

Historical and Cultural Aspects of Consultation

Historical Overview

When Europeans began to explore and immigrate to the Americas, they entered into treaties with sovereign Indian nations. After the founding of the U.S., the country continued the practice of making treaties and dealing with Indian tribes on a government-to-government basis. Throughout the country's history, despite periods of conflict and shifting national policies in Indian affairs, the government-to-government relationships between the U.S. and Indian tribes has endured. The Constitution, treaties, laws, and court decisions have consistently recognized a unique political relationship between Indian tribes and the U.S.

Treaties were created for and signed by the original inhabitants of this country, misnamed by Christopher Columbus as "Indians." The use of that term is still common, but it has now also become widespread to use the phrases "American Indians" or "Native Americans," which describe the peoples who live in "Indian Country." When Alaska became a state, its indigenous inhabitants became known as Alaska Natives. The U.S. government recognizes tribes as domestically dependent sovereign nations with the right to self-government. Treaties, including treaties with tribes, are a part of the Constitution, which describes treaties as the "supreme Law of the Land." The U.S. government works with tribes in a government-to-government basis in regard to policy, as well as regulatory and legislative issues that have a direct impact on tribes.

As a legal part of these treaties, Native people were guaranteed the right to live, hunt, and fish in their customary lands, to be educated, and to have health care provided in exchange for millions of acres of land, mineral rights, and natural resources. Native people believe their health is a right and that their access to health care is bought and paid for.

Tribal Consultation

The U.S. government and its agencies have formalized a working relationship with tribes in a manner to meet these commitments called "tribal consultation." Tribal consultation allows tribes to participate in the decision-making process on policy, regulatory, and legislative issues that have a direct impact on tribes. This participation helps tribes to not only take advantage of their treaty-mandated rights but also to hold the federal government accountable for promises made to tribes.

Consultation is grounded in the government-to-government relationship established by the U.S. Constitution, treaties, statutes, case law, and policy. The federal government has a trust responsibility to protect tribal sovereignty, self-determination, assets and resources, and treaty and other reserved rights. Executive orders published by current and past presidents reaffirm this responsibility and the need for consultation at the government-to-government level.



Tribal Engagement

Section 1902(a)(73) of the Social Security Act requires a state in which one or more Indian health programs or urban Indian organizations furnish health care services to establish a process for the state Medicaid agency to seek advice on a regular, ongoing basis from designees of Indian health programs, whether operated by the Indian Health Service (IHS), tribes, or tribal organizations under the Indian Self-Determination and Education Assistance Act (ISDEAA), or Urban Indian Organizations under the Indian Health Care Improvement Act. Section 2107(e)(I) of the Social Security Act was also amended to apply these requirements to the Children's Health Insurance Program (CHIP).

Federal Laws, Regulations, Executive Documents, and Court Decisions

Executive orders published by current and past presidents and guiding policies adopted by the Centers for Medicare & Medicaid Services (CMS) reaffirm the trust responsibility between the U.S. government and tribes, in addition to reaffirming the need for consultation at the government-to-government level. For example, President Barack Obama released the below memorandum on tribal consultation on November 5, 2009:

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release

November 5, 2009

MEMORANDUM FOR THE HEADS OF EXECUTIVE DEPARTMENTS AND AGENCIES

SUBJECT: Tribal Consultation

The United States has a unique legal and political relationship with Indian tribal governments, established through and confirmed by the Constitution of the United States, treaties, statutes, executive orders, and judicial decisions. In recognition of that special relationship, pursuant to Executive Order 13175 of November 6, 2000, executive departments and agencies (agencies) are charged with engaging in regular and meaningful consultation and collaboration with tribal officials in the development of Federal policies that have tribal implications, and are responsible for strengthening the government-to-government relationship between the United States and Indian tribes.

History has shown that failure to include the voices of tribal officials in formulating policy affecting their communities has all too often led to undesirable and, at times, devastating and tragic results. By contrast, meaningful dialogue between Federal officials and tribal officials has greatly improved Federal policy toward Indian tribes. Consultation is a critical ingredient of a sound and productive Federal-tribal relationship.



