAG and IHS at all stages of the policy development process to design mutually-beneficial solutions.

Each year, the Administration, Congress, and State governors propose changes to Medicare, Medicaid, and SCHIP programs. As CMS works to develop Administration budget and policy proposals, promulgate regulations required in legislation, or respond to Congressional inquiries on proposed legislation, CMS should take special care to identify issues that may impact AI/AN beneficiaries and the I/T/U system. Changes in eligibility rules, benefits packages, cost-sharing requirements, provider payment rates, and financing can have profound consequences on the Indian health system. Any changes in CMS programs must be accompanied by a plan to ensure that all AI/ANs who meet eligibility requirements are participating in Medicare, Medicaid, and SCHIP programs. AI/AN beneficiaries enrolled in those programs must have the option to use their local tribal and IHS facilities, and those facilities should be reimbursed

[1] The acronym "I/T/U" refers to the components of the Indian health delivery system: "I" stands for the Indian Health Service; "T" for Tribally-operated health programs; and "U" for urban Indian organizations which operate health programs for Indian people in urban areas.

for services provided. The objectives and tasks outlined in Goal 2, if fully implemented, will assure that proposed administrative, regulatory, and legislative changes are analyzed for their impact on the Indian health system. Likewise, this goal encourages CMS to support legislation that preserves and improves AI/AN access to CMS programs.

Goal 3: Increase AI/AN access to and use of CMS services.

AI/AN participation in CMS programs and services has been hindered by a number of factors, which are discussed in more depth in the Background of this plan (p. 37). The most significant barrier to enrollment is consumer cost sharing; others include lack of transportation to offices where eligibility determination is made, difficulty filling out applications and documentation requirements, difficulty navigating the bureaucracy, and confusion about choices regarding managed care plans. Some AI/ANs fear that information provided in Medicaid applications could be shared with other agencies and have negative repercussions. Communication barriers also exist. English is not the first language for many AI/AN, and enrollment information is rarely translated into Native languages. Telephone and computer enrollment methods are often not readily available. Goal 3 and its objectives provide recommendations for improving AI/AN enrollment in Medicare, Medicaid, and SCHIP. Strategies include developing a communication plan to assist Tribes to better understand CMS programs and encourage participation, providing additional training and outreach to I/T/U personnel on CMS programs, improving outreach and communication to AI/AN beneficiaries, and routinely evaluating the quality and effectiveness of these efforts.

Goal 4: Develop and improve CMS data systems in order to evaluate and improve the capacity of CMS to serve American Indians and Alaska Natives.

CMS maintains extensive data systems that could provide valuable information for Indian program and policy decisions. These systems should be capable of providing AI/AN program enrollment data, AI/AN health service utilization data, information concerning AI/AN health status, and payment data to estimate healthcare costs to CMS and quantify reimbursements to the I/T/U system. While CMS has well-functioning data systems for Medicaid and Medicare, the systems do not have consistent protocols for identifying AI/AN beneficiaries or I/T/U providers. SCHIP does not identify AI/AN beneficiaries or I/T/U providers at all. Goal 4 will allow CMS, IHS, and tribal health advocates to remedy existing data system deficiencies, and in doing so, improve their utility for program planning and evaluation, policy impact analysis, performance measurement, health status monitoring, and targeted enrollment efforts. One step in this process is to integrate CMS and IHS data in Medicaid, Medicare, and SCHIP so that they better identify AI/AN beneficiaries, I/T/U providers, and their services and payments. The final objective is to analyze ongoing CMS research activities to identify projects that are relevant to AI/AN participation in CMS programs. Recommendations can then be provided on how to better integrate AI/AN issues into CMS's general research activities.

Goal 5: Establish and improve access to CMS funded long-term care services throughout Indian Country.

The number of AI/AN elders is growing rapidly, and more must to be done to address the needs of this growing population. The IHS has not historically funded long-term care (LTC) services, and very little tribal infrastructure exists to provide LTC. As millions of baby-boomers have approached retirement age, the federal government has responded by providing new long-term care initiatives. The Medicaid program is the most important source of financing for LTC services in the United States. Because the IHS has not developed long term care capacity and few Tribes have been able to do so, Indian Country has not benefited from Medicaid's LTC funding in the same way that the general population has, despite the disproportionately high level of eligibility among Indian elders.[2] This is due to a number of barriers, including a limited number of nursing homes on or near reservations, federal and state Medicaid requirements for reimbursement, and state certification requirements that make it difficult for tribal programs to qualify. Goal 5 asks CMS to partner with Tribes to elevate the importance of long-term care issues in Indian Country. This goal will inventory LTC programs currently provided by IHS and tribal health programs, identify CMS-funded LTC programs, and assess how IHS and tribal health programs can utilize more efficient and economical home and community based services. Recommendations will be synthesized in a long-term care Service Delivery Plan that will be shared with Tribes and used by CMS and TTAG to educate tribal leaders about the importance of LTC planning and implementation.

Evaluation and Accountability

Appendix B contains a "Timeline, Budget, and Evaluation Plan" matrix that will be used by TTAG and the CMS Office of Tribal Affairs as an accountability tool during periodic reviews (p. 48). The Evaluation Plan succinctly documents our goals and objectives, assigns each objective to a responsible entity (CMS office, personnel, or TTAG), specifies an outcome measure that will be used to determine successful completion, and includes a timeline by which each objective should be completed. The matrix also includes budget recommendations that can be used by TTAG and CMS in the budget formulation process. Strategic Plan goals, timelines, and evaluation plans will be reevaluated annually by TTAG and CMS using this evaluation tool, and changes or deviations from the proposed goals and objectives will be made accordingly to the Plan.

[2] Dave Baldridge. "The Elder Population and Long Term Care" in *Promises to Keep: Public Health Policy of AI/AN in the 21st Century.* Edited by Mim Dixon and Yvette Roubideaux, Washington, DC: American Public Health Association, 2001.

Introduction

Plan Purpose and Use

The fundamental purpose of this plan is to improve access for American Indians and Alaska Natives (AI/ANs) in programs provided by the Centers for Medicare & Medicaid Services (CMS), and support the participation of Indian Health Service (IHS), tribal, and urban Indian providers (I/T/U) in the delivery of CMS services.

The Centers for Medicare and Medicaid Services' *2010-2015 American Indian & Alaska Native Strategic Plan* is designed to guide CMS and the Tribal Technical Advisory Group (TTAG) in achieving this mission. The intent of this plan is to layout feasible, high-priority goals and objectives that provide strategic direction to this complex undertaking. It is anticipated that CMS will work with TTAG to more fully develop individual tasks, and will implement these activities over the next five years. Some tasks can be accomplished with effective leadership and communication without requiring any additional funding. Others will require additional resources, which are estimated in this plan.

The AI/AN Strategic Plan is consistent with and supports the Mission, Vision, Goals and Objectives of CMS. The Executive Summary describes the many links that exist between the overarching goals and objectives of CMS and the more specific objectives for AI/ANs that are described in this plan. This document provides an action plan through which CMS and Tribes, working together, can accomplish their mutual goals.

Tribal Consultation

The United States government has a unique legal and political relationship with American Indian Tribes and Alaska Natives villages. This special relationship recognizes Tribes as sovereign nations that retain the inherent right to self-govern, and that interact with the United States on a government-to-government basis. These rights are grounded in the U.S. Constitution and treaties, and are reinforced by judicial precedent and Presidential Executive Orders that direct federal agencies to consult with Tribes on a government-to-government basis. Tribal consultation is an open and continuous exchange of information that leads to mutual understanding and informed decision making between federal agencies and tribal governments. Tribal consultation should occur at the earliest possible point in the policy formulation process, particularly whenever decisions would significantly impact Tribes, would have a substantial compliance cost, or would result in new or changed policies. In recognition of this special relationship with tribal governments, CMS must consult with Tribes prior to making any interim or final decisions concerning Indian participation in Medicare, Medicaid, or SCHIP programs.

Indian Health Care System

The guarantee of health services to American Indians and Alaska Natives is the direct result of treaties and executive orders that were made between the United States and Indian Tribes. This federal trust responsibility forms the basis of federal health services for AI/AN people. This relationship has been reaffirmed by judicial decisions, executive orders, and Acts of Congress (See Appendix D, p. 62).

To carry out this federal obligation, the Indian Health Service (IHS) was created in 1955, after Congress transferred this responsibility from the Department of the Interior to the Department of Health, Education, and Welfare (now DHHS) with the expectation that it would be better equipped to improve the deplorable health status of Indian people. Twenty years later, Congress enacted the Indian Self-Determination and Education Assistance Act of 1975 (P.L.93-638) to enable Tribes and tribal organizations to directly operate health programs that would otherwise be operated by IHS, thereby empowering tribes to design and operate health programs that are responsive to community needs.

Congress also recognized that the Federal government had a responsibility to provide some measure of healthcare services to Indian people who do not live on or near a reservation. To address this, Title V of the Indian Health Care Improvement Act of 1976 (P.L. 94-437) authorized federal funding for urban Indian organizations to provide health services to AI/ANs, many of whom had been relocated to urban areas by federal relocation programs.

Today the Indian healthcare system includes 46 Indian hospitals (1/3 of which are tribally operated) and nearly 630 Indian health centers, clinics, and health stations (80% of which are tribally operated). When specialized services are not available at these sites, health services are purchased from public and private providers through the IHS-funded Contract Health Services (CHS) program. Additionally, 34 urban programs offer services ranging from community health to comprehensive primary care. Taken together, this complex healthcare delivery system is called the “I/T/U” system (IHS/Tribal/Urban).

AI/AN Health Disparities

At every stage of their lifespan, American Indians and Alaska Natives have significantly worse health status than the rest of the nation. Among infants and newborns, AI/ANs have the highest rate of Sudden Infant Death Syndrome (SIDS) of all racial/ethnic groups, and the AI/AN infant mortality rate is over 1.5 times higher than reported for non-Hispanic whites. Among AI/AN teens and young adults, suicide rates are 3 times greater than reported for the non-Hispanic white population, chlamydia rates are 5 times higher, the AIDS rate is nearly 1.5 times higher, and motor vehicle crashes are nearly 2 times higher than whites of similar age. Among adults and elders, the age-adjusted prevalence rate of diabetes for AI/ANs is over twice that for all U.S. adults. Complications from diabetes include blindness and vascular insufficiency that can lead to amputation and end stage renal disease, which also occur at higher rates

for AI/AN people. AI/ANs also have the highest death rate from chronic liver disease and cirrhosis, nearly 3 times higher than the rate for the total U.S. population.

A number of factors contribute to persistent disparities in AI/AN health status. American Indians and Alaska Natives have the highest rates of poverty in America, accompanied by high unemployment rates, lower education levels, poor housing, lack of transportation and geographic isolation. All of these factors contribute to insufficient access to health services. American Indians continue to experience trauma from damaging federal policies, including loss of culture, language, and access to traditional foods caused by forced relocation, boarding schools, and loss of tribal lands.

Many of the diseases that now impact American Indians and Alaska Natives are preventable or treatable. Historic and persistent under-funding of the Indian healthcare system has resulted in problems with access to care, and has limited the ability of the Indian healthcare system to provide the full range of medications and services that could help prevent or reduce the complications of chronic diseases.

CMS, IHS and Tribes must work together to help eliminate existing health inequalities. Together we can and must strengthen the ability of Indian health facilities to serve as the medical home for AI/ANs, offering culturally competent care with a public health focus, while fulfilling their important role as essential providers of Medicaid, Medicare, and State Child Health Insurance Programs (SCHIP) services. This plan offers CMS and TTAG a roadmap for making that happen.

Background on the Tribal Technical Advisory Group (TTAG)

The Tribal Technical Advisory Group (TTAG) serves as a policy advisory body to the Centers for Medicare & Medicaid Services (CMS), providing expertise on policies, guidelines, and programmatic issues. The 15 members are elected tribal leaders (or their designated employees) selected from the 12 Areas of the Indian Health Service (IHS), as well as representatives from the National Congress of American Indians (NCAI), the National Indian Health Board (NIHB), and the Tribal Self-Governance Advisory Committee (TSGAC).

TTAG Mission

The delivery of health services for American Indians and Alaska Natives (AI/AN) is guaranteed through the Federal Government's unique historical and legal relationship with Indian Tribes (See Appendix D, p. 62). In February 2004, the Centers for Medicare & Medicaid Services (CMS) convened the first TTAG meeting to enhance the government-to-government relationship, honor Federal trust responsibilities and obligations to Tribes and AI/AN people, and to increase understanding between CMS and tribal health programs, including those administered by IHS. TTAG's core function is to guide CMS policy-making to facilitate effective AI/AN participation in Medicare, Medicaid, and SCHIP.

TTAG Activities

As defined by its charter, the roles and responsibilities of the Tribal Technical Advisory Group are to:

- Identify evolving issues and barriers to access, coverage and delivery of services to AI/ANs, payment and other concerns related to CMS programs;
- Propose clarifications and other recommendations and solutions to address issues raised at tribal, regional and national levels;
- Serve as a forum for Tribes and CMS to discuss these issues and proposals for changes to CMS laws, regulations, policies and procedures;
- Participate in other CMS committees or workgroups as may be determined appropriate by CMS leadership;

- Identify priorities and provide advice on appropriate strategies for tribal consultation on issues at the tribal, regional and/or national levels;
- Respond to CMS on technical issues regarding Medicaid, Medicare and SCHIP programs and their impact on Tribes;
- Ensure that pertinent issues are brought to the attention of tribal Leaders, Tribes, tribal Health Directors and area national and regional tribal organizations, and that timely feedback is obtained;
- Participate in joint meetings, discussions, and conferences with State Medicaid TAGs and workgroups where appropriate and recommended by CMS; and
- Coordinate with CMS Regional Offices' tribal consultation initiatives.

TTAG Rationale and Expertise

TTAG meetings provide a forum for meaningful dialogue between Federal officials, elected tribal leaders, and designated representatives knowledgeable about Federal Indian policies, the Indian healthcare delivery system, and CMS-administered health programs. TTAG meetings facilitate the exchange of information and perspectives on the administration of CMS programs and their efficacy in Indian Country. TTAG meetings complement, but do not supplant, tribal consultation processes that also take place between CMS and individual Tribes. Authentic and meaningful involvement of TTAG in CMS policy formation can only take place when CMS and tribal interests are given the opportunity to explore and identify common ground, engage in joint fact-finding, and critically analyze interests and conflicts. Collaborative policymaking processes such as those demonstrated by TTAG increase the efficiency of decision-making processes and improve the quality of resultant decisions by encouraging mutually-beneficial consensus building to avoid protracted conflict.

2005-2010 Overview & Scorecard

The *2005-2010 CMS AI/AN Strategic Plan* was adopted by the Tribal Technical Advisory Group (TTAG) and submitted to the CMS Administrator on January 31, 2006. The five-year plan included five primary objectives and 55 action steps. Implementation of the *CMS AI/AN Strategic Plan* would have cost about $2.25 million per year, although most of the recommendations did not require additional funding. An additional $2 million was requested to develop and fund a Bi-Annual Research Plan. In actuality, CMS spent approximately $633,500 in FY 2005, $283,500 in FY 2006, $823,000 in FY 2007, and $826,000 in FY 2008 to fulfill TTAG goals and objectives.

