

Tribal Sovereign Authority and Self-Regulation of Health Care Services: The Legal Framework and the Swinomish Tribe's Dental Health Program

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I. Introduction

Across the United States, an important shift is taking place in the Indian health care arena. Over the past forty years, many American Indian Tribes have transitioned away from relying primarily on federal officials to provide a bare minimum in health care services to Indian people, and have begun instead to develop and operate complex tribal health care delivery systems that offer the highest level of health care possible. Health care has historically been considered, and remains today, a core component of the federal trust responsibility to Indians. However, that trust responsibility is increasingly being carried out through the transfer of resources and authority from federal agencies to Tribes to assume control and responsibility to design, implement, and provide direct programs and services that are better tailored to local tribal needs. This federal policy of supporting tribal sovereignty and tribal self-determination generally has indeed fostered and encouraged the development of a new, robust tribal health care system.

To date this new health care system has largely developed and evolved within the framework of existing federal health care and Indian law. More recently, some Tribes have begun to use their inherent tribal sovereign authority to innovate and expand the services they provide to Indian people beyond the services that might otherwise be available under state or federal law. This article will examine the historical backdrop against which the modern Indian health system has developed; describe the current legal framework that allows tribes to exercise tribal sovereign authority to provide and regulate health care services under tribal law; and discuss—as a concrete example—how these legal authorities have been used to make available much needed dental care to Indians who reside near the Swinomish Indian Tribal Community in Washington state.

II. Historical Backdrop

A. Origins of the Federal Responsibility for Indian Health Care

In permanently reauthorizing the Indian Health Care Improvement Act in 2010, Congress cited the federal government's need to fulfill its "special trust responsibilities and legal obligations to Indians"² and declared that "Federal health services to maintain and improve the

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² Pub. L. No. 111-148, Title X, § 10221(a), 124 Stat. 935 (2010) (codified at 25 U.S.C. § 1602).

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."³ The trust responsibilities and legal obligations cited by Congress reflect the dual concepts of federal supremacy over Indian affairs and a general federal-tribal "trust relationship" that together provide the legal, moral, and political justification for numerous federal services and programs for Indians, from education to housing to health care to many others.⁴ The roots of the federal trust duty can be traced to treaties, statutes, and judicial decisions from the earliest days of the Republic, and, along with the notion of plenary and exclusive federal power, has evolved to become one of the bedrock principles of our modern federal Indian policy.⁵ Another of these bedrock principles is the federal acknowledgement of retained inherent tribal sovereignty and the resulting right of tribes to exercise sovereign authority over their own lands and people.⁶

Before the United States Constitution was even adopted, the Confederation Congress outlined an early vision of United States Indian policy in the Northwest Ordinance, which established a government and certain laws for the newly created Northwest Territory. The Northwest Ordinance called for "[t]he utmost good faith" toward Indians and respect for their land and property rights; affirmed that their "rights, property, and liberty" should not be disturbed; and declared that "laws founded in justice and humanity, shall from time to time be made for preventing wrongs being done to them, and for preserving peace and friendship with them."⁷ Though not always borne out in practice, as the often gruesome history of the United States shows, this sentiment nevertheless sowed the early seeds of a consistently acknowledged (if aspirational) feature of our federal Indian policy: a good faith duty, with both moral and legal dimensions, toward Indian peoples as such that includes the recognition of tribal authority and self-determination.

³ Pub. L. No. 111-148, Title X, § 10221(a), 124 Stat. 935 (2010) (codified at 25 U.S.C. § 1601).

⁴ *See, e.g.*, 20 U.S.C. § 7401 (education: "It is the policy of the United States to fulfill the Federal Government's unique and continuing trust relationship with and responsibility to the Indian people for the education of Indian children); 25 U.S.C. § 4101 (housing: "there exists a unique relationship between the Government of the United States and the governments of Indian tribes and a unique Federal responsibility to Indian people" and "the Congress, through treaties, statutes, and the general course of dealing with Indian tribes, has assumed a trust responsibility for the protection and preservation of Indian tribes and for working with tribes and their members to improve their housing conditions and socioeconomic status so that they are able to take greater responsibility for their own economic condition"); 25 U.S.C. § 1901 (Indian child welfare: "Congress, through statutes, treaties, and the general course of dealing with Indian tribes, has assumed the responsibility for the protection and preservation of Indian tribes and their resources;" and "there is no resource that is more vital to the continued existence and integrity of Indian tribes than their children and that the United States has a direct interest, as trustee, in protecting Indian children who are members of or are eligible for membership in an Indian tribe"); 25 U.S.C. § 3701 (agricultural resource management: "the United States has a trust responsibility to protect, conserve, utilize, and manage Indian agricultural lands consistent with its fiduciary obligation and its unique relationship with Indian tribes").

