Tribal Technical Advisory Group

To the Centers for Medicare & Medicaid Services

c/o National Indian Health Board | 910 Pennsylvania Avenue, SE | Washington, DC 20003 | (202) 507-4070 | (202) 507-4071 fax

October 3, 2022

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Submitted via regulations.gov

Re: Nondiscrimination in Health Programs and Activities

Dear Mr. Becerra:

On behalf of the CMS Tribal Technical Advisory Group (TTAG), I write to provide a response to the Centers for Medicare and Medicaid Services (CMS); Office for Civil Rights (OCR), Office of the Secretary, HHS proposed rule, "Nondiscrimination in Health Programs and Activities" (HHS-02-2022-0012).

Preamble to Comments:

Before commenting specifically on this proposal, we highlight the important context in which TTAG's comments are offered, and which should inform CMS's consideration of them: the deep inequities in this nation's health care delivery system, and the Biden administration's commitment and urgent effort to eliminate them. Over the last year the entire federal government, including CMS, has been working to respond to the President's Executive Order 13985 on Advancing Racial Equity and Support for Underserved Communities Through the Federal Government (EO 13985).

For the first time, the federal government is taking a systematic approach to address equity issues. CMS has responded by first issuing its CMS Strategic Plan, "Pillar: Health Equity" that laid out CMS' definition of health equity and a broad strategy to advance equity through its programs. More recently, CMS has published its Framework for Health Equity 2022-2032, which is a more detailed ten-year plan intended to address equity and health disparity issues across Medicare, Medicaid, CHIP, and the Health Insurance Marketplaces.

Important to understand about health disparities is that American Indian and Alaska Native (AI/AN) people were once one of the healthiest people on this continent, before colonialism and the United States policies of termination, assimilation, and boarding schools caused an "intergenerational pattern of cultural and familial disruption"[1] that drive health disparities to this day. These drivers have manifested in some of the worst

health disparities for AI/AN people, including extraordinarily high and disproportionate rates of infant and maternal mortality, cancer, cardiovascular disease, depression and other behavioral health conditions, among other ailments. The recent Department of Interior Boarding School Report explains that "Native Americans continue to rank near the bottom of all Americans in terms of health, education, and employment. Many AI/ANs face unique challenges and harsh living conditions resulting from the United States having removed their Tribes to locations without access to adequate resources and basic infrastructure upon which their tribal governments can foster thriving communities."[2] It is important to acknowledge that efforts to address these disparities are often complicated by culturally inappropriate interventions and an inadequate understanding of the historical effects of United States policies and ongoing trauma of AI/AN people.[3] It is this history that is the root cause of the significant health disparities that affect AI/AN populations.

The TTAG is deeply appreciative that the President's EO 13985 and the CMS Framework for Health Equity provide an opportunity to focus on these concerns, and that the CMS Framework provides an opportunity to design, implement, and operationalize policies and programs to address health equity issues. The TTAG has always taken the position that CMS has ample legal authority to undertake distinct policies and programs specifically focused on AI/AN beneficiaries and the Indian Health Service (IHS) programs that provide their care, because of their unique legal status under the U.S. Constitution and the duties owed by the federal government under its treaty and trust responsibilities to AI/ANs.[4]

Under established principles of Indian law, programs and policies that are specifically established for Indigenous people and organizations do not constitute prohibited race-based classifications; rather, they are based on the unique political relationship between the federal government and Indian Tribes. This unique legal relationship, taken together with EO 13985 and CMS' Framework for Health Equity, provides a sound basis for CMS to adopt the TTAG recommendations on the Proposed Rule. We trust you will agree that the TTAG recommendations are directly related to CMS' Framework discussed in "Priority 2: Assess Causes of Disparities Within CMS Programs, and Address Inequities in Policies and Operations to Close Gaps." These TTAG's recommendations fit clearly in the intended outcomes of this chapter of the Framework as well as other priority areas therein.

Comments:

We support the Administration's decision to restore and strengthen implementation of Section 1557 of the Affordable Care Act and its protections against discrimination on the basis of race, color, national origin, sex, age, and disability. We strongly support the proposal to prohibit discrimination in all federally funded health plans.

American Indians and Alaska Natives are a Political Group

TTAG is concerned that the proposed rule does not adequately address or reflect the unique political relationship between AI/ANs and the federal government. As stated

above, the United States has a federal trust responsibility to provide health care services to AI/AN individuals. Like any other Executive Department Agency, the U.S. Department of Health and Human Services (the "Department") has a duty and responsibility to ensure that the laws it administers are implemented in a manner that respects Congress' authority to enact Indian-specific legislation that fulfills this responsibility.