The primary objectives of the 2005-2010 Plan were to:

1. Strengthen the ability of CMS to identify and analyze policy issues with regard to AI/AN beneficiaries and the I/T/U healthcare delivery system.
2. Implement the Medicare Modernization Act of 2003 (MMA), including the Medicare prescription drug benefit, in Indian communities in a manner that assures access to new services for AI/ANs.
3. Ensure that any proposals to reform Medicaid assess the impact on Tribes and consider the implications for AI/AN beneficiaries and I/T/U providers.
4. Refine and implement the CMS Tribal Consultation Policy.
5. Improve AI/AN access to CMS programs and services.

Within these goals, several of TTAG's core recommendations were to: hire three additional Indian health policy analysts at CMS, relocate Indian health specialist positions to a division in the Agency more concerned about policy than public relations, provide training on Indian healthcare to CMS staff and the Office of General Counsel (OGC), and improve data specific to AI/ANs so that outcomes of policy changes could be better evaluated.

The TTAG serves as a critical venue for Tribes to participate in CMS discussions and policy decisions. Guided by the *2005-2010 CMS AI/AN Strategic* Plan, TTAG experienced several notable successes and shortcomings during the first five-year period.

Successes Achieved under the 2005-2010 Strategic Plan

1. TTAG was recognized as an effective tool for obtaining expert advice and collaboration, and has been used as a model for other Federal Agencies when forming tribal advisory committees. Working together, TTAG drew attention to important CMS issues affecting service delivery for AI/ANs.
2. CMS officials met repeatedly with TTAG data contractors to better understand the data needs and issues of AI/ANs and I/T/U providers. These officials reviewed TTAG data reports and provided feedback to improve their usefulness to CMS.
3. In coordination with TTAG, culturally-relevant print and video outreach materials were developed for AI/AN beneficiaries, and training was provided to CMS employees to improve their understanding of unique healthcare issues affecting AI/ANs.
4. Training was provided to I/T/U employees on CMS programs, and "Medicine Dish" training programs were held monthly for AI/AN providers.
5. The number of positions in the Tribal Affairs Group and the Regional Native American Contacts were expanded; increasing AI/AN staffing at regional and national levels.

Setbacks and Challenges Faced during the 2005-2010 Strategic Plan Period

1. The CMS Tribal Consultation Policy was not approved or implemented.
2. Funds to fulfill the 2005-2010 Strategic Plan were insufficient to achieve specified goals and objectives.
3. As a key player in the I/T/U healthcare delivery system, IHS was inadequately involved in the collaborative fulfillment of goals and objectives for the 2005-2010 Strategic Plan. IHS is an integral partner, and must be more closely involved in the 2010-2015 Strategic Plan.
4. The I/T/U system has become increasingly reliant on CMS services. The IHS budget is provided by Congressional appropriations and is considered discretionary funding. Unlike Medicare and Medicaid, which are fully funded entitlement programs, IHS continues to be funded at less than half the level needed to provide appropriate care. This underfunding perpetuates a growing reliance on Medicare and Medicaid revenues by the I/T/U system.
5. Inadequate communication and late inclusion of Tribes in the CMS decision-making processes posed significant problems. As the Administration developed new budgets and policies, TTAG was frequently not consulted on provisions that could be detrimental to the Indian health system or were brought into the conversation too late. When budget and policy decisions were made without the input of TTAG, their recommendations could not be meaningfully heard and acted upon.

Scorecard Assessing the Completion of 2005-2010 Strategic Plan Goals & Objectives:

Objectives	Completed	Partially or Unsatisfactorily Completed	Not Started or Not Completed
Objective 1 - Strengthen CMS Policy:			
Add three Indian health insurance specialist positions	✓		
Develop principles to guide Indian healthcare decisions		✓	
Develop a Medicaid Indian Health Manual		✓	
Train attorneys in DHHS OGC in federal Indian law			✓
Provide intensive training on I/T/U to ten CMS staff		✓	
Convert 3 NACs to full-time		✓	
Objective 2 - MMA Implementation:			
On-going outreach and education plan for Part D	✓		
Develop methods to collect AI/AN data on dual eligibles and monitor trends; take action if needed		✓	
Send letter to States indicating that MAM claiming is allowed for Part D enrollment			✓
Develop outreach materials re: no penalty for late enrollment	✓		
Develop guidelines and a demonstration program for Tribes as group payers			✓
Provide timely regulations for Medicare-like rates		✓	
Analyze Medicare Advantage plans re: impact on I/T/Us			✓
Objective 3 - Medicaid Reform:			
Office of Leg. include AI/AN provisions in Medicaid reform			✓
Tribal consultation on Medicaid reform regulations			✓
Send letter to States re: tribal consultation on State Plans		✓	
Send letter to State Medicaid Directors re: MAM	✓		
Monitor impacts of Medicaid reform on AI/AN and I/T/U, and take corrective action if needed			✓
Objective 4 - CMS Tribal Consultation Policy:			
Leadership and commitment from CMS to implement Tribal Consultation Policy quickly			✓
Evaluate and improve data quality by establishing a CMS Data Workgroup		✓	
Improve data and evaluation capacity of CMS on AI/AN issues		✓	
Communicate results of CMS research in Indian Country			✓
Implement & evaluate a communications plan for AI/ANs using tribal organizations, meetings, and materials		✓	
Provide CMS internship opportunities for AI/ANs		✓	

Lessons Learned During the Initial TTAG Years

When TTAG formed in 2004, tribal leaders hoped to engage in meaningful dialogue with CMS decision-makers about important policy matters affecting Tribes and AI/AN beneficiaries. As time went on, however, many TTAG members began to feel frustrated. On multiple occasions they traveled great distances only to find themselves discussing critical policy and implementation issues with relatively low-ranking CMS staff via speakerphone, rather than in face-to-face conversation with key decision-makers. Instead of actively participating in policy formation, as had been anticipated by the tribal leaders, a less influential process emerged in which cordial meetings occurred but produced few substantive outcomes – even when the CMS Administrator or his designee was able to attend.

TTAG members tried several different approaches for sharing their recommendations with CMS leadership. Resolutions and letters were sent to the Administrator – Some focused on broad principles for approaching policy, while others provided detailed comments on draft regulations. Few of these letters were answered in writing.

Due to the newness of the TTAG undertaking, lines of communication had not yet been established to guarantee that TTAG issues reached appropriate CMS leaders. A review of TTAG policy recommendations submitted to CMS from 2004-2006 indicates that less than one-third of the group's recommendations were fully or partially fulfilled by CMS. Nearly one-quarter of TTAG's recommendations were ignored or went unaddressed, and approximately 40% were rejected by CMS in favor of some other policy decision.

Looking Toward the 2010-2015 Strategic Plan

Despite these challenges, TTAG representatives persisted, recognizing that this mechanism must succeed in order to provide a much-needed forum for Tribes to participate in CMS policy-making. Strengthening the TTAG process can significantly benefit both CMS and Tribes. Moving forward, the TTAG-CMS interaction should:

1. Enhance their substantive relationship, working closely alongside IHS as an integral partner. This requires the regular participation of key CMS and IHS officials with decision-making authority in TTAG meetings.
2. Reach agreement on a mutually-acceptable CMS Tribal Consultation Policy to alleviate uncertainty within CMS about *when* to consult with Tribes, on *what issues,* and *the most effective manner*.
3. Consult with Tribes and collaborate with TTAG at the earliest possible point in the policy formulation process, well before the public comment stage. By doing so, tribal and agency personnel can develop effective AI/AN policies for CMS-operated programs.

Goals and Objectives for 2010-2015

Strategic Plan's Guiding Mission

Improve access for American Indians and Alaska Natives in programs provided by the Centers for Medicare & Medicaid Services, and enhance I/T/U participation in service delivery.

Goal 1: Execute CMS's legal and political obligation to engage in meaningful consultation with Tribes and work closely with the Tribal Technical Advisory Group (TTAG).

Objective 1a – Prior to fiscal year 2010, CMS will adopt and implement a Tribal Consultation Policy that complies with Presidential Executive Order No. 13175 and the DHHS Tribal Consultation Policy, and will evaluate the effectiveness of its consultation processes on an annual basis.

Task 1: CMS will collaborate with TTAG to implement the agency's Tribal Consultation Policy, which will capitalize on the expertise of TTAG members to develop CMS policies that improve access and services for AI/AN people through the I/T/U system.

Informed implementation of the Consultation Policy will be facilitated by the Tribal Affairs Group, which will disseminate the policy document to all CMS personnel annually, and will provide annual training on the policy to CMS staff that have responsibility for AI/AN issues.

Once approved, TTAG and the Tribal Affairs Group will work with each CMS Division to develop illustrative scenarios to help CMS staff better understand how to implement the Consultation Policy, given their Division's regular scope of work.

Task 2: In partnership with TTAG and IHS, CMS will develop a written annual report documenting consultation activities, which will be disseminated to partners in the first quarter of each fiscal year. The report will assess both consultation processes and outcomes, exceeding requirements for the standard annual consultation report submitted by federal agencies to DHHS. This detailed report will be used by TTAG to monitor and evaluate consultation processes and their impact.

Budget request: $25,000 per year. These funds will be used to support tracking activities by CMS and process evaluations carried out by a qualified tribal consultant/organization, and review of the report with relevant stakeholders.

Objective 1b – By fiscal year 2010, CMS will develop a set of values and principles that will be used by the agency to guide administrative decisions regarding Indian health policy.

This objective appeared in the 2005-2010 CMS Strategic Plan but has not yet been completed.

Task 1: In recognition of the United States trust responsibility described in Appendix D (p. 62), TTAG and the CMS Office of External Affairs will work collaboratively to develop a set of values and principles that can be used by CMS to guide policy formation.

Budget request: $25,000 per year, through task completion. Funds will be used to support the completion of this task by a qualified consultant or tribal organization, and any partner meetings needed to develop mutually agreed upon values and principles.

Examples of such principles include:

- CMS recognizes that the tribal healthcare delivery system is politically, legally, and culturally unique and that any policies developed specifically for Indian healthcare can be designed to apply only to Indian health facilities and programs, and will not be considered to set precedent for other types of healthcare delivery systems.
- It is a well-settled canon of construction that federal laws enacted for the benefit of Indian Tribes are to be given a liberal interpretation, and that doubtful expressions are to be resolved in favor of Indian interests.
- CMS will develop enrollment strategies that maximize AI/AN participation in Medicaid, Medicare, and SCHIP, and will work collaboratively with I/T/U health service providers to carry out identified strategies.

Objective 1c – Each year, CMS will provide financial and administrative support to facilitate the ongoing activities of TTAG, and a sufficient budget to support TTAG activities included in the 2010-2015 Strategic Plan.

Task 1: CMS will fully fund the Tribal Technical Advisory Group, including TTAG travel, per diem, communication needs, basic staffing, and other related expenses. Fulfilling the TTAG charter, the Tribal Technical Advisory Group will consist of fifteen members, and will convene for face-to-face meetings up to three times per year. TTAG will serve as a policy advisory body to CMS, providing expertise on policies, guidelines, and programmatic issues affecting the delivery of health care for AI/ANs.

Budget request: $185,000 per year. Funds will be used to support the travel and per diem expenses of fifteen TTAG members, three times per year, and the ongoing communication and professional technical assistance needed to support TTAG meetings and activities.

Task 2: Each year, in collaboration with TTAG and the Indian Health Service (IHS), CMS will provide adequate funding to commission AI/AN-specific reports and carry out additional technical tasks related to mutually beneficial goals and objectives.

Budget request: $100,000 in 2010; $200,000 in each successive year. These funds will be used to support the commissioning of AI/AN specific reports addressing I/T/U barriers in delivering CMS services and I/T/U participation in current CMS initiatives. Additionally, these funds will cover travel and expenses for hosting collaborative meetings between IHS, CMS, and TTAG in order to engage in necessary tribal consultation processes.

Task 3: In accordance with Executive Branch requirements for tribal consultation, CMS will substantively involve TTAG in administrative, regulatory, and legislative policy questions early in the decision-making process.

Task 4: CMS will hire and retain at least 7 FTE personnel in their Tribal Affairs Group (TAG) who will provide policy and administrative support to TTAG, and will develop a personnel succession plan to ensure consistent and competent TAG staffing with expertise in the Indian healthcare system. The personnel succession plan should include recruitment, training, and promotion strategies, particularly for AI/ANs, including internships, cross-training opportunities for IHS employees, recruitment of AI/ANs to serve as Native American Contacts (NACs) in regional offices, and/or providing executive leadership training for AI/ANs in CMS.

Task 5: TTAG will regularly review the CMS AI/AN Strategic Plan using the Timeline & Evaluation Matrix in Appendix B (p. 48), and will make needed updates or revisions on an annual basis.

Task 6: To support implementation of the CMS AI/AN Strategic Plan, CMS and TTAG will meet regularly with IHS officials to develop joint action plans to carry out identified tasks and objectives.

Objective 1d – CMS personnel with the authority to make binding decisions will regularly participate in TTAG meetings, the Annual DHHS Budget Consultation session, and DHHS regional tribal consultation meetings and listening sessions.

Task 1: On an annual basis, the CMS Administrator, the Center for Drug and Health Plan Choice (CPC) Director, the Center for Medicare Management (CMM) Director, and the Center for Medicaid and State Operations (CMSO) Director will participate in at least three face-to-face meetings with TTAG, along with other CMS officials with pertinent expertise in the subject matter at hand.

Task 2: Key leadership from CMS Headquarters will attend annual DHHS regional tribal consultation meetings and listening sessions.

Task 3: By 2010, CMS and TTAG will revise the TTAG Charter to establish participatory requirements for key CMS officials.

Goal 2: Identify current and future administrative, regulatory, and legislative policies that unfavorably impact AI/AN beneficiaries and I/T/U providers. Consult with Tribes and work closely with TTAG and IHS at all stages of the policy development process to design mutually-beneficial solutions.

Objective 2a – CMS will enhance its support of I/T/U providers and AI/AN beneficiaries by providing thorough analyses of administrative rules and policies, and by taking administrative steps to encourage culturally appropriate and effective service delivery.

Task 1: CMS will confer with TTAG members on administrative matters that impact AI/ANs or I/T/U providers, including but not limited to: payment methodologies, enrollment eligibility requirements, and provider qualifications.

Task 2: In consultation with TTAG, CMS will review data reports, research findings, and recommendations addressing the enrollment of AI/ANs in CMS programs, and will support administrative, regulatory, and legislative policies that remove barriers to enrollment.

Budget request: $25,000 per year. Funds will be used to support the involvement of a qualified consultant or tribal organization to review research findings and generate recommendations that address the enrollment of AI/ANs.