⁵ *See* COHEN'S HANDBOOK OF FEDERAL INDIAN LAW §§ 5.02[1]&[2], 5.04[3][a] (Nell Jessup Newton et al., eds., 2012 ed.) [hereinafter "Cohen's Handbook"].

⁶ *Id.* at § 4.01[1][a].

⁷ 32 J. Continental Cong. 340-41 (1787) ("The utmost good faith shall always be observed towards the Indians; their lands and property shall never be taken from them without their consent; and, in their property, rights, and liberty, they shall never be invaded or disturbed, unless in just and lawful wars authorized by Congress; but laws founded in justice and humanity, shall from time to time be made for preventing wrongs being done to them, and for preserving peace and friendship with them.").

Two months after the Northwest Ordinance was enacted by the Continental Congress, the United States Constitution was signed. That document lay the foundation for a continuing government-to-government relationship between Indian tribes and the United States by recognizing tribes as separate sovereigns and by vesting exclusive authority over Indian affairs with the federal government (as opposed to the States). Specifically, the Indian Commerce Clause grants Congress the power “[t]o regulate Commerce with foreign Nations, and among the several States, and with the Indian Tribes[.]”⁸ As its first order of business in exercising its new powers over Indian affairs, the First Congress enacted the Nonintercourse Act in 1790, forbidding any person from carrying on “any trade or intercourse with the Indian tribes, without a license for that purpose” and prohibiting the purchase of lands from Indians or tribes without the consent of the United States.⁹ Congress’ early decision under its Indian commerce clause powers to deal with Indians at the tribal level, and on a sovereign-to-sovereign basis, was a significant one in the development of a national Indian policy.¹⁰

Congress’ acknowledgment of the government-to-government nature of Indian affairs followed naturally from the practice of treaty-making with Indian tribes, which had begun during colonial times. After the Constitution was in place, the new federal government continued to enter into bilateral treaties with individual Indian tribes pursuant to the Article II Treaty Clause.¹¹ At the same time, general and specific promises made in those treaties helped to shape the young Congress’ view of its responsibilities to Indian tribes on a national level.¹² In many treaties, the United States agreed to take tribes under its “protection” and to provide annuities or payments, goods and supplies, and various health and educational services or resources in exchange for settlement rights to vast quantities of land and commitments of peace.¹³ In a 1957

⁸ U.S. Const., art. I, § 8, cl. 3.

⁹ Act of July 22, 1790, 1 Stat. 137 (1790).

¹⁰ Matthew L.M. Fletcher, *The Original Understanding of the Political Status of Indian Tribes*, 82 ST. JOHN’S L. REV. 153, 170-72 (2008).

¹¹ The Treaty Clause grants the President the power to make treaties with the advice and consent of the Senate. U.S. Const., art. II, § 2, cl. 2.

¹² See, e.g., Cohen’s Handbook § 1.03[2], noting that “Each substantive provision of the first Trade and Intercourse Act fulfilled an obligation previously assumed by the United States in treaties with various tribes.”

¹³ See, e.g., Treaty with the Six Nations, preamble, Oct. 22, 1784, 7 Stat. 15 (“The United States of America give peace to the Seneca’s, Mohawks, Onondagas and Cayugas, and receive them into their protection[.]”); Treaty with the Miamies, art. 6, Oct. 23, 1826, 7 Stat. 300 (“The United States agree to appropriate the sum of two thousand dollars annually, as long as Congress may think proper, for the support of poor infirm persons of the Miami tribe, and for the education of the youth of the said tribe; which sum shall be expended under the direction of the President of the United States.”); Treaty with the Winnebago, arts. 4 & 5, Sept. 15, 1832, 7 Stat. 370 (promising to construct a school and provide for the education of children, including clothing, board and lodging; funds for agriculturalists, oxen, ploughs, and other agricultural implements; and “for the services and attendance of a physician at Prairie du Chien, and of one at Fort Winnebago, each, two hundred dollars, per annum,” among other items); Treaty with the Ottawas, art. 4, Mar. 28, 1836, 7 Stat. 491 (promising “Three hundred dollars per annum for vaccine matter, medicines, and the services of physicians, to be continued while the Indians remain on their reservations”); Treaty with the Flatheads, art. 5, July 16, 1855, 12 Stat. 975 (promising to erect a hospital, among other things, “keeping the same in repair, and provided with the necessary medicines and furniture, and to employ a physician” for a period of 20 years); Treaty with the Klamath, 1864, art. 4, 16 Stat. 707 (promising to erect and maintain a school and hospital on the reservation for a period of twenty years); Treaty of Fort Laramie, art. XIII, Apr. 29, 1868, 15 Stat.