Existing CMS regulations also recognize that Indian health programs are entitled to provide services to Indian people, and are exempt from the prohibition on discrimination on the basis of race, color, or national origin in Title VI of the Civil Rights Act.[1]

In order to fulfill that trust responsibility, Congress has the authority to enact Indian-specific laws and include Indian-specific provisions in general laws.[2] These Indian-specific laws and provisions are based on political, rather than racial, distinctions and do not violate prohibitions on racial discrimination. In *Morton v. Mancari*, the U.S. Supreme Court recognized that "[t]he plenary power of Congress to deal with the special problems of Indians is drawn both explicitly and implicitly from the Constitution itself."[3]

The Indian Health Service/Tribal/Urban Indian Organization (I/T/U) system is the primary vehicle by which the United States fulfills its trust obligation to provide the services and resources needed to "to maintain and improve the health of the Indians." In addition, many AI/AN people receive care through systems operated or supported in whole or in part by the Department, including Medicaid and Medicare. At times, the Department has also partnered with other agencies, like the Department of Veterans Affairs, to better fulfill the trust responsibility for healthcare. In fulfillment of the trust responsibility, the United States has provided or supported services at I/T/U providers, or through other programs, which are at times limited to AI/ANs.

The IHS itself states on its website that "[i]t's important to clarify that the IHS […] can provide healthcare to only eligible Alaska Native and American Indians at its federal hospitals and clinics."[4] The TTAG requests that the proposed rule be amended to explicitly refer in the Preamble to the unique political status of Indian Tribes, the federal trust responsibility for Indian health, and the Indian health program exemption to non-discrimination claims under Title VI and otherwise.

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[1] 45 C.F.R. § 80.3(d).
[2] *See*, e.g., Indian Health Care Improvement Act, 25 U.S.C. § 1601, et seq.; Indian Self-Determination and Education Assistance Act, 25 U.S.C. §450, et seq.; Indian Education Act, 20 U.S.C. §7401, et seq.; Tribally Controlled Schools Act, 25 U.S.C. §2501, et seq.; Tribally Controlled College or University Assistance Act, 25 U.S.C. §1801, et seq.; Native American Housing Assistance and Self-Determination Act, 25 U.S.C. §4101, et seq.; Indian Child Welfare Act, 25 U.S.C. §1901, et seq.; Indian Child Protection and Family Violence Prevention Act, 25 U.S.C. §3201, et seq.; Indian Employment, Training, and Related Services Demonstration Act, 25 U.S.C. §3401, et seq.
[3] 417 U.S. 535, 551–52 (1974).
[4] Indian Health Service, IHS.gov. *For Patients,* https://www.ihs.gov/forpatients/.

Reinstate Application of Section 1557 Protections to all HHS Programs and Activities

The TTAG generally supports the proposal to interpret Section 1557 to cover all of the health programs and activities administered by the Department, ensuring protection from discrimination to people in more programs. However, as discussed above, it is important that the Department, as well as Department personnel, including personnel in the Office of Civil Rights and the Office of Solicitor General, recognize that Section 1557 does not prohibit I/T/U programs from limiting services to IHS beneficiaries, nor does it prohibit the Department from taking action in furtherance of the trust responsibility on behalf of Indian health care providers and AI/AN beneficiaries. Such actions include the issuance of Indian-specific regulations and sub-regulatory guidance, the approval of Indian-specific State Plan Amendments, and the approval of State Demonstration Waivers that address issues unique to Indian health care providers.

The United States and its federal agencies have the constitutional authority to take unique action on behalf of Indian Country. The Department has taken many such actions in the past and should continue to do so in the future. Section 1557 poses no impediment to the Department carrying out its statutory obligations and federal trust responsibility to Indian Country.

The TTAG also supports the reinstatement of the application of Section 1557 to health insurers that receive federal financial assistance, recognizing the significant role they have in the provision of health care.

Include Sexual Orientation and Gender Identity as Forms of Discrimination "Based on Sex"

The TTAG urges CMS to move forward with its proposal to amend previous language so it will *again* identify and recognize discrimination on the basis of sexual orientation and gender identity as prohibited forms of discrimination based on sex, consistent with the U.S. Supreme Court's holding in *Bostock v. Clayton County*.[5] As proposed, CMS should also amend its own regulations in order to apply the protections to Medicaid fee-for-service (FFS) programs and managed care programs. This will promote consistency across the Department's programs of policies and requirements that prohibit discrimination based on sexual orientation or gender identity.

No Additional Reporting Requirements Without Funding

We also request that no reporting requirements be imposed unless it is supported by funding. As you know, IHS, Tribal facilities, and UIOs are often understaffed and underfunded, and therefore the burden on them is higher when it comes to designating reporting duties to staff. Tribal facilities also face unique difficulties hiring in remote and rural locations where many Tribal facilities are located. The IHS, Tribal facilities, and

[5] 140 S. Ct. 1731 (2020).

UIOs cannot be asked to divert their scarce funding to comply with additional reporting requirements.

Conclusion

We appreciate your consideration of the above comments and recommendations and look forward to engaging with the Department further.

Sincerely,

W. Ron Allen, CMS/TTAG Chair
Jamestown S'Klallam Tribe, Chairman/CEO