Task 3: CMS will work with TTAG and IHS to administratively expand the ability of I/T/U providers to participate in and obtain reimbursement for all CMS covered services.

Task 4: By 2010, CMS will work with the TTAG Outreach & Education subcommittee to develop an Indian Health Manual that contains all policy documents related specifically to Indian healthcare. The contents of the manual will be made available online, to provide guidance to Indian health facilities on CMS payment policies.

This task appeared in the 2005-2010 CMS Strategic Plan but has not yet been completed.

Budget request: $10,000 per year. Funds will be used to support the development of an Indian Health Manual by a qualified consultant or tribal organization, ongoing revisions and updates, and maintenance of a CMS-administered website.

Task 5: To improve the knowledge and understanding of CMS employees about healthcare issues affecting AI/ANs, the CMS Administrator will provide leadership within the DHHS Interdepartmental Council, in partnership with the IHS Director, in instituting a department-wide training on American Indian and Alaska Native issues, to be coordinated by the Office of Personnel Management. Annual training(s) should utilize AI/AN trainers with experience and knowledge of the subject. Representatives of CMS fiscal intermediaries should also participate in these trainings.

Task 6: On an annual basis, CMS will review its advisory committee structure to identify opportunities for AI/ANs to participate on committees, and TTAG will recommend qualified individuals for consideration as members.

Task 7: CMS will identify meaningful internship opportunities for AI/ANs and will work with external organizations such as IHS to coordinate such internships.

Objective 2b – CMS will thoroughly analyze regulatory policies to determine their impact on I/T/U providers and AI/AN beneficiaries, and will take regulatory action to improve service delivery.

Task 1: CMS Office of Strategic Operation and Regulatory Affairs will confer with TTAG to identify and evaluate regulatory policies that affect AI/ANs or I/T/U providers. All published rules should include TTAG recommendations for enhancing the provision of health services to AI/AN people.

Task 2: CMS will consult with TTAG and Area Indian Health Boards on Federal and State health reform initiatives and programs that impact I/T/U providers and AI/AN beneficiaries, and will require States to demonstrate that they are consulting with Tribes in their jurisdiction on health reform initiatives that impact AI/AN users of Medicaid, Medicare, and SCHIP.

Budget request: $150,000 per year. Funds will be used to support the completion of this task by qualified consultants or tribal organizations, who will track Federal and State health reform initiatives, evaluate their impact on I/T/U providers and AI/AN beneficiaries, and develop recommendations to preserve AI/AN access and I/T/U provider participation.

Task 3: In the development of regulations to carry out Medicaid, Medicare and SCHIP laws, the CMS Office of Strategic Operation and Regulatory Affairs will analyze each provision with regard to its financial and operational impact on Indian healthcare, and will ensure that regulations maximize AI/AN participation through the I/T/U system.

Budget request: $50,000 in 2010; $100,000 in each successive year. Funds will be used to support the completion of this task by a qualified consultant or tribal organization, who will track Medicaid, Medicare and SCHIP regulations, and will offer recommendations to maximize AI/AN participation through the I/T/U system.

Objective 2c – CMS and the Office of Legislation will provide timely analysis of legislation that affects AI/AN access to CMS services or I/T/U participation in the delivery of CMS services.

Task 1: CMS will confer with TTAG to evaluate policies that affect AI/ANs or I/T/U providers in all new legislation. When necessary, external consultants will be hired to provide critical analyses.

Budget request: $50,000 in 2010; $100,000 in each successive year. Funds will be used to support the completion of this task by a qualified consultant or tribal organization, who will evaluate policies that affect AI/ANs or I/T/U providers in new legislation, and offer technical assistance to maximize AI/AN participation through the I/T/U system.

Task 2: CMS will consult with Tribes and confer with TTAG and IHS, and will respond in a timely way to any congressional requests for comment on legislation that will impact AI/AN participation in Medicaid, Medicare, or SCHIP, or the role of I/T/U providers. Such legislation could include, but is not limited to, the Reauthorization of the Indian Health Care Improvement Act or amendments to the Social Security Act, the Deficit Reduction Act, or the Medicare Modernization Act.

Task 3: CMS will incorporate the following provisions for Indian healthcare in any legislation proposed by the Administration, and will seek to incorporate these provisions in any legislation introduced by Congress:

a. All AI/AN Medicaid, Medicare, and SCHIP beneficiaries should have the choice of using their local tribal and IHS facilities, and those facilities should be reimbursed for services provided.

b. AI/AN Medicaid and SCHIP beneficiaries should be exempt from state-imposed premiums and co-pays.

c. Retain the 100 percent federal medical assistance percentage (FMAP) for Medicaid services provided by IHS and tribal health programs.

d. Available reimbursement methodologies should include, but not be limited to: the IHS encounter rate, the Federally Qualified Health Center (FQHC) rate, and the fee-for-service reimbursement rate.

e. Retain and expand the ability of I/T/U providers to participate in and obtain reimbursement for CMS covered services.

f. Other provisions necessary to support the viability and sustainability of the Indian health I/T/U system and optimal healthcare access for AI/AN beneficiaries.

Goal 3: Increase AI/AN access to and use of CMS services.

Objective 3a – Each year, CMS will design and implement a communications plan to assist Tribes in better understanding CMS programs, and encourage their full participation in CMS issues and TTAG discussions.

Task 1: CMS will work with TTAG and its Outreach & Education subcommittee to develop a communications plan that facilitates a better understanding of CMS programs among I/T/U providers.

Task 2: CMS will use tribal organizations such as the National Indian Health Board (NIHB), the National Congress of American Indians (NCAI), and the Tribal Self-Governance Advisory Committee to share CMS information with Tribes via established communication channels, such as newsletters, websites, e-mails, and meetings.

Budget request: $25,000 per year. Funds will be used to by national and regional tribal organizations to disseminate CMS information via established communication channels.

Task 3: At the request of tribal organizations, CMS will participate in tribal meetings, such as the CMS Day at the National Indian Health Board's Consumer Conference and meetings of Area Indian Health Boards.

Budget request: $75,000 per year. Funds will be used to support registration and travel expenses for CMS staff attending tribal meetings and conferences, in support of tribal consultation processes.

Task 4: CMS should contract with Area Indian Health Boards and other tribal organizations to publicize CMS trainings and provide travel assistance for tribal participation in regional trainings.

Budget request: $60,000 in 2010, $70,000 in 2011, $80,000 in 2012, $90,000 in 2013, $100,000 in 2014. Funds will be used by regional and national tribal organizations to publicize CMS meetings and facilitate tribal participation in regional trainings.

Objective 3b – CMS will work with TTAG to provide ongoing outreach and education for I/T/U facilities and AI/AN consumers about new or expanded Medicaid, Medicare, and SCHIP programs established by policy or legislation.

Task 1: CMS will work with TTAG and IHS to ensure that I/T/U providers have the administrative mechanisms needed to implement new and expanded CMS programs, which will ensure that AI/ANs are able to access services and enroll in CMS programs, and that I/T/U facilities are participating providers.

Budget request: $100,000 per year. Funds will be used to support the completion of this task by a qualified consultant or tribal organization.

Task 2: CMS will work with TTAG and IHS to develop guidelines to implement new CMS programs in Indian Country and, when necessary, will establish tribal demonstration programs.

Budget request: $100,000 per year. Funds will be used to support the completion of this task by a qualified consultant or tribal organization, necessary partner meetings between CMS and IHS, and associated demonstration programs.

Objective 3c – CMS will improve its outreach and education activities targeting I/T/U providers by providing training and CMS-related capacity building assistance.

Task 1: In collaboration with TTAG, CMS will develop an annual training plan for I/T/U providers using appropriate Information Technology (IT) communication systems. For each training provided, evaluations will be distributed to participating I/T/U facilities to assess the training's quality and impact and to identify topics that I/T/U facilities would like included in future trainings. TTAG will assist in reviewing evaluation forms, evaluation summary reports, and the annual training plan.

Budget request: $60,000 per year. These funds will be used to support the development of an annual training plan, training evaluation forms, and the development of post-activity evaluation reports.

Task 2: CMS will hold annual training meetings in each of the IHS Areas to provide information about Medicare, Medicaid, and SCHIP to I/T/U employees to improve their provision of CMS services and increase enrollment of AI/AN beneficiaries.

Budget request: $300,000 per year. These funds will be used by the 12 IHS areas to hold annual trainings and meetings for I/T/U employees (at approximately $25,000 per area).

Task 3: CMS will provide resources to Tribes, IHS, and tribal organizations in each of the IHS Areas to implement strategies that will increase AI/AN enrollment in CMS programs.

Budget request: $300,000 per year. These funds will be used by the 12 IHS areas to implement innovative and effective enrollment strategies targeting eligible AI/AN beneficiaries (at approximately $25,000 per area).

Task 4: *Open Door Forums* will be scheduled specifically for issues related to Indian healthcare at least two times per year, with TTAG assisting in developing topics for the calls.

Task 5: As new programs and policies are developed by CMS, special training sessions will be held in a timely way, through meetings in the IHS Areas, Open Door Forums, or other available IT communication systems.

Objective 3d – CMS will improve its outreach and education efforts targeting eligible American Indians and Alaska Natives.

Task 1: CMS should contract with Tribes, Area Indian Health Boards, and other tribal organizations to assist CMS in creating and distributing materials that are culturally appropriate and effective in AI/AN communities, including:

- Translating materials
- Hiring graphic artists who are AI/AN
- Developing radio programs for tribal radio stations
- Placing materials in effective communication channels

Budget request: $180,000 per year. These funds will be used to develop, design, produce and disseminate culturally appropriate, educational outreach materials (estimated at $15,000 per IHS Area).

Task 2: By 2011, CMS will hire a consultant to explore alternatives to providing funding for positions at I/T/U facilities to assist AI/AN with enrollment in Medicaid, Medicare, and SCHIP. The consultant will then work with CMS and TTAG members to develop recommendations to facilitate implementation.

Budget request: $50,000 for a one-time project. Funds will support exploratory research and the completion of this task by a qualified consultant or tribal organization.

Objective 3e- Working with TTAG, CMS will evaluate the quality and effectiveness of CMS outreach and education activities and their impact on AI/AN enrollment and access to services.

Task 1: TTAG will work with the Division of Research in the Office of External Affairs to develop surveys and other appropriate data collection methods to measure the effectiveness of outreach and education activities to increase AI/AN enrollment and access to services, including: written materials, trainings, on-line resources, etc.

Goal 4: Develop and improve CMS data systems in order to evaluate and expand the capacity of CMS to serve American Indians and Alaska Natives.

Objective 4a – In 2010 and 2011, CMS will work with TTAG and IHS to identify strategies that will make CMS data systems capable of reporting AI/AN enrollment, service utilization, health status and payment data from Medicare, Medicaid, and SCHIP programs.

Task 1: By January 2010, a consultant or qualified tribal organization will be selected by the TTAG Data Advisory subcommittee and hired by CMS to study Medicaid, Medicare, and SCHIP program data for AI/AN enrollees and I/T/U providers. The consultant will work closely with CMS and IHS to collect and report data on AI/AN enrollment, CMS services, and I/T/U payments using the three definitions of AI/AN recommended by TTAG and its Data Advisory subcommittee reports from 2007-2009.

CMS programs currently use a racial definition that records a single race for each beneficiary (AI or AN), and whether or not their ethnicity was Hispanic. This system fails to identify multi-racial individuals. In Census 2000, AI/ANs were the racial group with the largest proportion of people indicating multi-racial heritage. Likewise, members of federally recognized Tribes can be of both AI/AN and Hispanic heritage. Current CMS practices group Hispanic AI/ANs in with Hispanics.

The three definitions of AI/AN that are more appropriate and accurate include the: 1) Census definition, which includes AI or AN as one of any races self-declared by the beneficiary regardless of ethnicity; 2) IHS definition, which includes AI or AN as coded in IHS beneficiary data; and 3) tribal definitions, which includes AI or AN with tribal documentation of citizenship or identity.

In 2010 and 2011, the data consultant will prepare an annual report that includes findings from the study of the Medicare, Medicaid, and SCHIP data and make specific recommendations on additional data systems improvements that are still needed. The consultant will also work with CMS officials to determine what costs would be associated with having the CMS Office of Research Development and Information (ORDI) take on AI/AN and I/T/U data analyses and reporting, and will submit a proposed budget for such activities to the TTAG Administrator.

Budget request: $200,000 per year in 2010 and 2011. Funds will support the completion of this highly technical task by a qualified consultant or tribal organization.

Objective 4b – From 2010 to 2011, the Enterprise Data Architecture Group at CMS will work with TTAG and the Indian Health Service (IHS) to develop data systems that improve system linkages with IHS, to enable reporting of AI/AN enrollment, service utilization, health status and payment data segmented by IHS administrative areas (12 IHS areas). The intent of this objective is to improve the utility of AI/AN and I/T/U data to facilitate program planning and evaluation, performance measurement, health status monitoring, and targeted enrollment efforts.

Task 1: In 2010 and 2011, the CMS Enterprise Data Architecture Group will work collaboratively with the TTAG Data Advisory subcommittee, the data consultant (hired in Task 1), and IHS to implement the data improvement strategies recommended in the TTAG Data Advisory subcommittee reports from 2007-2009.

Task 2: By December 2011, CMS will improve the data system linkages that occur between IHS and the Medicaid and Medicare programs, so that Medicaid and Medicare data collected and reported by CMS includes data for AI/ANs and I/T/U providers, as defined by IHS, and allows reporting of that data segmented the 12 IHS administrative areas. By implementing recommended data improvement strategies, the CMS Office of Research, Development and Information will have the capacity to collect and generate AI/AN-specific data reports by December 2011.

The Medicaid program produces Medicaid IHS Program data through these linkages; they need to be enhanced in quantity and quality in the 35 states with AI/ANs who use I/T/U providers. Policies and protocols for the data linkages need to be specified so that they are done uniformly and comprehensively in the 35 states. IHS AI/AN information, which is coded as AI or AN in the linked IHS beneficiary data, needs to be retained and available for reporting in Medicaid State Information Systems. Data on the providers (I/T/U) also needs to be retained and available for reports segmented by provider type.

Presently, the Medicare program can produce Medicare IHS Program data through linkages between its Enrollment Database and IHS. By using the IHS beneficiary status code it already has, Medicare can generate reports on its enrollment, services, and payment for AI/ANs using an IHS facility. By also linking IHS provider data fields to Medicare provider data fields, Medicare data can be reported separately for all three I/T/U provider types.

Task 3: From 2012 to 2015, the CMS Office of Research Development and Information will produce AI/AN and I/T/U data reports on Medicaid, Medicare, and SCHIP data on a quarterly basis, which will be distributed to the CMS Administrator and members of TTAG. Quarterly reports will be compiled into an annual report that includes demographic, enrollment, service use and payment data by IHS Area and provider type (I/T/U) for AI/AN, using definitions from the 2005-2010 AI/AN CMS Strategic Plan.