report to Congress, the Public Health Service (PHS) noted: “By 1871, when Congress terminated treaty-making, at least 2 dozen treaties had provided for some kind of medical service, including an occasional hospital. Although most of the treaties imposed time limits of 5 to 20 years on the provision of care, the Federal Government adopted a policy of continuing services under so-called ‘gratuity appropriations’ after the original benefit period expired.”¹⁴ The origins of many of the federal service programs for Indians today, including health care programs for Indians, can thus be traced to these treaty promises.¹⁵

The concepts of the federal trust responsibility and exclusive federal authority over Indian affairs (including the federal provision to Indians of goods and services like health care), have thus been consistently acknowledged in the laws and policies of the United States in some form, although that form has evolved over time. This is perhaps most starkly apparent in historical decisions of the Supreme Court, which has been credited as the first federal body to explicitly identify a trust responsibility as such. The Court’s early framing of the federal-tribal relationship was overtly paternalistic and patronizing, but recognized both that the federal government owed a special duty of protection to Indian people by virtue of its relationship and dealings with them and that states lacked governing authority over Indian territory. In a case often cited as the earliest explicit recognition of a trust responsibility, Chief Justice John Marshall in *Cherokee Nation v. Georgia* described Indian tribes as “domestic dependent nations” under the protection of the United States and whose “relation to the United States resembles that of a ward to his guardian.”¹⁶ In a follow-up case, *Worcester v. Georgia*, Chief Justice Marshall held that the State of Georgia could not enforce its criminal laws against non-Indians residing in Cherokee territory, writing:

The Cherokee nation, then, is a distinct community occupying its own territory, with boundaries accurately described, in which the laws of Georgia can have no force, and which the citizens of Georgia have no right to enter, but with the assent of the Cherokees themselves, or in conformity with treaties, and with the acts of congress. The whole intercourse between the United States and this nation, is, by our constitution and laws, vested in the government of the United States.¹⁷

The Supreme Court now recognizes greater State authority within Indian country, particularly over non-Indians, but federal supremacy in the realm of Indian affairs and inherent

635 (“The United States hereby agrees to furnish annually to the Indians the physician, teachers, carpenter, miller, engineer, farmer, and blacksmiths, as herein contemplated, and that such appropriations shall be made from time to time, on the estimate of the Secretary of the Interior, as will be sufficient to employ such persons.”).

¹⁴ U.S. Pub. Health Serv., Health Services for American Indians 86 (1957).

¹⁵ See Cohen’s Handbook § 1.03[1]; 25 U.S.C. § 1901 (Congressional finding that “Congress, through statutes, treaties, and the general course of dealing with Indian tribes, has assumed the responsibility for the protection and preservation of Indian tribes and their resources”).

¹⁶ *Cherokee Nation v. State of Ga.*, 30 U.S. 1, 17 (1831). Later, in *United States v. Kagama*, the Supreme Court opined: “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. This has always been recognized by the executive, and by congress, and by this court, whenever the question has arisen.” *United States v. Kagama*, 118 U.S. 375, 384 (1886).

¹⁷ *Worcester v. Georgia*, 31 U.S. 515, 561(1832).

tribal sovereign authority are still the law of the land.¹⁸ Additionally, over time, the federal trust responsibility has come to be recognized as a general fiduciary duty, with the relationship compared to one between a trustee and its beneficiary rather than a guardian and its ward, arising not because Indian people cannot care for themselves but because the nature and history of the relationship between the federal government and Indian tribes created certain ongoing obligations. This federal view of the trust relationship and the federal power that accompanies it has evolved through and is reflected in judicial decisions, Acts of Congress, and Executive Orders and other policies that, acknowledge the special status of Indian tribes within our federal system and establish a range of programs and services for Indians.¹⁹

B. The Evolution of Federal Indian Health Care Programs and Responsibilities

The obligation to provide for Indian health has long been viewed by federal policymakers as a necessary component of the federal trust responsibility.²⁰ It has also been viewed as a moral imperative, as well as a public health necessity, owing to the introduction of devastating new diseases and other consequences of colonialism with harmful impacts on Indian health. It was these latter concerns that drove the earliest appropriations of funding specifically for Indian health care, while the former began to take root and became more firmly entrenched over time. In its comprehensive 1957 report to Congress on the administration of Indian health services, the PHS noted that “[a]s early as 1802 or 1803, Army physicians took emergency measures to curb smallpox and other contagious diseases among Indian tribes in the vicinity of military posts. Without doubt these measures were intended primarily to protect soldiers at the forts from infection, but Indians benefitted.”²¹ In 1832, Congress appropriated \$12,000 in funding and directed the Secretary of War to employ physicians to administer smallpox vaccines to Indians.