My Administration is committed to regular and meaningful consultation and collaboration with tribal officials in policy decisions that have tribal implications including, as an initial step, through complete and consistent implementation of Executive Order 13175. Accordingly, I hereby direct each agency head to submit to the Director of the Office of Management and Budget (OMB), within 90 days after the date of this memorandum, a detailed plan of actions the agency will take to implement the policies and directives of Executive Order 13175. This plan shall be developed after consultation by the agency with Indian tribes and tribal officials as defined in Executive Order 13175. I also direct each agency head to submit to the Director of the OMB, within 270 days after the date of this memorandum, and annually thereafter, a progress report on the status of each action included in its plan together with any proposed updates to its plan.

Each agency's plan and subsequent reports shall designate an appropriate official to coordinate implementation of the plan and preparation of progress reports required by this memorandum. The Assistant to the President for Domestic Policy and the Director of the OMB shall review agency plans and subsequent reports for consistency with the policies and directives of Executive Order 13175.

In addition, the Director of the OMB, in coordination with the Assistant to the President for Domestic Policy, shall submit to me, within 1 year from the date of this memorandum, a report on more (OVER) 2 the implementation of Executive Order 13175 across the executive branch based on the review of agency plans and progress reports. Recommendations for improving the plans and making the tribal consultation process more effective, if any, should be included in this report.

The terms "Indian tribe," "tribal officials," and "policies that have tribal implications" as used in this memorandum are as defined in Executive Order 13175.

The Director of the OMB is hereby authorized and directed to publish this memorandum in the Federal Register.

This memorandum is not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at law or in equity by any party against the United States, its departments, agencies, or entities, its officers, employees, or agents, or any other person. Executive departments and agencies shall carry out the provisions of this memorandum to the extent permitted by law and consistent with their statutory and regulatory authorities and their enforcement mechanisms.

BARACK OBAMA

CMS Tribal Consultation Policy, November 17, 2011



The CMS Tribal Consultation Policy established the process through which CMS would engage in ongoing consultation with tribes regarding federal policies impacting tribes and Indian health programs. The rationale for the CMS Tribal Consultation Policy is founded upon and affirmed through Executive Order 13175 in 2000, as well as presidential memoranda in 1994, 2004, and 2009.

CMS Tribal Consultation Strategy

The CMS Tribal Consultation Strategy affirmed the definition of consultation developed by the Department of Health & Human Services (HHS) Working Group. CMS established two goals: establishing and maintaining communications and ongoing consultation mechanisms. According to the CMS Tribal Consultation Strategy, CMS headquarters and regional offices share a joint responsibility to implement, maintain, and continuously improve tribal consultation and to promptly address issues raised by tribes.

Tribal Leader Letter, May 29, 2009

This letter from CMS to tribal leaders provided a summary of changes to the Act impacting American Indian/Alaska Native (AI/AN) communities that resulted from the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) and the American Recovery and Reinvestment Act of 2009 (the Recovery Act).

Executive Order 13175, November 2000

While replacing the previous Executive Order (EO 13084), EO 13175 reaffirmed the objectives of the previous EO while also requiring federal departments and agencies to respect tribal sovereignty and encourage tribes to develop standards specific to tribal communities. Furthermore, regarding regulations that impose significant financial burdens on tribes or preempt tribal law, EO 13175 explicitly outlined parameters under which federal agencies would either avoid the implementation of such regulations, compensate tribes for expenses incurred through compliance with the regulation, or consult with tribes to develop a mutually agreed upon alternative to satisfy both the regulation and the needs of the tribe.

Executive Order 13084, May 1998

This EO sought to establish regular and meaningful consultation between the federal government and tribes on matters significantly or uniquely impacting tribes and tribal communities, reduce the imposition of unfunded mandates upon tribal governments, and streamline the application process for and increase the availability of waivers to tribal governments.



Presidential Memo, April 1994

This memo sought to clarify and strengthen the government-to-government relationship between the U.S. and tribes. Specifically, the memo required that departments operate in a government-to-government relationship with tribes and, to the greatest extent possible, consult with tribes on matters impacting tribes and tribal communities. Additionally, departments were expected to remove procedural impediments adversely impacting the trust responsibility or government-to-government relationship between tribes and the U.S. Lastly, the memo sought to increase interdepartmental collaboration on issues involving tribal consultation and to interpret EO 12875 (“Enhancing the Intergovernmental Partnership”) to address the unique needs of tribal communities.