Task 4: CMS will work to ensure that race and Tribe data for AI/ANs is collected for Medicaid, Medicare, and SCHIP beneficiaries at the time of enrollment, in a manner that allows beneficiaries to report multiple races, a separate ethnicity, and tribal citizenship or identity (as done by the U.S. Census).

Task 5: The results of all data analyses completed by CMS that contain information about AI/ANs will be promptly communicated to Tribes and members of Indian Country. Any questions by CMS personnel about how best to facilitate this process should be directed to TTAG.

Objective 4c – By 2012, CMS and TTAG will update and annually revise its AI/AN research and evaluation plan to track and evaluate CMS program services and policy impacts for AI/ANs and I/T/Us.

Task 1: Using the AI/AN and I/T/U data generated quarterly by the CMS Office of Research Development and Information, CMS and TTAG will revise and prioritize its AI/AN research and evaluation plan by 2012. The plan will examine current CMS research activities, identify existing projects that may be relevant or applicable to AI/ANs, and identify unique topics not presently covered by CMS research activities.

Task 2: CMS will work with the TTAG Data Advisory subcommittee, Tribal Epidemiology Centers, the DHHS Health Research Advisory Committee for AI/ANs, and the NCAI Policy and Research Center to update the plan on an annual basis.

Budget request: $60,000 per year in 2012, 2013, and 2014. Funds will support the completion of this task by a qualified consultant or tribal organization, who will coordinate consultation activities needed to update and prioritize the comprehensive AI/AN research and evaluation plan.

Objective 4d – By 2013, CMS and TTAG will begin to carry out priority research activities identified in its AI/AN research and evaluation plan.

Task 1: To implement priority research and evaluation activities identified in the TTAG AI/AN research and evaluation plan, the CMS Office of Research Development and Information will integrate AI/AN research priorities into its own research agenda, or a qualified Tribal Epidemiology Center or external consultant will be hired to conduct needed research.

Budget request: $250,000 per year in 2013 and 2014. These funds will be used to hire an expert consultant or a qualified tribal organization to carry out research activities.

Goal 5: Establish and improve access to CMS funded Long Term Care (LTC) services throughout Indian Country.

Objective 5a – To enhance the provision of Long Term Care (LTC) services in Indian Country, CMS will develop a LTC report by January 2010 that will identify and evaluate opportunities for Tribes to use Medicare, Medicaid, and waiver provisions to improve upon and expand LTC services.

Task 1: Working with TTAG and IHS, CMS will produce a LTC report by January 2010 that will improve our understanding of existing and future LTC needs in Indian Country.

Budget request: Work in progress. In FY 2008 this activity was funded at $30,000; an additional $50,000 is requested for FY 2009.

The LTC report will include an inventory of current LTC services provided by IHS and tribal providers, including a description of existing programs for elders and individuals with disabilities, and a summary of LTC services provided by IHS and tribal programs. The LTC report will also include an inventory of State Medicaid Plans and waivers that provide long term care services in States where Indian Tribes are located, and will summarize model programs and how IHS and tribal providers participate. Additionally, the LTC report will identify opportunities and barriers for Medicare and Medicaid funding of LTC services in Indian Country and present "best practices" or models of successful LTC programs in Indian Country.

Objective 5b - By September 2010, CMS will develop an *AI/AN LTC Service Delivery Plan* and a *LTC Model Toolkit* to expand the availability of LTC services for AI/AN beneficiaries.

Task 1: Based on the information contained in the LTC report (Objective 5a), CMS will work with TTAG and IHS to develop an *AI/AN LTC Service Delivery Plan* containing strategies to overcome existing administrative or regulatory policy barriers for the implementation of LTC services in Indian Country, and recommendations on how to engage States and CMS in promising options for financing LTC services in Indian Country.

Task 2: Working with TTAG and IHS, CMS will develop a *LTC Model Toolkit* by September 2010 for use by IHS, Tribes, and tribal organizations in the development of LTC programs. The toolkit will include information on LTC services that are accessible and/or covered under State Plans and waivers, and will include options available to IHS, Tribes, and tribal organizations to overcome barriers and improve access to LTC services and financing.

Budget request: $75,000 for a one-time project. Funds will support the completion of this task by a qualified consultant or tribal organization, who will produce a *LTC Model Toolkit*. These funds will also cover any partner meetings needed to develop the model toolkit.

Task 3: By September 2010, TTAG and CMS will print and supply the *LTC Model Toolkits* to Tribes and State Medicaid Programs, provide technical assistance supporting its use and implementation, and will encourage them to work with IHS, Tribes, and tribal organizations to ensure successful implementation of LTC programs in Indian Country.

Budget request: $50,000 per year from 2010-2015. These funds will be used to print, disseminate, annually update, and provide technical assistance on use of the *LTC Model Toolkit*.

Objective 5c – Throughout the next five years, CMS and TTAG will work collaboratively to educate tribal leaders about long term care program planning and implementation, particularly regarding services that address the needs of elders, veterans, and persons with disabilities.

Task 1: By September 2010, CMS and TTAG will develop overarching principles and talking-points that describe the importance of LTC services in Indian Country.

Task 2: By 2011, CMS and TTAG will develop audience-specific educational materials that describe the importance of LTC services in Indian Country, and will disseminate these materials to tribal leaders.

Budget request: $20,000 per year. These funds will cover formative research, media design, printing, and dissemination.

Task 3: On an annual basis, CMS will work with TTAG and IHS to identify existing meetings or conferences that are attended by tribal leaders, at which workshops or presentations could be provided on LTC services in Indian Country. When appropriate, experts in this field will provide workshops or presentations.

Budget request: $25,000 per year. These funds will cover travel, per diem, and registration expenses for presentations at five or more national meetings/conferences ($5,000 per meeting).

Task 4: From 2012-2014, CMS will support an annual *AI/AN LTC Conference* for experts to provide education on LTC and allow tribal LTC programs to share their experiences with each other. To increase participation and maximize limited resources, TTAG will collaborate on this task with the CMSO Division of Disabled and Elderly Health Program Group, the National Indian Health Board, the National Congress of American Indians, the National Indian Council on Aging (NICOA), and the Agency for Healthcare Research and Quality.

Budget request: $100,000 per year in 2012, 2013, and 2014. These funds will cover conference planning, facility costs, speaker fees, travel, and registration expenses for a national AI/AN LTC conference.

AI/AN Healthcare Background

American Indians and Alaska Natives

There are 562 federally-recognized American Indian Tribes and Alaska Native entities in the United States, whose members are eligible for Federally-funded programs and services, including health care services provided by the Indian Health Service (IHS). Each Tribe has its own cultural and linguistic underpinnings and establishes its own governmental structure. The IHS is an agency within the Department of Health and Human Services that provides a comprehensive health service delivery system for approximately 1.9 million of the nation's estimated 3.3 million American Indians and Alaska Natives (AI/AN) who live on or near Indian reservations and Alaska Native Villages. Individual AI/ANs are also eligible beneficiaries of the Medicare, Medicaid and State Children's Health Insurance Programs when they meet the criteria for and enroll in those programs.

AI/AN Federal Policy

Federal Indian policy is a complex and comprehensive amalgam that draws upon treaties between Indian Nations and the United States, Indian-specific provisions in the U.S. Constitution, federal laws, U.S. Supreme Court cases and other case law. While federal Indian policy has shifted significantly throughout history, there are three basic legal principles that have remained constant that continue to guide the administration of federal programs:

1. **Federal trust responsibility.** The federal government has a unique historical and enduring legal relationship with and resulting responsibility to Indian Tribes, including the responsibility to provide health care for tribal members (See Appendix D, p. 62).

2. **Government-to-government relationship.** The federal government has acknowledged its responsibility to interact with Indian Tribes on a government-to-government basis. A key feature of this relationship obligates federal agencies to consult with tribal governments on federal policies that affect Tribes. The fundamental principles of consultation are set out in Executive Order 13175 (Nov. 6, 2000) and the related Presidential Executive Memorandum dated September 23, 2004.

3. **Tribal sovereignty.** Tribes are independent sovereign governments that are subordinate only to the United States as superior sovereign. They are not political subdivisions of any state and are not subject to state laws, except by Acts of Congress.

Indian Health Service Funding Levels

Medicare and Medicaid are considered entitlement programs in the federal budget process with funding based on utilization. By contrast, IHS funding is considered a "discretionary" program in the federal budget. Medicare and Medicaid outlays grow each year in proportion to the number of people served, the services provided, and the cost of health care. The IHS budget, however, is generally subject to the same constraints that are placed on the overall federal discretionary budget, including programs not related to health care. These constraints usually require that the budget be balanced without raising taxes or increasing the deficit. In this budget neutral environment, when entitlement funding increases, the discretionary budget must decline unless offset by other federal revenues. For the past two decades, increases in the IHS budget have been consistently less than the rate of inflation and do not properly reflect increases in the IHS user population. Each year there is less buying power and more people needing service.

Health care for AI/AN is severely rationed. The level of services fluctuates in response to the available dollars and the number of beneficiaries served. Because IHS does not have a defined benefit package, the funding and services available vary at each facility and program. Unlike in the private sector, an increase in the number of Indian health care users does not result in increased revenues. Since 1990, the IHS-eligible population has increased at a rate of 1.6 percent per year. Congressional spending for the IHS has not kept pace with population growth, or with medical inflation.

Indian health funding nationally was at 51 percent of the level of need in 2004. This included both direct Congressional appropriations for the IHS and collections from third parties such as Medicaid and Medicare. These calculations were made using actuarial methods for personal medical services, with the Federal Employee Health Plan benefit package as a benchmark at an estimated cost of $3,582 per user. In 2002 an additional $1.8 billion would have been required to bring Indian health care spending into parity with medical spending for federal employees.

CMS Funding for Indian Health Care

In 1976 Congress authorized Medicare and Medicaid (CMS) payment for services delivered in Indian health facilities (whether operated by the IHS or Tribes) through amendments to the Social Security Act made in the Indian Health Care Improvement Act of 1976 (P.L. 94-437) (IHCIA). The statutory language clearly indicates that Congress intended Indian health programs to access Medicaid and Medicare revenues. This funding was expected to provide critical resources to improve the quality of health care for AI/ANs to reduce existing disparities and facility deficiencies. The IHCIA directs that Medicaid and Medicare revenues shall not offset Congressional appropriations for the IHS, so that the total amount of funding for Indian health care would increase through use of CMS services, and not merely be shifted from one funding stream to another.

In recognition of the federal trust responsibility for Indian health, Congress stipulated that a 100 percent federal medical assistance percentage (FMAP) would apply to states for Medicaid services delivered to AI/ANs through IHS facilities. A Memorandum of Agreement (MOA) clarified that this 100 percent FMAP to states also applies to payments made for services provided through tribally-owned facilities.

Because Indian health information systems were designed for healthcare management and not for billing, it has been difficult to establish accurate costs of services. The IHS encounter rate was developed for Medicare and Medicaid payments by taking the combined costs of covered services and dividing that cost by the number of patient visits. Over time, the methodology for calculating the IHS encounter rate has become more sophisticated, using Method E cost reports for all Indian health hospitals. There are eight rates that are updated annually and published in the Federal Register that distinguish between inpatient and outpatient services, with rates for Alaska that are different from the lower 48 states. In addition to the IHS encounter rate, tribal health outpatient programs and facilities are eligible for Federally Qualified Health Center (FQHC) designation and most meet the requirements for Rural Health Center designation. Many IHS and tribal hospitals qualify for Critical Access Hospital designation.

Since Medicare Part B pays only 80 percent of allowable charges, the IHS encounter rate for outpatient Medicare services reflects a 20 percent reduction in payment. Consistent with the federal trust responsibility, IHS does not charge Indian consumers for services. Thus, the already under-funded Indian health system is forced to subsidize the Medicare program for services provided to Medicare beneficiaries.

Impact of CMS on Indian Health Care

Medicaid and Medicare payments represent a higher portion of funding for the Indian health system than any other source of funding except appropriations to IHS, yet reimbursements to I/T/U providers represent only a tiny portion of total Medicare and Medicaid expenditures.

- Even if all IHS beneficiaries under 19 years old and over 65 were enrolled in Medicaid or Medicare, they would represent only 1 percent of the total CMS beneficiary population.
- Payments to Indian health providers comprise about one-tenth of one percent of the CMS program outlays. In FY 2007, the Medicare and Medicaid collections reported by IHS were $677 million, which represents approximately 24 percent of the total funding for IHS health services. In 2007, CMS program outlays were $561 billion.
- Changes in CMS policies and programs applicable to Indian health can have a significant impact on Indian health program budgets, while they are insignificant in the overall CMS budget. The additional services that can be provided by Medicare and Medicaid payments directly affect the health status of American Indians and Alaska Natives served by the IHS system.

Choice of Medicaid and Medicare Payment Types

In view of funding shortfalls and the chronic health status deficiencies of AI/ANs, Indian health programs strive to maximize all sources of revenue, use their resources efficiently, and devote as much available funding as possible to direct patient care. This is consistent with the CMS Operational Objective for Program Administration:

> *"6. Develop and refine payment systems to foster efficiency, promote innovative service delivery and appropriate utilization, and ensure access to care for beneficiaries."*

There are advantages and disadvantages for various payment methodologies. The IHS encounter rate is a straightforward payment method that is simple and efficient to administer; therefore, it does not divert limited funding for health care services to costly administrative functions. However, the Medicare IHS encounter rate is only available for outpatient services that are an extension of hospital services.

The IHS encounter rate is calculated annually based on the cost of IHS services that are actually provided under the constrained budget available to IHS, not on the cost of all services that are covered by Medicaid and Medicare programs. These services are further constrained by space limitations in outdated Indian health facilities and various constraints in reimbursement authority for some Medicaid and Medicare covered services.

The Federally Qualified Health Centers (FQHC) rate is also an encounter rate, but by law, FQHC designation is available only to clinical operations of Tribes and urban Indian organizations; it cannot be used by IHS-operated facilities. While Tribes may choose to use the FQHC rate, they often have inherited the very limited accounting systems developed by the IHS and there have been insufficient IHS funds available to invest in upgrading business office information technology, making it impossible for many tribally-operated facilities to supply the data needed for calculation of an FQHC rate. In addition, some Tribes prefer not to use the FQHC rate because the amount is capped for Medicare services at a rate too low to compensate them for the actual costs of care.

IHS and tribal programs are limited in the extent to which they can participate in capitated payment systems, for several reasons. First, the IHS cannot enter into risk bearing arrangements inherent in capitation payments due to legal constraints imposed on federal agencies by the Anti-Deficiency Act. Tribes are usually unable to assume risk because they cannot be liable for delivering a benefit package to one group of IHS-beneficiaries when there is insufficient funding to provide that same benefit package to all IHS-beneficiaries. Furthermore, tribal populations are often so small that it is not possible to use statistical methods to develop reliable actuarial projections of costs.