¹⁸ See *infra*, part III.A. Federal supremacy over Indian affairs does not mean that the states do not retain the obligation to protect the equal rights of, and provide state services to, Indian people who are also state residents or citizens, to the same extent as all other state residents or citizens. See Cohen’s Handbook § 14.02[2][d] (citing cases holding that states may not deny Indians state services on the grounds that federal services are available as an alternative). Indeed, as part of the IHCLIA reauthorization in 2010 Congress codified a “payor of last resort” provision to ensure that other federal, state, and local programs remain responsible for payment for services provided by the Indian Health Service and tribal health programs where those other federal, state, and local programs would otherwise pay for an individual’s care. 25 U.S.C. § 1623(b).

¹⁹ See, e.g., *Cobell v. Norton*, 240 F.3d 1081, 1086 (D.C. Cir. 2001) (citing *United States v. Mitchell* (“*Mitchell II*”), 463 U.S. 206, 225 (1983)); *Supra* note 4 (listing federal statutes invoking the federal trust responsibility); Exec. Order No. 13175, 65 Fed. Reg. 67249 (Nov. 6, 2000) *reprinted in* 2000 U.S.C.C.A.N. at B77; White House Memorandum for Heads of Executive Departments and Agencies, Nov. 5, 2009. In 2012, the Supreme Court noted that while the federal trust responsibility to Indian tribes is not the same as a private trust enforceable under the common law, “The Government, following ‘a humane and self imposed policy ... has charged itself with moral obligations of the highest responsibility and trust,’ [...], obligations ‘to the fulfillment of which the national honor has been committed[.]’” *United States v. Jicarilla Apache Nation*, 131 S. Ct. 2313, 2324 (2011) (internal citations omitted) (citing *Seminole Nation v. United States*, 316 U.S. 286, 296–297 (1942) and *Heckman v. United States*, 224 U.S. 413, 437 (1912)). The trust relationship and its general obligations extend across the federal government to include every member of the legislative and executive branches, though whether any particular responsibilities enforceable as a matter of federal law exist is dependent on the context.

²⁰ See *supra*, notes 13 & 14 and accompanying text.

²¹ U.S. Pub. Health Serv., *Health Services for American Indians* 86 (1957).

In 1849, when the Bureau of Indian Affairs was transferred from the War Department to the Department of the Interior, the responsibility to provide for Indian health care was transferred along with it. The transfer resulted in some increase in the scope of Indian health care services beyond emergency vaccinations and fulfillment of specific treaty promises. However, Indian health continued to be funded through patchwork legislation and from miscellaneous funds, and the modest increase in resources that accompanied the transfer proved inadequate to the task of ensuring minimum standards of health among Indian people.²² As the PHS reported in its 1957 Report, “In 1892, Commissioner [of Indian Affairs Thomas J.] Morgan, having repeatedly exhorted Congress ‘in the name of humanity’ to provide money for Indian hospitals at every agency and boarding school, described the lack of such facilities as ‘a great evil, which in my view amounts to a national disgrace.’”²³

Congress began appropriating general funds for Indian health care in fiscal year 1911.²⁴ Two years later, President Taft addressed Congress, citing a series of surveys that revealed shockingly high rates of disease among Indians and asking Congress to increase funding for Indian health care. President Taft characterized his request as a requirement of the federal government’s special responsibilities to Indian tribes, stating: “As guardians of the welfare of the Indians, it is our immediate duty to give to the race a fair chance for an unmaimed birth, healthy childhood, and physically efficient maturity.”²⁵ Congress did increase the annual appropriations for Indian Health, and in 1921 passed the Snyder Act, authorizing the Bureau of Indian Affairs to carry out programs “for the relief of distress and conservation of health,” among other purposes.²⁶ The Snyder Act provided the first statutory authorization for Indian health care programs, though the established programs were discretionary and appropriations levels were left for Congress to determine on an annual basis.²⁷

In 1928, a comprehensive survey of the economic and social state of Indians within the United States, known as the Meriam Report, revealed that the health status of Indian people remained extremely poor. The Meriam Report blamed inadequate appropriations for the lack of effectiveness of the Indian Service in addressing Indian health care, among other issues.²⁸ At that time, however, Indian policy favored the assimilation of Indians into the general population and the eventual dissolution of Indian tribes as distinct political and cultural groups. A larger focus was therefore put on integrating Indians into the public health system in the states and local communities where they resided. For example, in 1934, Congress passed the Johnson O’Malley Act, authorizing the Bureau of Indian Affairs to enter into agreements with States and their political subdivisions to provide various social services including “medical attention” and “relief

²² U.S. Pub. Health Serv., *Health Services for American Indians* 87 (1957); H.R. Rep. No. 94-1026(I), at 14 (1976).

²³ U.S. Pub. Health Serv., *Health Services for American Indians* 87 (1957).

²⁴ Act of Apr. 4, 1910, 36 Stat. 269; U.S. Pub. Health Serv., *Health Services for American Indians* 88 (1957).

²⁵ Cohen’s Handbook § 22.04[1].

²⁶ 25 U.S.C. § 13.