American Recovery and Reinvestment Act, Sec. 5006: ARRA Tribal Consultation Provisions

State Medicaid directors have federal guidance to help them implement provisions under Section 5006 of the Recovery Act. Medicaid currently allows states to impose enrollment fees, premiums, and cost-sharing charges on Medicaid and CHIP participants. Section 5006 of the Recovery Act precludes them from imposing these charges on Indian applicants, according to the guidance released recently by the CMS. These provisions offer cost-sharing protections and other various exemptions under Medicaid for Indian beneficiaries and participants served by Indian health providers. The Social Security Act allows states to impose enrollment fees, premiums, cost sharing and similar charges to Medicaid participants under Title XIX at 1916 and 1916A of the Social Security Act and to CHIP under Title XXI at 2103(e) of the Social Security Act.

Specifically, Section 5006(a) of the Recovery Act exempts AI/ANs from paying enrollment fees, premiums, or similar charges if they are served by an Indian health care provider.

Section 5006 of the Recovery Act amends 1916 and 1916A of the Social Security Act to preclude states from imposing any cost sharing to Indian Medicaid participants effective July 1, 2009, under certain circumstances. The Recovery Act did not change the cost-sharing exemptions in CHIP. CHIP exempts all AI/ANs from cost sharing. See 42 CFR § 457.535 of the Social Security Act for greater detail on this exemption. Notably, this section exempts Indians from paying a deductible, coinsurance, copayment, or similar charges for Medicaid-covered services if an AI/AN individual receives care from an Indian health care provider.

Section 5006(e) of the Recovery Act codified HHS’ obligation to maintain a Tribal Technical Advisory Group (TTAG) within CMS. The TTAG has tribal representatives appointed from the 12 IHS service areas, a representative of the IHS and a representative from a national urban Indian organization.



ARRA Protections for Indians in Medicaid and CHIP, January 2010

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

**Center for Medicaid and State Operations**

SMDL#: 10-001
ARRA #: 6

January 22, 2010

Re: ARRA Protections for Indians in Medicaid and CHIP

Dear State Medicaid Director:

This letter is one of a series that provides guidance on the implementation of the American Recovery and Reinvestment Act of 2009 (Recovery Act), Public Law 111-5. Section 5006 of the Recovery Act provides protections for Indians in Medicaid and the Children's Health Insurance Program (CHIP). The amendments made by this section were effective on July 1, 2009. This letter provides a brief overview to assist States with implementation of these new provisions for Indians in your programs.

Section 5006 of the Recovery Act provides certain premium and cost-sharing protections under Medicaid and exemption for certain Indian-specific property from consideration in determining Medicaid eligibility and from Medicaid estate recovery. It also provides certain Medicaid managed care protections for Indian health programs and Indian beneficiaries and establishes new requirements for consultation on Medicaid and CHIP with Indian health programs. The new provisions are described in greater detail below.

Premium and Cost-Sharing Protections Under Medicaid

The Social Security Act (the Act) allows States to impose enrollment fees, premiums, cost-sharing and similar charges under certain conditions on Medicaid participants under title XIX and CHIP participants under title XXI of the Act. The Medicaid provisions are at section 1916 of the Act for nominal premiums and cost-sharing and at section 1916A of the Act for alternative premiums and cost-sharing, as authorized by the Deficit Reduction Act of 2005 (DRA), Public Law 109-171. CHIP provisions can be found at section 2103(e) of the Act.

Section 5006(a) of the Recovery Act amends sections 1916 and 1916A of the Act, to preclude States from imposing Medicaid premiums or any other Medicaid cost sharing on Indian applicants and participants served by Indian health providers and to assure that Indian health providers, and providers of contract health services (CHS) under a referral from an Indian health provider, will receive full payment. These provisions apply to the Medicaid program. Premiums and cost-sharing exemptions for Indians under CHIP are not affected. These provisions became effective **July 1, 2009**. Specifically, section 5006(a):



Health Care Reform

IHS, the agency that facilitates the health care provided to tribes, has been chronically underfunded. Through self-determination, tribes are trying to generate more funds to meet the needs of their tribal members and to try to stay afloat. Health care is currently going through a major change and restructuring through the Recovery Act. Health services for American Indians have been chronically underfunded for generations; Native people have not had access to quality health care nor an ability to easily train, recruit, or grow an infrastructure of Native health providers.

Health care in Indian Country will undergo significant changes over the next 10 years with comprehensive reforms already underway due to recent federal and state legislation. There is little in health care that is not affected by the new authorities, funding, and regulations that make up health care reform. The goal is good health, but the vast majority of the new funding supports increasing access to acute health care services with a smaller percentage assigned to public health activities, including health promotion and disease prevention.² The chosen method of increasing access in health care reform is by expanding health care insurance coverage, both private and public.