AI/AN Low Enrollment in Medicaid and Medicare

Because IHS care is supplied to AI/ANs without charge, many Indian people do not see any need to enroll in Medicaid, Medicare, or SCHIP. They believe that the federal government should fully fund the Indian health care system. IHS and tribal programs must work vigorously to persuade patients who are eligible for Medicare and Medicaid to enroll in those programs, especially if such enrollment requires payment of a premium or co-pay. SCHIP regulations exempt AI/AN children from premiums and co-pays in order to facilitate SCHIP access for these children, but CMS does not have a consistent policy for waiving AI/AN cost sharing across all programs.

Even when there are no financial barriers, there are other problems that keep many eligible American Indians and Alaska Natives from enrolling in Medicaid, Medicare and SCHIP. Some of these problems include needing information in their native language, low literacy, lack of transportation to an enrollment site, needing help to understand forms and fill them out, and cultural differences that make it difficult to navigate the enrollment processes and bureaucracies. AI/AN enrollment in Medicaid, Medicare and SCHIP is more likely to happen when the following two conditions occur: 1) Indian health facilities require patients to apply for alternate resources before they can receive needed Contract Health Service authorization for medical specialty care; and 2) Indian health facilities directly assist patients in the enrollment process.

When CMS attempted to measure the gap between eligibility and enrollment of AI/AN in Medicaid and Medicare, they found that the data were inadequate to make meaningful estimates of the rate of under enrollment. Urban Indian clinics generally charge for their services, so there is a greater incentive for their patients to enroll in private and public insurance programs. There is variation among states in their efforts to enroll Medicaid beneficiaries; however, in the current financial climate both states and the federal government are seeking to reduce Medicaid expenditures by reducing enrollments, rather than assuring that each person who is eligible is enrolled in these important programs.

Problems, Causes, & Solutions

In the past several years, Tribes have identified several challenges associated with CMS policies and programs, particularly in relation to AI/AN access to CMS services, choice of providers, and payment methods and policies. There are several root causes for these challenges:

- **Authorization for Indian health providers to bill Medicaid and Medicare is relatively recent, and systems require redesign to interface effectively**. The Indian health system and the CMS programs evolved separately with very different guiding principles. CMS programs are designed as health insurance for consumers who seek medical care from private sector providers. By contrast, the Indian healthcare system is based on a public health model. Both are very complex organizations with systems and rules that are difficult for outsiders to comprehend. System fixes are needed to make programs managed by the two agencies interface effectively. However, since AI/ANs comprise such a small portion of the CMS budget and beneficiary population, a disproportionate amount of time and resources would be needed to make the two systems work effectively together. In the absence of clear direction from CMS leadership, employees are likely to take the most conservative and conventional approaches that perpetuate the established practices of the agency.

- **CMS staff do not understand the Indian health system, the special status of Tribes in federal law, or the classification of AI/AN as a political designation that is different from a racial group**. Often CMS rules and regulations do not make sense in the context of Indian communities and Indian health facilities. This is difficult for most employees at CMS to understand when they have not had firsthand experience in Indian Country. Fortunately, this root cause can largely be addressed through education and experience. Without education, CMS personnel attribute the rationale for AI/AN-specific services as being rooted in issues of equality and justice, rather than in their trust obligation.

  Stemming from this mindset, many people in CMS view AI/ANs as a racial minority or a special interest group, and take the position that any special accommodations for AI/ANs ought to be extended to other minority groups. Many CMS employees also believe that it is in the best interest of AI/ANs to bring their healthcare systems into conformity with mainstream America. Those who understand that Tribes are political and governmental entities rather than a racial category are more likely to respond creatively to the unique challenges of delivering healthcare in Indian Country. In addition, those who have experience with the quality of Indian health programs are also more likely to respond positively.

- **The CMS institutional organization undermines efforts to properly address the needs of Tribes**. The CMS organization is designed to address "race" issues, but is not designed to address policy issues affecting Tribes as political entities. In the process of policy development, there is a consistent review to assure compliance with laws related to civil rights. This is done at the highest levels of DHHS through the Office of Civil Rights (OCR) in the Office of the Secretary of DHHS, and the corresponding section of the Office of the General Counsel. There is no equivalent office to review CMS policy to assure the same level of consideration is given to the federal trust responsibility, the designation of Tribes as political entities, and other aspects of federal Indian law and policy. At CMS, Indian issues are handled primarily in the Office of External Affairs, which is seen by the organization as having a mission of communication, rather than policy review and development. In at least two recent cases, OCR and OGC have held that the states' requests to design Medicaid programs to meet the needs of AI/AN should be rejected because they were considered to be discriminatory based on race. As a result of these decisions, some employees in CMS believe that OCR limits their flexibility to respond to the solutions put forth by Tribes to improve enrollment in Medicaid and Medicare.

  CMS must find ways to balance and/or reconcile the civil rights perspective (in which AI/AN are regarded as a racial group) and federal Indian law that regards Tribes as political entities. Outside DHHS, this type of reconciliation has been shown by the independent U.S. Commission on Civil Rights, which has undertaken a broad review of AI/AN health and found that there should be special provisions for AI/AN. Resolution of this issue has become even more urgent with the recent trend to give more flexibility for states to design their Medicaid programs.

- **CMS does not provide incentives for employees to become advocates for Indian health care**. There is a perceived hierarchy for CMS career employees. There are more rewards and promotions for those who work in Medicare. Those who work in Medicaid have fewer career opportunities than those who work in Medicare. Those who work on issues that involve outside agencies tend to be marginalized in CMS. There is a perception that reaching out to work with other agencies, even within DHHS, is not rewarded by CMS. Thus, working on Indian health issues is not seen as a good career step for CMS employees. Most employees do not even think about the Indian health implications of most CMS decisions.

- **There are differing approaches to the processes of problem solving. Within CMS there is a linear approach to decision-making**. Issues and the recommended response work their way to higher levels in the organization until a decision is made and then it is announced without opportunities to appeal the decision. In most American Indian and Alaska Native cultures there is a consensus approach to decision-making that involves a more circular process. In keeping with this tradition, tribal leaders and their technical advisors generally expect a process that has the following steps:

1) There is an attempt by technical experts working for both CMS and Tribes to solve problems at the lowest level of the bureaucracy that is empowered to make decisions;
2) If the problem cannot be resolved in a mutually beneficial manner, the issues that create obstacles to that outcome are identified;
3) Tribal technical advisors return to the negotiating table with information to address each of the issues that has been identified and request reconsideration;
4) If the problem still cannot be resolved, Tribes take a more political approach and tribal leaders are engaged in conferring with the top leadership of CMS;
5) If CMS leadership cannot resolve the issue to mutual satisfaction, tribal leaders meet with the Secretary of the Department of Health and Human Services to get attention to the problem;
6) If the Secretary is unable or unwilling to find an acceptable solution, tribal leaders seek a meeting with the White House;
7) If the Administration is unable to respond satisfactorily to the issues, Tribes seek a legislative solution through Congress;
8) As a last resort, Tribes reserve the right to seek a legal remedy through federal courts.

Within CMS, there is an assumption that Tribes are working at all levels simultaneously and that the first time a decision is announced is the final decision. People who work in CMS cannot understand why issues keep resurfacing when they believe that an answer has been given. When Tribes move to a higher level in their stepwise approach to problem resolution, CMS sends the issue back to the person who dealt with it originally and that individual usually sees the process as re-work, duplication, a waste of resources, an exercise in futility, and a drain on their limited time for which there is competition from many other sources.

- **Communications are hampered by a mismatch in scope**. CMS is a "stove pipe" organization with expertise compartmentalized in different centers, offices, divisions, groups and individuals. Few positions require staff to deal with large, interrelated systems issues. By contrast, Indian cultures are characterized by a holistic view of the world, with all things interrelated. When tribal leaders talk about CMS issues, the conversations become very broad. They talk about the past, the present and the future. They talk about the complexities of Indian law and the Indian health system. Nearly everyone in CMS feels that their expertise is too narrow to be able to respond to these types of discussions.

  Indians want to talk about correcting the mistakes of the past, while the CMS staff wants to talk about a single, specific, new issue. Thus, CMS looks for the right people to bring to the table; however, the CMS staff who are there rarely believe they can respond to the issues that are raised by tribal leaders. Tribal leaders become frustrated because they cannot have the conversation that they want to have with people who are capable of making decisions. CMS staff are afraid that these

types of situations will spin out of control and that they will be personally attacked verbally. Alternatively, they worry that if they listen respectfully and try to respond in a culturally correct manner, it will be interpreted by tribal leaders as commitment to act on an issue when they are not empowered to take the actions necessary to follow through.

- **CMS finds it difficult to make American Indian and Alaska Native issues a priority**. The issues for Tribes, AI/AN and the Indian health system are very complex, but the populations and providers are very small. While some CMS staff understand tribal issues, it is difficult for them to find the time to research and write justifications to advocate for exceptions for AI/AN. It is also difficult for them to use their influence to persuade others to act on these recommendations that apply to less than one percent of CMS program eligibles. CMS staff are under pressure to work on issues affecting the other 99 percent of CMS program eligibles, so it is the path of least resistance to allow the complex issues related to AI/AN to remain unresolved.

Solution: Strategic Approaches

The challenge for CMS is to provide funding for covered services for beneficiaries in a manner that supports the Indian health system. At various times and places, federal and state governments have tried to re-make Tribes to look more like other types of institutions, but this has proven unsuccessful and unwarranted. The current federal policy of Indian self-determination and self-governance recognizes the rights of Tribes to design their own programs to meet the needs of their tribal members. This has led to improvements in health delivery and health status.

There is sufficient legal justification to create special rules for Indian health care that do not apply anywhere else. Primary to this “special case” approach are the federal trust responsibility, tribal sovereignty, and the government-to-government relationship. Other special conditions include the lack of market forces to support a private sector presence in much of Indian Country, the duty of the federal government to provide free health care to AI/AN, the lack of incentives for AI/AN to enroll in Medicaid, Medicare and SCHIP, and other barriers to enrollment. Furthermore, laws exempt Indian health facilities from non-discrimination standards that apply in other types of health facilities. The public health model and team approach to delivering Indian health services make it impossible to isolate costs of services in the same way that it is done with the private sector medical model. Concepts such as “market based approaches” and “profit” don’t apply in a setting where there are no profits and the total funding is at half the level of need. Rather than revisit these unique circumstances each time a policy is written, CMS can adopt a consistent set of principles that guides decisions and institutionalizes the process for review of issues to assure that Indian health concerns are addressed appropriately and effectively.

Even beyond the need for CMS to recognize the complex Indian health system differences are the compelling health status statistics for America's indigenous populations. Tribes have made great strides in reducing preventable health problems, but AI/AN still suffer disproportionately from disease.

To strategically and systematically improve AI/AN health, CMS must partner with Tribes to support and strengthen the Indian health care system. To minimize the administrative costs to both CMS and Tribes, the best approaches are simple and designed specifically to interface with Indian health care providers. There is a growing understanding that both CMS and IHS are responsible for health care for American Indians and Alaska Natives. Both share the federal trust responsibility. CMS has acknowledged that it must engage Tribes in a government-to-government relationship. With the help of the Tribal Technical Advisory Group (TTAG), CMS is developing new ways for the agency to work with Tribes. The CMS AI/AN Strategic Plan is intended to help guide that process.

Appendix A: Common Terms & Acronyms

AI/AN	American Indians and Alaska Natives
CHS	Contract Health Services (IHS program to purchase services)
CMM	Center for Medicare Management (in CMS)
CMS	Centers for Medicare & Medicaid Services
CMSO	Center for Medicaid and State Operations
CPC	Center for Drug and Health Plan Choice
DHHS	Department of Health and Human Services
FMAP	Federal Medical Assistance Percentage (for Medicaid)
FQHC	Federally Qualified Health Centers
I/T/U	Health care services operated by the IHS, Tribes and urban Indian clinics
IHCIA	Indian Health Care Improvement Act (P.L. 94-437)
IHS	Indian Health Service (a federal agency in DHHS)
LTC	Long Term Care
MA	Medicare Advantage (managed care plan)
MAM	Medicaid Administrative Match
MMA	Medicare Modernization Act of 2003
MOA	Memorandum of Agreement
NICOA	National Indian Council on Aging
NIHB	National Indian Health Board
OCR	Office of Civil Rights
OEA	Office of External Affairs
OGC	Office of General Counsel (in DHHS)
ORDI	Office of Research, Development and Information
Part C	Medicare managed care plans, also called Medicare Advantage
Part D	Medicare prescription drug benefit authorized in MMA
SCHIP	State Children's Health Ins. Program
TAG	Tribal Affairs Group (in CMS)
TTAG	Tribal Technical Advisory Group to CMS

Appendix B: Timeline, Budget, & Evaluation Plan

Goal 1: Execute CMS's legal and political obligation to engage in meaningful consultation with Tribes and work closely with the Tribal Technical Advisory Group (TTAG).				
Objective 1a: CMS will adopt and implement a Tribal Consultation Policy that complies with Presidential Executive Order No. 13175 and the DHHS Tribal Consultation Policy, and will evaluate its consultation processes on an annual basis. (See p. 22)	**Entities Responsible:** • TTAG • CMS Administrator	**Outcome Measures:** Written Tribal Consultation Policy adopted by CMS; Plan disseminated to staff annually; Consultation "scenarios" developed and disseminated; Consultation training provided annually to CMS staff; Consultation Evaluation Report produced annually.	**Timeline:** Policy implemented by 2010. Ongoing task implementation from 2010-2014.	**Budget by FY:** 2010 – $25,000 2011 – $25,000 2012 – $25,000 2013 – $25,000 2014 – $25,000 **FMIB#** 9318
Objective 1b: CMS will develop a set of values and principles that will be used by the agency to guide administrative decisions regarding Indian health policy. (See p. 23)	**Entities Responsible:** • TTAG • Tribal Affairs Group • CMS Administrator's Office	**Outcome Measures:** Written values and principles developed and distributed to CMS personnel.	**Timeline:** By 2010.	**Budget by FY:** 2010 - $25,000 2011 – $0 2012 – $0 2013 – $0 2014 – $0 **FMIB#** 9318

Goal 1 Continued: Execute CMS's legal and political obligation to engage in meaningful consultation with Tribes and work closely with the Tribal Technical Advisory Group (TTAG).				
Objective 1c: CMS will provide financial and administrative support to facilitate the ongoing activities of TTAG, and a sufficient budget to support TTAG activities included in the 2010-2015 Strategic Plan. (See p. 24)	**Entities Responsible:** • TTAG • Tribal Affairs Group • CMS Office of Financial Management	**Outcome Measures:** Active TTAG membership (15); 3 TTAG meetings per year; Sufficient budget to fulfill objectives and tasks, including AI/AN-specific reports; TAG fully staffed; TAG personnel succession plan created; Strategic Plan reviewed and updated regularly.	**Timeline:** Annually: 2010- 2014	**Budget by FY:** 2010 – $285,000 2011 – $385,000 2012 – $385,000 2013 – $385,000 2014 – $385,000 **FMIB#** 8822
Objective 1d: CMS personnel with the authority to make binding decisions will regularly participate in TTAG meetings, the Annual HHS Budget Consultation session, and HHS regional tribal consultation meetings and listening sessions. (See p. 25)	**Entities Responsible:** • CMS Administrator • CPC Director • CMM Director • CMSO Director	**Outcome Measures:** TTAG meeting attendance three times per year; Attendance at the annual HHS Budget Consultation session; Attendance at HHS regional tribal consultation meetings; TTAG Charter revised to include participatory requirements for CMS officials.	**Timeline:** Continually: 2010- 2014	**Budget by FY:** 2010 – $0 2011 – $0 2012 – $0 2013 – $0 2014 – $0 **FMIB#** none