²⁷ Betty Pfefferbaum et. al., *Learning How to Heal: An Analysis of the History, Policy, and Framework of Indian Health Care*, 20 *Am. Indian L. Rev.* 365, 376-77 (1996).

²⁸ Institute for Government Research, *The Problem of Indian Administration* 189 (Lewis Meriam ed., Johns Hopkins Press 1928).

of distress.”²⁹ Nevertheless, the Meriam Report recognized the unique federal responsibility to Indian tribes and urged caution in the transition of service administration, stating as a fundamental principle that:

... under the Constitution of the United States and in accordance with the historical development of the country, the function of providing for Indians is the responsibility of the national government. ... [T]he national government should not transfer activities incident to this function to individual states unless and until a particular state is prepared to conduct that activity in accordance with standards at least as high as those adopted by the national government.³⁰

The assimilationist tone of federal Indian policy continued into the 1950s, despite passage of the landmark Indian Reorganization Act in 1934,³¹ which generally encouraged the organization of tribal governments and the exercise of greater tribal self-government. Regardless, the responsibility to provide health care to Indians was never in fact shifted from the federal government to the States. Rather, in 1954 Congress enacted legislation transferring the responsibility for Indian health services to the Public Health Service, a proposal that had been made some decades earlier but never acted upon.³² The Bureau of Indian Affairs had been relying on Public Health Service officers to assist in administering Indian health programs since 1926, and the transfer was intended in part to secure better resources and more qualified staff.³³ The Division of Indian Health was thus created in the Public Health Service, under the U.S. Surgeon General.

By 1955, the Indian health appropriation had grown to nearly \$18 million,³⁴ a dramatic increase from the \$40,000 appropriated in 1911, and the Division of Indian Health administered a \$24.5 million total budget.³⁵ However, the Division reported to Congress that the funding was still insufficient: “Especially in recent years, rising medical costs and contraction in the value of the dollar, not to mention increased utilization of services by the Indians, have largely offset increases in appropriations.”³⁶

²⁹ Act of Apr. 16, 1934, ch. 147 § 1, 48 Stat. 596 (1934) (codified as amended at 25 U.S.C. § 452). The provision of health care services under the Johnson O’Malley Act was limited by the fact that many Indians still lived in areas where local health services were simply not available. U.S. Pub. Health Serv., Health Services for American Indians 92 (1957).

³⁰ Institute for Government Research, *The Problem of Indian Administration* 98 (Lewis Meriam ed., Johns Hopkins Press 1928).

³¹ 25 U.S.C. § 461 et seq.

³² Pub. L. No. 83-568, c. 658, § 1, 68 Stat. 674 (1954) (codified as amended at 25 U.S.C. § 2001).

³³ Cohen’s Handbook § 22.04[1]; Pfefferbaum et. al., *supra* note ___, at 382.

³⁴ U.S. Pub. Health Serv., Health Services for American Indians 88 (1957).

³⁵ H.R. Rep. No. 94-1026(I), at 14 (1976).

³⁶ U.S. Pub. Health Serv., Health Services for American Indians 88 (1957).

The tenor of Indian policy changed markedly in the 1960s. The “Termination” policy of the 1950s was repudiated, and a new era of tribal self-determination took its place.³⁷ By 1976, as Congress considered draft legislation that would become the Indian Health Care Improvement Act, the Indian Health Service annual budget had grown to \$274 million.³⁸ Still, the poor state of Indian health was appalling, and the House Committee on Interior and Insular Affairs noted that Indians and Alaska Natives “suffer a health status far below that of the general population.”³⁹ The Committee Report also stated that “any effort to fulfill Federal responsibilities to the Indian people must begin with the provision of health services.”⁴⁰ Congress affirmed that view in enacting the IHCA for the first time later that year, finding: “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.”⁴¹

C. The Modern Federal Legal Framework for Indian Health Care

Enactment of the IHCA marked a major turning point in the provision of federal health care services to Indian people. Though rooted in the same broad trust responsibility as earlier acts of Congress, the IHCA was the first federal legislation to enact specific statutory programs for Indian health care. The comprehensive reform measures included in the IHCA were designed to address a slew of problems identified and viewed by Congress as impediments to a better health status for Indian people as a whole, including: “inadequate, outdated, inefficient, and undermanned facilities”; “shortage of personnel”; “insufficient services in such areas as laboratory, hospital inpatient and outpatient, eye care and mental health services, and services available through contracts with private physicians, clinics, and agencies”; “related support factors”; “lack of access of Indians to health services due to remote residences, undeveloped or underdeveloped communication and transportation systems, and difficult, sometimes severe, climate conditions”; and “lack of safe water and sanitary waste disposal services.”⁴²

³⁷ Cohen’s Handbook § 1.07.