The goal of health care reform is not clearly expressed in a vision statement or list of objectives. It includes controlling costs; expanding health insurance through Medicaid and health insurance exchanges as well as health insurance reforms intended to keep more insured; expanding safety net clinics, expanding public health including health care research, health promotion, and disease prevention programs; and increasing the health care workforce—all with the hope of improving the health of the nation. Significantly, it includes a specific goal to reduce health care disparities between racial and ethnic minorities and the general population. The political status of tribes and the existence of treaties and legislation, such as the Indian Health Care Improvement Act, permanently reauthorized by the Affordable Care Act (ACA), commit the federal government to the provision of health care services for Indian people. Thus, the political status of Indian tribes and AI/AN people underlies special aspects of the ACA.

The path to sustainable, well-recognized health care reform includes controlling costs. Since employer-based and public health insurance is still the mainstay of the health care system, insurance payment mechanisms are the foundation of most attempts to control costs. That is, you get what you pay for, and most experts express dissatisfaction with what the current system produces. Some call the expansion of health insurance coverage Round One of health care reform and payment for performance Round Two. There is little awareness in the general public that most health care insiders believe the current system requires significant changes in existing funding mechanisms in order to maintain the current system—much less support universal health insurance coverage. The analysis in this report focuses on Round One, insurance expansion, but notes that Indian health programs need to pay attention to how payment reform may affect their program in the years to come.

²Health is broadly defined in most health care legislation, but it stops far short of addressing the most important social determinants of health. For a discussion see “A New Way to Talk About the Social Determinants of Health,” Robert Wood Johnson Web site, accessed December 21, 2010.



Indian Country and Indian People

The definitions of Indian Country and AI/ANs are imprecise. Indian Country certainly includes Indian reservations and ceded reservation lands, but no definition can capture the connotation of Indian Country and what it means to Native people. In a nation that was at one time all Native American, historical principles are overtaken by political realities. In the present day, at its broadest, it includes locations where Indian people live and where they engage in cultural activities. Most AI/ANs would reject any definition of Indian Country that is narrowly drawn, but the term is still widely used despite its variable definitions. It is not essential to a good understanding of Indian health to have a precise definition of Indian Country. AI/ANs live in every state, and many have rights that are not waived by residing outside reservation lands or even outside a broader definition of Indian Country. Since IHS only funds health programs in 37 states (including urban programs in Chicago, IL, and Baltimore, MD, which are in states with no federally recognized tribes), access to these services is obviously a function of both eligibility (*is the person AI/AN?*) and proximity (*can that person get to the services?*). Thirty-five states where there are both federally recognized tribes and IHS-funded programs are called reservation states, and they do retain significance from that aspect alone. They are states where sovereign Indian nations are located, and some have boundaries that extend beyond a single state; for example, Navajo Nation is in three different states and is geographically larger than several states.

Who is an AI/AN? Tribes define who is eligible for tribal citizenship. The Bureau of Indian Affairs (BIA) estimates that in 2005 there were approximately 2 million tribal members.³ The IHS currently follows a policy of “unrestricted descendency,” which means that anyone who is a descendent of a member of a federally recognized tribe (or its equivalent in California and Alaska) is eligible for IHS-funded services.⁴ Urban Indian programs have a more expansive definition of eligibility that includes state-recognized tribes and other Indians without a direct and substantiated link to federally recognized tribes. Tribes are advocating for a uniform definition of Indian for the purposes of enrollment in Medicaid, CHIP, or the health exchange plans. The preferred definition essentially accepts anyone as AI/AN who has previously been found eligible for a federal benefit for any federal agency on the basis of their being Indian. For example, if a person has previously secured an Indian education scholarship or health services through IHS, tribal, or Urban Indian health programs based on being Indian, they would be an eligible Indian for the special provisions that cover Indians and Medicaid, CHIP, or the health insurance exchanges.

³ In the BIA’s 2005 American Indian Population and Labor Force Report, the latest available, the total number of enrolled members of the (then) 561 federally recognized tribes was shown to be less than half the Census number, or 1,978,099.

⁴ Dear Tribal Leader Letter, January 10, 2000, Dr. Michael Trujillo.