Goal 2: Identify current and future administrative, regulatory, and legislative policies that impact AI/AN beneficiaries and I/T/U providers. Work closely with TTAG and IHS at all stages of the policy development process to design mutually-beneficial solutions.				
Objective 2a: CMS will enhance its support of I/T/U providers and AI/AN beneficiaries by providing thorough analyses of administrative rules and policies, and by taking administrative steps to encourage culturally appropriate and effective service delivery. (See p. 26)	**Entities Responsible:** • CMS Administrator • CPC Director • CMM Director • CMSO Director • Tribal Affairs Group	**Outcome Measures:** Increase in I/T/U participation and reimbursement for CMS services; Distribution of the *Indian Health Policy Manual*; Department-wide training on AI/AN issues; Placement of AI/ANs on advisory committees; Placement of AI/AN interns.	**Timeline:** Continually: 2010-2014	**Budget by FY:** 2010 – $35,000 2011 – $35,000 2012 – $35,000 2013 – $35,000 2014 – $35,000 **FMIB#** 9318
Objective 2b: CMS will thoroughly analyze regulatory policies to determine their impact on I/T/U providers and AI/AN beneficiaries, and will take regulatory action to improve service delivery. (See p. 27)	**Entities Responsible:** • CMS Administrator • CPC Director • CMM Director • CMSO Director • Tribal Affairs Group	**Outcome Measures:** Documentation of policies & TTAG recommendations; Documentation of timely response to congressional requests; Inclusion of beneficial AI/AN provisions in legislation.	**Timeline:** Continually: 2010-2014	**Budget by FY:** 2010 – $200,000 2011 – $250,000 2012 – $250,000 2013 – $250,000 2014 – $250,000 **FMIB#** 9318
Objective 2c: CMS and the Office of Legislation will provide timely analysis and support for legislation that affects the health of American Indians and Alaska Natives. (See p. 28)	**Entities Responsible:** • CMS Administrator • Tribal Affairs Group • Office of Legislation	**Outcome Measures:** Documentation of legislation & TTAG recommendations; Inclusion of beneficial language in legislation.	**Timeline:** Continually: 2010-2014	**Budget by FY:** 2010 – $50,000 2011 – $100,000 2012 – $100,000 2013 – $100,000 2014 – $100,000 **FMIB#** 9318

Goal 3: Increase AI/AN access to and use of CMS services.				
Objective 3a: CMS will design and implement a communications plan to assist Tribes in better understanding CMS programs, and encourage their full participation in CMS issues and TTAG discussions. (See p. 29)	**Entities Responsible:** • TTAG Education and Outreach Committee • Office of External Affairs	**Outcome Measures:** Written *Communication Plan*; CMS contracts with tribal organizations; CMS participation in relevant meetings; Travel assistance provided; Number of attendees at regional trainings.	**Timeline:** Annually: 2010- 2014	**Budget by FY:** 2010 – $160,000 2011 – $170,000 2012 – $180,000 2013 – $190,000 2014 – $200,000 **FMIB#** 8821
Objective 3b: CMS will work with TTAG to provide ongoing outreach and education for I/T/U facilities and AI/AN consumers about new or expanded Medicaid, Medicare, and SCHIP programs established by policy or legislation. (See p. 29)	**Entities Responsible:** • TTAG • IHS • Office of External Affairs	**Outcome Measures:** Documentation of administrative mechanisms; Development of guidelines for new programs; Demonstration projects implemented.	**Timeline:** Annually: 2010 - 2014	**Budget by FY:** 2010 – $200,000 2011 – $200,000 2012 – $200,000 2013 – $200,000 2014 – $200,000 **FMIB#** 8821
Objective 3c: CMS will improve its outreach and education activities targeting I/T/U providers by providing training and CMS-related capacity building assistance. (See p. 30)	**Entities Responsible:** • TTAG • Office of External Affairs • Tribal Affairs Group • IHS	**Outcome Measures:** Annual provider training plan; Documentation of trainings & meetings (agendas, post-training evaluations); List of topics for Open Door forums; Documentation of other special trainings provided.	**Timeline:** Annually: 2010-2014	**Budget by FY:** 2010 – $660,000 2011 – $660,000 2012 – $660,000 2013 – $660,000 2014 – $660,000 **FMIB#** 9350

Goal 3 Continued: Increase AI/AN access to and use of CMS services.				
Objective 3d: CMS will improve its outreach and education efforts targeting eligible American Indians and Alaska Natives. (See p. 31)	**Entities Responsible:** • TTAG • Office of External Affairs • Tribal Affairs Group • IHS	**Outcome Measures:** Documentation of materials developed and disseminated; Consultant hired; Tracking enrollment rates over time.	**Timeline:** Annually: 2010-2014	**Budget by FY:** 2010 – $180,000 2011 – $230,000 2012 – $180,000 2013 – $180,000 2014 – $180,000 **FMIB#** 8821
Objective 3e: Working with TTAG, CMS will evaluate the quality and effectiveness of CMS outreach and education activities and their impact on AI/AN enrollment and access to services. (See p. 31)	**Entities Responsible:** • TTAG • Office of External Affairs • Tribal Affairs Group • IHS	**Outcome Measures:** Surveys, focus groups, and other evaluative reports; Tracking of enrollment rates over time.	**Timeline:** Annually: 2010-2014	**Budget by FY:** 2010 – $0 2011 – $0 2012 – $0 2013 – $0 2014 – $0 **FMIB#** none

Goal 4: Develop and improve CMS data systems in order to evaluate and expand the capacity of CMS to serve AI/ANs.				
Objective 4a: In 2010, CMS will work with TTAG and IHS to identify strategies that will make the CMS data systems capable of reporting AI/AN enrollment, service utilization, health status and payment data from Medicare, Medicaid and SCHIP programs. (See p. 32)	**Entities Responsible:** • TTAG Data Advisory subcommittee • CMS Enterprise Data Architecture Group • IHS • TTAG Consultant	**Outcome Measures:** Data consultant hired; Annual Reports Produced.	**Timeline:** Continually: 2010-2011	**Budget by FY:** 2010 – $200,000 2011 – $200,000 2012 – $0 2013 – $0 2014 – $0 **FMIB#** New #
Objective 4b: From 2010 to 2011, the Enterprise Data Architecture Group at CMS will work with TTAG and IHS to develop data systems that improve system linkages with the Indian Health Service to enable reporting of AI/AN enrollment, service utilization, health status and payment data segmented by IHS administrative area (12 IHS areas). (See p. 33)	**Entities Responsible:** • TTAG Data Advisory subcommittee • CMS Enterprise Data Architecture Group • IHS • TTAG Consultant	**Outcome Measures:** Recommendations Implemented; Data reports produced quarterly.	**Timeline:** Continually: 2010-2015	**Budget by FY:** 2010 – $0 2011 – $0 2012 – $0 2013 – $0 2014 – $0 **FMIB#** none

Goal 4 Continued: Develop and improve CMS data systems in order to evaluate and improve the capacity of CMS to serve AI/ANs.				
Objective 4c: CMS and TTAG will update and annually revise its AI/AN research and evaluation plan to track and evaluate CMS program services and policy impacts for AI/ANs and I/T/Us. (See p. 34)	**Entities Responsible:** • TTAG • IHS • TTAG Consultant • CMS Office of Research, Development, and Information • Tribal Epidemiology Centers • HHS Health Research Advisory Committee for AI/ANs • NCAI Policy and Research Center	**Outcome Measures:** Consultant contracted; Annual plan revised and prioritized.	**Timeline:** Annually: 2012-2014	**Budget by FY:** 2010 – $0 2011 – $0 2012 – $60,000 2013 – $60,000 2014 – $60,000 **FMIB#** New #
Objective 4d: CMS and TTAG will begin to carry out priority research activities identified in its AI/AN research and evaluation plan. (See p. 34)	**Entities Responsible:** • TTAG • CMS Office of Research, Development, and Information • Tribal Epidemiology Centers or external consultant	**Outcome Measures:** Priority research activities carried out.	**Timeline:** Continually: 2013-2014	**Budget by FY:** 2010 – $0 2011 – $0 2012 – $0 2013 – $250,000 2014 – $250,000 **FMIB#** New #

Goal 5: Establish and improve access to CMS funded Long Term Care (LTC) services throughout Indian country.				
Objective 5a: To enhance the provision of Long Term Care (LTC) services in Indian Country, CMS will develop a LTC report by January 2010 that will identify and evaluate opportunities for Tribes to use Medicare, Medicaid, and waiver provisions to improve upon and expand LTC services. (See p. 35)	**Entities Responsible:** • TTAG • NIHB • Tribal Affairs Group • IHS	**Outcome Measures:** LTC Report written.	**Timeline:** By January 2010.	**Budget by FY:** 2010 – $0 2011 – $0 2012 – $0 2013 – $0 2014 – $0 **FMIB#** none
Objective 5b: CMS will develop an *AI/AN LTC Service Delivery Plan* and a *LTC Model Toolkit* to expand the availability of LTC services for AI/AN beneficiaries. (See p. 35)	**Entities Responsible:** • TTAG • Tribal Affairs Group • State Medicaid Programs • IHS	**Outcome Measures:** AI/AN LTC Service Delivery Plan developed; LTC Model Toolkit developed; LTC Model Toolkit printed and disseminated; Log of technical assistance provided to States and Tribes.	**Timeline:** Continually: 2010-2014	**Budget by FY:** 2010 – $125,000 2011 – $50,000 2012 – $50,000 2013 – $50,000 2014 – $50,000 **FMIB#** 8821
Objective 5c: CMS and TTAG will work collaboratively to educate tribal leaders about long term care program planning and implementation. (See p. 36)	**Entities Responsible:** • TTAG; Tribal Affairs Group • NIHB; NICOA • CMSO Division of Disabled and Elderly Health Program Group(• AHRC	**Outcome Measures:** Tribal LTC values and principles developed; Development of educational materials; List of meetings/conferences attended; AI/AN LTC Conference.	**Timeline:** Annually: 2010-2014	**Budget by FY:** 2010 – $25,000 2011 – $45,000 2012 – $145,000 2013 – $145,000 2014 – $145,000 **FMIB#** 8821

Appendix C: Tasks by Fiscal Year

	Objectives & Tasks	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Goal 1	**Objective 1a - CMS Tribal Consultation Policy**					
	Task 1 – Collaborate with TTAG to implement the agency's Tribal Consultation Policy	✓				
	Task 2 – Produce annual report documenting consultation activities and outcomes	$ 25,000	$ 25,000	$ 25,000	$ 25,000	$ 25,000
	Objective 1b - CMS AI/AN Values and Principles					
	Task 1 – Develop values and principles to guide CMS AI/AN policy formation	$ 25,000				
	Objective 1c - TTAG Financial and Administrative Support					
	Task 1 – CMS will fully fund TTAG	$ 185,000	$ 185,000	$ 185,000	$ 185,000	$ 185,000
	Task 2 – CMS will commission AI/AN-specific reports and TTAG objectives	$ 100,000	$ 200,000	$ 200,000	$ 200,000	$ 200,000
	Task 3 – CMS will involve TTAG in all stages of CMS policy formulation	✓	✓	✓	✓	✓
	Task 4 – CMS will hire at least 7 FTE and develop a personnel succession plan for the Tribal Affairs Group	✓	✓	✓	✓	✓
	Task 5 – TTAG will use the Timeline and Evaluation Matrix to review and update the CMS AI/AN Strategic Plan	✓	✓	✓	✓	✓
	Task 6 – CMS and TTAG will meet annually with IHS to collaborate on tasks associated with this strategic plan	✓	✓	✓	✓	✓
	Objective 1d - CMS Participation in TTAG Meetings and Consultation Activities					
	Task 1 – CMS, CPC, CNM, CMSO and TTAG will have at least three face-to-face meetings annually	✓	✓	✓	✓	✓
	Task 2 – Key CMS leadership will attend regional DHHS consultation meetings	✓	✓	✓	✓	✓
	Task 3 – CMS and TTAG will revise the TTAG Charter to include participatory req.	✓				
	Totals	**$ 335,000**	**$ 410,000**	**$ 410,000**	**$ 410,000**	**$ 410,000**

	Objectives & Tasks	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Goal 2	**Objective 2a – CMS Administrative Policies**					
	Task 1 - CMS will confer with TTAG on administrative matters that impact AI/ANs or I/T/U providers	✓	✓	✓	✓	✓
	Task 2 – CMS will review data reports, research findings, and recommendations re: AI/AN enrollment in CMS	$ 25,000	$ 25,000	$ 25,000	$ 25,000	$ 25,000
	Task 3 – CMS will work with IHS and TTAG to expand participation and reimbursement for I/T/U providers	✓	✓	✓	✓	✓
	Task 4 – CMS and TTAG will develop an online Indian Health Manual containing AI/AN payment policies	$ 10,000	$ 10,000	$ 10,000	$ 10,000	$ 10,000
	Task 5 –Provide department-wide AI/AN training for CMS employees	✓	✓	✓	✓	✓
	Task 6 – CMS will annually review its advisory committees to identify opportunities for AI/AN participation	✓	✓	✓	✓	✓
	Task 7 – CMS will identify meaningful internship opportunities for AI/ANs	✓	✓	✓	✓	✓
	Objective 2b – CMS Regulatory Policies					
	Task 1 - CMS will confer with TTAG to will identify regulatory policies that affect AI/ANs or I/T/U providers	✓	✓	✓	✓	✓
	Task 2 – CMS will confer with TTAG and Area Indian Health Boards on Federal and State policies that affect AI/ANs and will require that States consult with local Tribes	$ 150,000	$ 150,000	$ 150,000	$ 150,000	$ 150,000
	Task 3 - Analyze how Medicaid, Medicare, and SCHIP regulations affect AI/ANs	$ 50,000	$ 100,000	$ 100,000	$ 100,000	$ 100,000
	Objective 2c – CMS Legislative Policies					
	Task 1 - CMS will confer with TTAG to evaluate policies that affect AI/ANs or I/T/U providers in all new legislation	$ 50,000	$ 100,000	$ 100,000	$ 100,000	$ 100,000
	Task 2 – CMS will respond in a timely way to congressional requests for comment on CMS legislation impacting AI/ANs or I/T/Us	✓	✓	✓	✓	✓
	Task 3 - CMS will incorporate provisions for AI healthcare in legislation proposed by the Administration or Congress	✓	✓	✓	✓	✓
	Totals	**$ 285,000**	**$ 385,000**	**$ 385,000**	**$ 385,000**	**$ 385,000**