³⁸ H.R. Rep. No. 94-1026(I), at 14 (1976). The “Division of Indian Health” was retitled the “Indian Health Service” in 1968, and that title remains today. *Id.*

³⁹ H.R. Rep. No. 94-1026(I), at 15 (1976).

⁴⁰ H.R. Rep. No. 94-1026(I), at 13 (1976).

⁴¹ Indian Health Care Improvement Act, Pub. L. No. 94-437, § 2, 90 Stat. 1400 (1976) (codified at 25 U.S.C. § 1601).

⁴² Congress included each of these factors in its findings, stating:

(f) Further improvement in Indian health is imperiled by—

(1) inadequate, outdated, inefficient, and undermanned facilities. For example, only twenty-four of fifty-one Indian Health Service hospitals are accredited by the Joint Commission on Accreditation of Hospitals; only thirty-one meet national fire and safety codes; and fifty-two locations with Indian populations have been identified as requiring either new or replacement health centers and stations, or clinics remodeled for improved or additional service;

(2) shortage of personnel. For example, about one-half of the Service hospitals, four-fifths of the Service hospital outpatient clinics, and one-half of the Service health meet only 80 per centum of staffing standards for their respective services;

(3) insufficient services in such areas as laboratory, hospital inpatient and outpatient, eye care and

In order to address the staffing shortage in Indian health facilities, Title I of the IHCIA created grant and scholarship programs to encourage Indians to enter the health profession and to recruit health care professionals into the Indian health care system.⁴³ Title II also authorized additional staffing positions and funding for direct and indirect patient care, field health, dental care, mental health, substance abuse, training, maintenance, and more.⁴⁴ To address “inadequate, outdated, inefficient, and undermanned facilities” within the system, Title III authorized appropriations for the construction and renovation of hospitals, health centers, health stations, and staff housing. Title III also authorized funding to “supply unmet needs for safe water and sanitary waste disposal facilities in existing and new Indian homes and communities.”⁴⁵ In addition, Title V of the IHCIA authorized the Secretary to enter into contracts with urban Indian organizations to establish programs “to make health services more accessible to the urban Indian population.”⁴⁶

The IHCIA also helped Tribes and the IHS to leverage existing federal resources to increase access to health care for Indians. Section 401 of the IHCIA, for example, added Section 1880 of the Social Security Act to permit IHS hospitals (including those operated by Indian tribes) to collect Medicare reimbursement. Importantly, Section 401 specified that any Medicare payments received under the new Section 1880 “shall not be considered in determining appropriations for health care and services to Indians.”⁴⁷ Section 402 of the IHCIA similarly added Section 1911 of the Social Security Act, making IHS and tribal health facilities eligible to collect Medicaid reimbursements,⁴⁸ and amended Section 1905 of the Social Security Act to

mental health services, and services available through contracts with private physicians, clinics, and agencies. For example, about 90 per centum of the surgical operations needed for otitis media have not been performed, over 57 per centum of required dental services remain to be provided, and about 98 per centum of hearing aid requirements are unmet;

(4) related support factors. For example, over seven hundred housing units are needed for staff at remote Service facilities;

(5) lack of access of Indians to health services due to remote residences, undeveloped or underdeveloped communication and transportation systems, and difficult, sometimes severe, climate conditions; and

(6) lack of safe water and sanitary waste disposal services. For example, over thirty-seven thousand four hundred existing and forty-eight thousand nine hundred and sixty planned replacement and renovated Indian housing units need new or upgraded water and sanitation facilities.

Indian Health Care Improvement Act, Pub. L. No. 94-437, § 2(f), 90 Stat. 1400 (1976) (25 U.S.C. § 1601(f)).

⁴³ Indian Health Care Improvement Act, Pub. L. No. 94-437, tit. I, 90 Stat. 1400 (1976).

⁴⁴ *Id.* at tit. II.

⁴⁵ *Id.* at tit. III.

⁴⁶ *Id.* at tit. IV.

⁴⁷ Indian Health Care Improvement Act, Pub. L. No. 94-437, § 401, 90 Stat. 1400 (1976), *codified at* 42 U.S.C. § 1395qq.

⁴⁸ Indian Health Care Improvement Act, Pub. L. No. 94-437, § 402, 90 Stat. 1400 (1976), *codified at* 42 U.S.C. § 1396j.

apply a 100 per centum Federal medical assistance percentage “with respect to amounts expended as medical assistance for services which are received through an Indian Health Service facility whether operated by the Indian Health Service or by an Indian tribe or tribal organization[.]”⁴⁹

Overall, the IHCIA was designed to “authorize a sustained and coordinated Federal health effort” to “establish a firm foundation upon which a continuous program capable of meeting the total health needs of the Indian and Alaska Native people could be maintained[.]”⁵⁰ However, the goal was not only to increase the “quantity and quality of health services” available to Indians, but also to “encourage the maximum participation of Indians in the planning and management of those services.”⁵¹ In this way the IHCIA was also a reflection of the burgeoning federal policy of tribal self-determination, the cornerstone of which is the Indian Self-Determination and Education Assistance Act (ISDEAA), enacted in 1975, just one year prior to the IHCIA.⁵²

The ISDEAA, also known by its Public Law number, 93-638, was intended to promote Indian self-determination by increasing tribal control over services provided to tribal members.⁵³ In order to achieve that goal, the ISDEAA allows tribes to take over federal programs for Indians (including health programs) by contracting with the federal government to carry them out, in effect stepping into the shoes of the federal agencies that formerly provided those programs and services. This has the effect of allowing tribes to build the capacity to perform essential governmental functions as well as to improve the programs themselves by making them more responsive to local tribal needs.⁵⁴ Over the years the ISDEAA has had a profound impact on the delivery of health care services to Indian people.

⁴⁹ Indian Health Care Improvement Act, Pub. L. No. 94-437, § 402(e), 90 Stat. 1400 (1976), *codified at* 42 U.S.C. § 1396d(b).

⁵⁰ S. Rep. No. 94-133, at 14 (1975). It should be noted, however, that the IHCIA did not appropriate funding, so the implementation of its various provisions is still dependent on annual discretionary appropriations by Congress.

⁵¹ Indian Health Care Improvement Act, Pub. L. No. 94-437, § 2, 90 Stat. 1400 (1976), *codified at* 25 U.S.C. § 1601(b).

⁵² Pub. L. No. 93-638, 88 Stat. 2203 (1975) (codified as amended at 25 U.S.C. §§ 5301-5399).

⁵³ See H.R. REP. NO. 93-1600, at 1, 6-7, *reprinted in* 1974 U.S.C.C.A.N. 7775, 7776, 7781-82. The legislative goals of the ISDEAA are also summarized as follows in the Act’s Congressional declaration of Policy:

The Congress declares its commitment to the maintenance of the Federal Government’s unique and continuing relationship with, and responsibility to, individual Indian tribes and to the Indian people as a whole through the establishment of a meaningful Indian self-determination policy which will permit an orderly transition from federal domination of programs for, and services to, Indians to effective and meaningful participation by the Indian people in the planning, conduct, and administration of those programs and services. In accordance with this policy, the United States is committed to supporting and assisting Indian tribes in the development of strong and stable tribal governments, capable of administering quality programs and developing the economies of their respective communities.

25 U.S.C. § 5302(b).

⁵⁴ Geoffrey D. Strommer & Stephen D. Osborne, *The History, Status, and Future of Tribal Self-Governance Under the Indian Self-Determination and Education Assistance Act*, 39 AM. IND. L. REV. 1, 21 (2014).

The tribal assumption of federal programs under the ISDEAA began with self-determination contracting under Title I. Though Congress was forced to enact several amendments to the ISDEAA to address deep-seated agency resistance to handing over its federal authority and associated funding to tribes,⁵⁵ Title I contracting nevertheless showed immediate promise. Title I gives all federally recognized Indian tribes and eligible tribal organizations the right to contract for funds and responsibilities for programs provided to Indians by either the Department of the Interior or the Department of Health and Human Services,⁵⁶ and restricts the agencies' ability to decline a contract proposal except where specific statutory criteria justify a declination. With respect to contract funding, the awarding agency is required to provide "not less than the appropriate Secretary would have otherwise provided for the operation of the programs or portions thereof for the period covered by the contract" (in other words, the same amount the agency would have spent to operate the program itself),⁵⁷ as well as "contract support costs" to cover administrative and overhead costs that are not included in the program amount.⁵⁸

Contracts negotiated under Title I are unique government-to-government agreements, and while they are considered legally binding to the same extent as regular contracts,⁵⁹ they differ significantly in other ways from ordinary government procurement contracts. For one thing, ISDEAA contracts are generally exempt from the Federal Acquisition Regulations and other Federal contracting or cooperative agreement laws.⁶⁰ And, while tribes and the agencies have the flexibility to negotiate any provision into a Title I contract that they wish, the Act requires that certain mandatory provisions be included in all contracts in order to strike a balance between Congress's policy of promoting tribal self-determination and maintaining reasonable federal oversight over how contracted responsibilities are carried out.⁶¹ Contracting tribes are required to provide an annual audit, but any additional reports must be justified by the agency and negotiated by the parties.⁶² Additionally, an agency may unilaterally reassume a contracted program, but only if there is a violation of the rights or endangerment to the health, safety, or welfare of any person, or if a contractor mismanages trust funds or lands, or interests in such lands.⁶³ And, contracting tribes have the right to reallocate funds awarded in a contract, provided the reallocation does not "have an adverse effect on the performance of the contract,"⁶⁴

⁵⁵ The most significant amendments include: Indian Self-Determination and Education Assistance Act Amendments of 1988, Pub. L. No. 100-472, 102 Stat. 2285; Tribal Self-Governance Act of 1994, Pub L. No. 103-413, 108 Stat. 4250; and Tribal Self-Governance Amendments of 2000, Pub. L. No. 106-260, 114 Stat. 711.