	Objectives & Tasks	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Goal 3	**Objective 3a – Communication Strategies to Improve AI/AN Access and Use**					
	Task 1 - CMS will work with TTAG and its Outreach & Education subcommittee to develop a communications plan targeting I/T/U providers	✓	✓	✓	✓	✓
	Task 2 - CMS will use tribal organizations to share CMS information via established communication channels	$ 25,000	$ 25,000	$ 25,000	$ 25,000	$ 25,000
	Task 3 - At the request of tribal organizations, CMS will participate in tribal meetings	$ 75,000	$ 75,000	$ 75,000	$ 75,000	$ 75,000
	Task 4 - CMS will contract with tribal organizations to publicize and provide travel assistance to Tribes to participate in CMS trainings	$ 60,000	$ 70,000	$ 80,000	$ 90,000	$ 100,000
	Objective 3b – Guidelines and Mechanisms to Improve AI/AN Access and Use					
	Task 1 – CMS will work with IHS and TTAG to ensure I/T/Us have administrative mechanisms to implement CMS programs	$ 100,000	$ 100,000	$ 100,000	$ 100,000	$ 100,000
	Task 2 – CMS will work with IHS and TTAG to develop guidelines to implement new CMS programs in Indian Country	$ 100,000	$ 100,000	$ 100,000	$ 100,000	$ 100,000
	Objective 3c – CMS Outreach and Education Targeting I/T/U Providers					
	Task 1 - CMS and TTAG will develop a training plan for I/T/Us using Information Technology communication systems	$ 60,000	$ 60,000	$ 60,000	$ 60,000	$ 60,000
	Task 2 - CMS will hold trainings in each of the IHS Areas to provide information about Medicare, Medicaid, and SCHIP to I/T/Us	$ 300,000	$ 300,000	$ 300,000	$ 300,000	$ 300,000
	Task 3 – CMS will provide Tribes, IHS, and tribal organizations with resources to increase AI/AN enrollment	$ 300,000	$ 300,000	$ 300,000	$ 300,000	$ 300,000
	Task 4 - Open Door Forums will be scheduled specifically for issues related to Indian healthcare at least two times per year	✓	✓	✓	✓	✓
	Task 5 - As new programs and policies are developed by CMS, special training sessions will be held in a timely fashion	✓	✓	✓	✓	✓

Goal 3	**Objective 3d – CMS Outreach and Education Targeting AI/AN beneficiaries**					
	Task 1 - CMS will contract with Tribes and tribal organizations to assist in creating and distributing culturally appropriate materials	$ 180,000	$ 180,000	$ 180,000	$ 180,000	$ 180,000
	Task 2 - CMS will hire a consultant to explore alternatives to funding for I/T/Us to assist AI/AN with enrollment in Medicaid, Medicare, and SCHIP		$ 50,000			
	Objective 3e – Evaluating Outreach Activities in relation to AI/AN Access and Use					
	Task 1 - TTAG will work with CMS to develop surveys and other appropriate data collection methods to measure the effectiveness of outreach and education activities	✓	✓	✓	✓	✓
	Totals	**$ 1,200,000**	**$ 1,260,000**	**$ 1,220,000**	**$ 1,230,000**	**$ 1,240,000**

	Objectives & Tasks	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Goal 4	**Objective 4a – CMS will Analyze and Improve Data Systems**					
	Task 1 – A consultant will be hired to study Medicaid, Medicare and SCHIP program data for AI/AN enrollees, work with CMS to improve data systems, and produce annual reports	$ 200,000	$ 200,000			
	Objective 4b – CMS will Improve Data Linkages					
	Task 1 - The CMS Enterprise Data Architecture Group will work with TTAG, the data consultant, and IHS will implement data improvement strategies	✓	✓			
	Task 2 - CMS will improve data system linkages between IHS and Medicaid & Medicare to ensure that collected data is AI/AN-specific	✓	✓			
	Task 3 - CMS will produce AI/AN and I/T/U data reports on Medicaid, Medicare, and SCHIP data on a quarterly basis			✓	✓	✓
	Task 4 – CMS will work to ensure that AI/AN data collected at enrollment will allow beneficiaries to report multiple races and ethnicities	✓	✓	✓	✓	✓
	Task 5 - Data analyses conducted by CMS containing information on AI/ANs will be communicated to Tribes and Indian Country	✓	✓	✓	✓	✓
	Objective 4c – AI/AN Research and Evaluation Plan					
	Task 1 – With AI/AN and I/T/U data generated quarterly by the CMS Office of Research Development and Information, CMS and TTAG will revise and prioritize its AI/AN research and evaluation plan			✓		
	Task 2 – CMS will work with the TTAG Data Advisory Committee, Tribal Epidemiology Centers, HHS Health Research Advisory Committee for AI/ANs, and NCAI Policy and Research Center to update the plan on an annual basis.			$ 60,000	$ 60,000	$ 60,000
	Objective 4d – Implement Priority AI/AN Research					
	Task 1 - CMS Office of Research Development and Information will integrate AI/AN research priorities into its research agenda				$ 250,000	$ 250,000
	Totals	**$ 200,000**	**$ 200,000**	**$ 60,000**	**$ 310,000**	**$ 310,000**

	Objectives & Tasks	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Goal 5	**Objective 5a – Identify and Improve Long Term Care for AI/ANs**					
	Task 1 – CMS will produce an AI/AN LTC report that will improve our understanding of existing and future LTC needs in Indian Country	✓				
	Objective 5b - Develop AI/AN LTC Plan and Model Toolkit					
	Task 1 - Based on information collected in the AT/AN LTC report, CMS, TTAG and IHS will develop an AI/AN LTC Service Delivery Plan	✓				
	Task 2 – CMS, IHS and TTAG will develop a LTC Model Toolkit for use by IHS, Tribes, and tribal organizations in the development of LTC programs	$ 75,000				
	Task 3 - TTAG and CMS will supply the LTC Model Toolkits to Tribes and State Medicaid Programs, and will provide technical assistance on its use	$ 50,000	$ 50,000	$ 50,000	$ 50,000	$ 50,000
	Objective 5c – Facilitate LTC Education and Implementation					
	Task 1 - CMS and TTAG will develop overarching principles that describe the importance of LTC services.	✓				
	Task 2 - CMS and TTAG will develop educational materials that describe the importance of LTC services in Indian Country.		$ 20,000	$ 20,000	$ 20,000	$ 20,000
	Task 3 – CMS will identify existing meetings attended by tribal leaders, at which workshops or presentations could be provided on LTC services in Indian Country	$ 25,000	$ 25,000	$ 25,000	$ 25,000	$ 25,000
	Task 4 - CMS will support an annual AI/AN LTC Conference to provide education and allow programs to share expertise			$ 100,000	$ 100,000	$ 100,000
	Totals	**$ 150,000**	**$ 95,000**	**$ 195,000**	**$ 195,000**	**$ 195,000**

Appendix D: Legal Basis for Special CMS Provisions for AI/ANs

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

It is beyond question that the obligation to carry out the trust responsibility to Indians applies to all agencies of the federal government -- including the Centers for Medicare & Medicaid Services (CMS) -- as evidenced by Presidential Executive Orders and Special Memoranda.[3] Furthermore, with regard to health care for AI/ANs, federal law assigns comprehensive duties to the Secretary of the Department of Health and Human Services (HHS) in order to achieve the goals and objectives established by Congress for Indian health. The trust responsibility, and laws enacted pursuant thereto, provides ample authority for the Secretary -- whether acting through the IHS, CMS, or other agency of DHHS -- to take pro-active efforts to achieve the Indian health objectives Congress has articulated.

Origins of the trust responsibility to Indians

The federal trust responsibility to Indians, and the related power to exercise control over Indian affairs in aid of that responsibility, is rooted in the United States Constitution -- most significantly the Indian Commerce Clause, the Treaty Clause, and the exercise of the Supremacy Clause.[4] The Constitution

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

4 *Morton v. Mancari*, 417 U.S. 535, 551-552 (1974) ("The plenary power of Congress to deal with the special problems of Indians is drawn both explicitly and implicitly from the Constitution itself."); *McClanahan v. Arizona*

contains no explicit language that defines the trust relationship. Rather, the parameters of the trust responsibility have evolved over time through judicial pronouncements, treaties, Acts of Congress, Executive Orders, regulations, and the ongoing course of dealings between the federal government and Indian tribal governments.

The earliest formal dealings between the federal government and Indian tribes were undertaken through treaty-making. From the United States' perspective, treaty objectives were essentially two-fold: cessation of hostilities to achieve/maintain public peace, and acquisition of land occupied by tribal inhabitants. Tribes doubtless had a peace-making motive as well, but in return for the vast tracts of land they relinquished to the more powerful federal government, tribes also obtained the promise -- expressed or implied -- of support for the social, educational, and welfare needs of their people, including health care. These treaties/promises were the first expression of the federal government's obligation to Indian tribes.

The initial express recognition that a trust responsibility existed came from the courts. In the landmark case of *Cherokee Nation v. Georgia*, 30 U.S. 1 (1831), Chief Justice John Marshall established the legal foundation for the trust responsibility by describing Indian tribes as "domestic dependent nations" whose relationship with the United States "resembles that of a ward to his guardian." *Id*. at 17. That theme -- and the duty of the federal sovereign to Indian tribes -- carried forward some 50 years later when, in *United States v. Kagama*, 118 U.S. 375, 384 (1886), the Supreme Court acknowledged that tribes are under the protection and care of the United States:

> "From their very weakness and helplessness, so largely due to the course of dealing of the federal government with them, and the treaties in which it has been promised, there arises the duty of protection, and with it the power [of protection]."[5]

Through nearly two centuries of case law, the courts have extensively examined the parameters of the trust responsibility to Indians, frequently in the context of whether the federal government has the authority to perform an action and whether there are limitations on the exercise of Congressional power over Indian affairs. While Congress has plenary authority over Indian matters through the

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State Tax Comm'n, 411 U.S. 164, 172, n.7 (1973); s*ee also* TASK FORCE NO. 9, VOL. 1, AMERICAN INDIAN POLICY REVIEW COMM'N 31 (1976) (explaining the origins of Constitutional power to regulate Indian affairs as flowing from Congress's treaty making powers, powers to regulate commerce with Indian tribes, and its authority to withhold appropriations); FELIX S. COHEN, HANDBOOK OF FEDERAL INDIAN LAW 220-225 (1982); Reid Payton Chambers, *Judicial Enforcement of the Federal Trust Responsibility to Indians*, 27 STAN. L. REV. 1213, 1215-1220 (1975).

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

Constitution, the "guardian-ward" relationship articulated by Chief Justice Marshall should require that federal actions be beneficial, or at least not harmful, to Indian welfare. This is not to say, however, that the United States has always acted honorably toward Indians throughout its history.[6] Nonetheless, the fact that our government has failed in some instances to act in an honorable manner toward Indians does not and should not absolve the superior sovereign from its responsibility to carry out its obligations honorably. As noted by the preeminent Indian law scholar, Felix S. Cohen --

> "[W]here Congress is exercising its authority over Indians rather than some other distinctive power, the trust obligation apparently requires that its statutes be based on a determination that *the Indians will be protected*. Otherwise, such statutes would not be rationally related to the trustee obligation."[7]

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

In pursuit of its authority under the Constitution and the trust responsibility, Congress has enacted Indian-specific laws on a wide variety of topics[8] as well as included Indian-specific provisions in general laws to address Indian participation in federal programs.[9] In the landmark case of *Morton v. Mancari*,

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

[7] FELIX S. COHEN, HANDBOOK OF FEDERAL INDIAN LAW 221 (1982) (emphasis added).

[8] *See, e.g.,* Indian Self-Determination and Education Assistance Act, 25 U.S.C. §450, *et seq.*; Indian Education Act, 20 U.S.C. §7401, *et seq.*; Tribally Controlled Schools Act, 25 U.S.C. §2501, *et seq.*; Tribally Controlled College or University Assistance Act, 25 U.S.C. §1801, *et seq.*; Native American Housing Assistance and Self-Determination Act, 25 U.S.C. §4101, *et seq.*; Indian Child Welfare Act, 25 U.S.C. §1901, *et seq.*; Indian Child Protection and Family Violence Prevention Act, 25 U.S.C. §3201, *et seq.*; Indian Employment, Training, and Related Services Demonstration Act, 25 U.S.C. §3401, *et seq.*

[9] *See, e.g.,* 42 U.S.C. §1395qq (eligibility of IHS/tribal facilities for Medicare payments); 42 U.S.C. §1396j (eligibility of IHS/tribal facilities for Medicaid payments); 42 U.S.C. §1397bb(b)(3)(D) (assurance of SCHIP services to eligible low-income Indian children); Elementary and Secondary Education Act, as amended, 20 U.S.C. §6301, *et seq.* (funding set-asides throughout this law for the benefit of children enrolled in the Bureau of Indian Affairs school system); Impact Aid Program, 20 U.S.C. §7701, *et seq.* (federal aid to public school districts for Indian children living on Indian lands); Carl D. Perkins Vocational and Applied Technology Education Act, 20 U.S.C. §§2326 and 2327 (funding set-aside for Indian vocational education programs and tribal vocational institutions); Higher Education Act, 20 U.S.C. §1059c (funding for tribally-controlled higher education institutions); Individuals with Disabilities Education Act, 20 U.S.C. §1411(c) (funding set-aside for Bureau of Indian Affairs schools); Head Start Act, 42 U.S.C. §9801, *et seq.* (includes funding allocation for Indian tribal programs and special criteria for program eligibility); Federal Highway Act, 23 U.S.C. §101, *et seq.* (1998 and 2005 amendments include funding set-asides for Indian reservation roads programs and direct development of regulations through Negotiated Rulemaking with tribes).

417 U.S. 535 (1974), the Supreme Court set out the standard of review for such laws -- the "rational basis" test. In *Mancari*, the Court reviewed an assertion by non-Indians that the application of Indian preference in employment at the Bureau of Indian Affairs (as ordered in the Indian Reorganization Act[10]) was racially discriminatory under the then-recently amended civil rights law which prohibited racial discrimination in most areas of federal employment.

While the Supreme Court's civil rights jurisprudence has generally applied strict scrutiny when reviewing classifications based on race, color, or national origin,[11] in *Mancari* the Court determined that this test was not appropriate when reviewing an Indian employment preference law. Indeed, the Court declared that the practice under review was not even a "racial" preference. Rather, in view of the unique historic and political relationship between the United States and Indian tribes, the Court characterized the preference law as *political* rather than *racial,* and said that "[a]s long as the special treatment [for Indians] can be tied rationally to the fulfillment of Congress' unique obligation toward the Indians, such legislative judgments will not be disturbed." *Id*. at 555. Here, the Court found that hiring preferences in the federal government's Indian service were intended *"to further the Government's trust obligation toward the Indian tribes",* to provide greater participation in their own self-government, and "to reduce the negative effect of having non-Indians administer matters that affect Indian tribal life" in agencies such as the BIA which administer federal programs for Indians. *Id*. at 541-542 (emphasis added).[12]

Once the link between special treatment for Indians as a political class and the federal government's unique obligation to Indians is established, "ordinary rational basis scrutiny applies to Indian

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[10] 25 U.S.C. §461, *et seq.* The Indian hiring preference appears at 25 U.S.C. §472.

[11] The Supreme Court has interpreted Title VI to allow racial and ethnic classifications only if those classifications are permissible under the Equal Protection Clause. *Regents of Univ. of Cal. v. Bakke*, 438 U.S. 265, 287 (1978). In this regard, the Court has also stated that "all racial classifications, imposed by whatever federal, state, or local governmental actor, must be analyzed by a reviewing court under strict scrutiny. In other words, such classifications are constitutional only if they are narrowly tailored measures that further compelling governmental interests." *Adarand Constructors, Inc. v. Pena*, 515 U.S. 200, 227 (1995).

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

classifications just as it does to other non-suspect classifications under equal protection analysis." *Narragansett Indian Tribe v. National Indian Gaming Comm'n.*, 158 F.3d 1335, 1340 (D.C. Cir. 1998).

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

> "The decisions of this Court leave no doubt that federal legislation with respect to Indian tribes, although relating to Indians as such, *is not based upon impermissible racial classifications*. Quite the contrary, classifications singling out Indian tribes as subjects of legislation are expressly provided for in the Constitution and supported by the ensuing history of the Federal Government's relations with Indians." *Antelope*, 430 U.S. at 645 (emphasis added).

Recognition of the federal trust responsibility in health laws

Since the early part of the 20th century, Congress has enacted a number of laws that authorize, direct, and fund the provision of health care services to Indian people.[13] Here, however, we focus on only one of those laws: the Indian Health Care Improvement Act (IHCIA).[14]

Enacted in 1976 as Public Law 94-437, the IHCIA brought statutory order and direction to the delivery of federal health services to Indian people. Its legislative history catalogued the deplorable conditions of Indian health that demanded legislative attention: inadequate and under-staffed health facilities; improper or non-existent sanitation facilities; prevalence of disease; poor health status; inadequate funding;[15] low enrollment of Indians in Medicare, Medicaid, and Social Security; serious shortage of

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

[14] 25 U.S.C. §1601, *et seq.*

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

health professionals, including Indian health professionals; and the need for health care for Indian people who had moved from reservations to urban areas. The legislation addressed each of these deficiencies through focused titles: Manpower; Health Services; Health Facilities (including sanitation facilities); Access to Medicare and Medicaid; Urban Indian Health; and a feasibility study for establishing an American Indian School of Medicine.[16]

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

- Sec. 1880 made IHS hospitals (including those operated by Indian tribes[17]) eligible to collect Medicare reimbursement
- Sec. 1911 made IHS and tribal facilities eligible to collect reimbursements from Medicaid
- An amendment to Sec. 1905(b) applied a 100 percent FMAP to Medicaid services provided to an Indian by an IHS or tribally-operated facility.

Sections 1880 and 1911 were intended to bring additional revenue into the Indian health system in order to address the deplorable condition of Indian health facilities, many of which were in such a poor state they were unable to achieve accreditation. The application of a 100% FMAP to the Medicaid-covered services provided by these facilities was made in express recognition of the federal government's treaty obligations for Indian health. The Committee of jurisdiction observed that since the United States already had an obligation to pay for health services to Indians as *IHS beneficiaries,* it was appropriate for the U.S. to pay the full cost of their care as *Medicaid beneficiaries*.[18] This action is consistent with the status of AI/ANs as a *political* designation.

Through amendments to Sec. 1880 made in 2000 and 2003, IHS and tribal hospitals and clinics are now authorized to collect reimbursements for all Medicare Part A and Part B services. As health care providers, IHS and tribal health programs are authorized to collect reimbursements under Medicare Parts C and D, as well. [19]

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

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

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

[19] In fact, Congress expressly authorized the Secretary of HHS to issue standards to assure access by pharmacies operated by the IHS, tribes and urban Indian organizations to the new Medicare prescription drug benefit (42

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

> "Federal health services to maintain and improve the health of the Indians are consonant with and required by the Federal Government's historical and unique legal relationship with, and resulting responsibility to, the American Indian people."[20]
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> "The Congress hereby declares that it is the policy of this Nation, in fulfillment of its special responsibilities and legal obligation to the American Indian people, to assure *the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy*."[21]

In 1992, Congress amended the IHCIA to enumerate 61 health status objectives for Indians that were to be met by the year 2000.[22]

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

Federal trust responsibility and the Executive Branch

The federal government's general trust duty to provide social services and its duty as a trustee to protect and manage Indian trust property are different types of duties and thus are treated differently by the courts.[23] Courts have generally been reluctant to impose liability for the federal government's

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U.S.C. §1395w-104(b)(1)(C)(iv)), and required the Secretary to establish procedures (including authority to waive requirements) to assure participation by these pharmacies in the transitional assistance feature of the temporary discount drug program. 42 U.S.C. §1395w-141(g)(5)(B).

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

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

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

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

failure to provide social services under the general trust relationship. [24] One notable exception is the case of *Morton v. Ruiz*[25] where the Supreme Court said the Bureau of Indian Affairs erred in refusing to provide welfare benefits to unemployed Indians who lived off, but near, their reservation. The Court reiterated that the "overriding duty of our Federal Government [is] to deal fairly with Indians wherever located", and that BIA's failure to publish eligibility criteria through Administrative Procedure Act regulations was not consistent with the "distinctive obligation of trust incumbent upon the Government in its dealings" with Indians.[26]

The IHCIA provisions quoted above expressly recognize a trust responsibility to maintain and improve the health of Indians, and establish a national policy to assure the highest possible health status to Indians as well as to provide all resources necessary to effect that policy. While there may be no currently-available mechanism to judicially enforce these policies, this does not make them meaningless. They establish the goals which the Executive Branch -- particularly the Department of Health and Human Services -- must strive to achieve as it implements this federal law. In fact, they justify -- indeed, require -- the Executive Branch to act in a pro-active manner to use its resources "to assure the highest possible health status for Indians." 25 U.S.C. §1602(a). The Executive Branch has a dual duty -- to carry out the policy established by Congress in federal law, and to perform the United States' trust responsibility to Indians in accord with the Congressionally-established standard.

Indian people take the United States at its word when reading the policy statement of the IHCIA, and have a right to expect its trustee to achieve the goal of assuring them the highest possible health status. As stated by Justice Black in his lament over the U.S. breaking faith with Indians, "Great nations, like great men, should keep their word."[27]

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

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

[25] 415 U.S. 199 (1974).

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

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

CMS has taken actions based on the trust responsibility. In recent years, HCFA/CMS has taken some steps to carry out the trust responsibility to Indians in its administration of the Medicare, Medicaid, and SCHIP programs. Each was a rational exercise of the agency's authority and justified by the United States' special obligations to Indian tribes.

A summary of these actions follows:

- In 1996, through a Memorandum of Agreement with IHS, HCFA re-interpreted the term "facility of the Indian Health Service" in Section 1911 to allow a tribally-owned facility operated under an ISDEAA agreement to elect designation as a "facility of the Indian Health Service". Previously, HCFA had interpreted the term "facility of the Indian Health Service" to include only facilities actually owned or leased by IHS. The MOA enabled these tribally-owned facilities to bill Medicaid at the annually-established Medicaid billing rates for IHS facilities and applied the 100% FMAP to Medicaid services provided by such facilities. <http://www.cms.hhs.gov/aian/moafinal.pdf>.
- The 1996 IHS/HCFA MOA incorporated the regulatory policy that states must accept as Medicaid providers IHS facilities who meet state requirements, but these facilities are not required to obtain a state license. 42 C.F.R. §431.110.
- In 1999, HCFA issued a guidance, followed by a proposed rule, to prohibit states from imposing any cost sharing on AI/AN children under SCHIP, citing the unique federal relationship with Indian tribes. This rule was subsequently promulgated in final form. 42 C.F.R. §457.535. This HCFA regulation reflects the agency's interpretation of how best to carry out the statutory provision requiring states to demonstrate how they will assure SCHIP access for eligible Indian children. 42 U.S.C. §1397bb(b)(3)(D).
- In 2000, HCFA announced that the policy prohibiting cost sharing for Indian children under SCHIP would be extended to Section 1115 Medicaid demonstration projects and stated the agency would no longer approve Section 1115 projects that impose such cost-sharing. <http://www.cms.hhs.gov/aian/11-07-00.asp>.
- In January, 2001, the HCFA State Medicaid Manual was revised to protect from estate recovery certain Indian-specific property held by a deceased Indian Medicaid beneficiary. *See* Part 3 - Eligibility, 01-01 General Financial Eligibility Requirements and Options, Sec. 3810.A.7.
- In 2001, CMS issued a policy statement that requires states to consult with tribes within their borders on Medicaid waiver proposals and waiver renewals before submitting them to CMS. <http://www.cms.hhs.gov/aian/081701a.pdf>.
- In 2002, the Director of the Center for Medicare agreed to continue the exemption of IHS and tribal clinics from the Outpatient Prospective Payment System. <http://www.cms.hhs.gov/aian/tl02-003_opps_120602.pdf>.
- In 2003, CMS chartered a Tribal Technical Advisory Group comprised of tribal leaders to advise the agency on Medicare, Medicaid, and SCHIP issues that impact Indian health programs.

Carrying out the trust responsibility to Indians in these and other ways coincides with and compliments CMS's stated program objectives, particularly the goal of improving "access to services for underserved

and vulnerable beneficiary populations, including eliminating health disparities." <http://www.cms.hhs.gov/about/mission.asp>.

The uniqueness of the Indian health system

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

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

- *Limited service population*. The IHS health care system is not open to the public. It is established to serve only American Indian/Alaska Native beneficiaries who fall within the eligibility criteria established by the IHS. *See* 42 C.F.R. §136.12. [28] The IHS estimates the service population served by IHS and tribally-operated programs in more than 30 states is approximately 1.8 million AI/ANs.
- *No cost assessed to patients*. IHS serves AI/AN beneficiaries without cost. For several years, Congress reinforced this policy with language in the annual IHS appropriations act that prohibited the agency to charge for services without Congressional consent.[29] IHS services at no cost to the Indian patient remains IHS policy today.
- *Indian preference*. Indian preference in hiring applies to the Indian Health Service. 42 C.F.R. §136.41-.43.[30] Such preference also applies to tribally-operated programs through the requirement that, to the greatest extent feasible, preference for training and employment must be given to Indians in connection with administration of any contract or grant authorized by any federal law to Indian organizations or for the benefit of Indians. 25 U.S.C. §450e(b).
- *Only tribes get rights under ISDEAA*. Indian tribes (and tribal organizations sanctioned by one/more tribes) -- and only those entities -- can elect to directly operate an IHS-funded program through a contract or compact from the Indian Health Service issued pursuant to the Indian Self-Determination and Education Assistance Act (ISDEAA). 25 U.S.C. §450 *et seq.* The tribal operator receives the program funds the IHS would have used and

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

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

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

additional funding for administrative costs. A tribal operator directly hires its staff and has the authority to re-design the program(s) it offers.

- *Use of HHS personnel*. To help staff their programs, tribes and tribal organizations are authorized by law to utilize employees of DHHS under Intergovernmental Personnel Act assignments and commissioned officers of DHHS under Memoranda of Agreement. 25 U.S.C. §450i.
- *Creation of specific health care providers*. Federal law has created health care delivery providers found only in the Indian health care system. *See* Community Health Representative Program, 25 U.S.C. §1616; Community Health Aide Program for Alaska, 25 U.S.C. §1616*l*. The Alaska Medicaid Plan reimburses Indian health programs for covered services provided by CHAPs in Alaska.
- *Federal Tort Claims Act coverage*. Pursuant to federal law, tribal health programs and their employees are covered by the FTCA. 25 U.S.C. §450f, note.
- *IHS as payor of last resort*. IHS is payor of last resort for eligible Indian beneficiaries, notwithstanding any state or local law to the contrary. 42 C.F.R. §136.61.
- *IHS-specific Medicare, Medicaid reimbursement rates*. On an annual basis, the IHS (in consultation with CMS) establishes the rates at which Medicare outpatient and Medicaid inpatient and outpatient services provided to eligible Indians shall be reimbursed to IHS facilities. *See, e.g.,* 70 Fed. Reg. 30,764 (May 27, 2005) (establishing reimbursement rates for calendar year 2005).
- *100% FMAP*. Medicaid-covered services provided to AI/ANs in IHS and tribal facilities are reimbursed at 100% FMAP in recognition that the responsibility for Indian health care is a totally federal obligation. Sec. 1905(b) of SSA.
- *No U.S. right of recovery from tribes*. If an Indian tribe (or a tribal organization sanctioned by one/more tribes) has a self-insured health plan for its employees, the United States is prohibited by law from recovering from that plan the cost of services provided. 25 U.S.C. §1621e(f).
- *Tribes are governments*. Upon achieving federal recognition, an Indian tribe is acknowledged to be and is treated as a *government* by the United States. The U.S. deals with Indian tribes on a government-to-government basis that is recognized in Executive Orders and consultation policies adopted by federal agencies.[31] Indian tribes determine their own governmental structure. They are not required to follow the U.S. model of separate legislative, executive, and judicial branches.
- *State law does not apply*. By virtue of the Supremacy Clause, state laws generally do not apply to the IHS system.[32] The Supreme Court has recognized that Indian tribal governments are not subject to state laws,

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

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

including tax laws, unless those laws are made expressly applicable by federal law. *See, e.g., McClanahan v. Arizona State Tax Comm'n,* 411 U.S. 164 (1973). Indian tribal governments are not political subdivisions of states.

- *Federal trust responsibility*. The United States has a trust responsibility to Indian tribes (described above).
- *Tribal sovereign immunity*. Indian tribal governments enjoy sovereign immunity except vis-à-vis the United States government, the superior sovereign. *See, e.g., United States v. United States Fidelity & Guaranty Co.,* 309 U.S. 506 (1940).

In sum, an Indian tribe that has elected to directly operate its health care program can simultaneously serve in several capacities -- as a sovereign government; as beneficiary of IHS-funded health care; as a direct provider of health care (including the right of recovery from third party payors); as administrator of a health program with responsibilities for advising its patients about eligibility for Medicare, Medicaid, and SCHIP; and as a sponsor of a health insurance plan for its employees (and the payor under such a plan if it is a self-insured plan). CMS must take these multiple roles into account and fashion special policies to effectively implement Medicare, Medicaid, and SCHIP in Indian Country in ways that assure full access by Indian beneficiaries and IHS/tribal providers.