⁵⁶ 25 U.S.C. § 5321(a)(1).

⁵⁷ 25 U.S.C. § 5325(a)(1).

⁵⁸ 25 U.S.C. § 5325(a)(2).

⁵⁹ *Cherokee Nation v. Leavitt*, 543 U.S. 631, 639 (2005).

⁶⁰ 25 U.S.C. § 5324(a)(1).

⁶¹ As amended, section 108(c) of the ISDEAA, 25 U.S.C. § 5329(c), sets out a "model agreement" that must be included in or incorporated by reference into every Title I contract.

⁶² 25 U.S.C. § 5324.

⁶³ 25 U.S.C. § 5330.

⁶⁴ 25 U.S.C. § 5325(o).

and to redesign any non-construction program, with agency approval, to better meet local conditions and needs.⁶⁵

In 1988, Congress expanded the ISDEAA by enacting the Tribal Self-Governance Demonstration Project under Title III.⁶⁶ The general intent behind self-governance is similar to self-determination: to implement Congress's policy of allowing tribes to assume control over service delivery of federally funded programs that benefit Indians and Alaska Natives, and enhancing the ability of tribal governments to govern their communities.⁶⁷ Self-governance implements this intent slightly differently, however, primarily by placing greater emphasis on minimizing federal agency oversight and maximizing flexibility for tribes to redesign programs and reallocate resources included in a self-governance agreement.⁶⁸ "In effect," self-governance tribes "receive funds in the contractual equivalent of block grants from the Secretary."⁶⁹ Initially the self-governance demonstration project applied only to Bureau of Indian Affairs (BIA) programs within Department of the Interior, but it proved very popular and was soon expanded to the Department of Health and Human Services, where the IHS resides.⁷⁰ In 1994, Congress enacted the Tribal Self-Governance Act, making the program permanent within the Department of the Interior under Title IV,⁷¹ and in 2000, Congress made Self-governance a permanent program within the Department of Health and Human Services under Title V.⁷²

Tribes and tribal organizations around the country have made great strides in strengthening tribal health care programs and services under the ISDEAA by leveraging local tribal accountability and expertise and combining tribal and federal resources under an increasing array of federal statutory authority. In 2010, the IHCA, which had previously required periodic reauthorization, was strengthened and permanently re-enacted under Section 10221 of the Affordable Care Act. Among the many new and updated provisions are: revisions to Section 119 to authorize establishment of a national community health aide program (previously operated only in Alaska) to train and certify community health aides and community health practitioners

⁶⁵ 25 U.S.C. § 5324(j). Proposals to redesign a program are subject to the same limited statutory declination criteria as a new contract proposal. *Id.*; 25 U.S.C. § 5321(a)(2).

⁶⁶ Indian Self-Determination and Education Assistance Act Amendments of 1988, Pub. L. No. 100-472, 102 Stat. 2285, *repealed by* Tribal Self-Governance Amendments of 2000, Pub. L. No. 106-260, § 10, 114 Stat. 711, 734.

⁶⁷ S. Rep. No. 100-274, at 1 (1987), *reprinted in* 1988 U.S.C.C.A.N. 2620, 2620-21.

⁶⁸ "Self-governance' refers both to the broad principle that tribes have the right to govern themselves, and to particular statutory rights enabling them to do so through the use of federal program funding. As a statutory initiative, self-governance (1) expands the types of programs and responsibilities that participating tribes can take over; (2) places greater emphasis on minimizing oversight by federal agencies; and (3) maximizes flexibility for tribes to redesign programs and reallocate resources in their agreements." Geoffrey D. Strommer & Stephen D. Osborne, *The History, Status, and Future of Tribal Self-Governance Under the Indian Self-Determination and Education Assistance Act*, 39 AM. IND. L. REV. 1, 31 (2014).

⁶⁹ *Id.* at 33.

⁷⁰ Indian Health Amendments of 1992, Pub. L. No. 102-573, 106 Stat. 4526.

⁷¹ Indian Self-Determination Act Amendments of 1994, Pub. L. No. 103-413, 108 Stat. 4250 (codified as amended at 25 U.S.C. §§ 5361-5368).

⁷² Tribal Self-Governance Amendments of 2000, Pub. L. No. 106-260, 114 Stat. 711 (codified at 25 U.S.C. §§ 5381-5399).

to provide health care, health promotion, and disease prevention services in Native communities;⁷³ Section 221, which exempts health care professionals employed by the IHS or a tribal health program from state licensing requirements in the state in which they are located, provided they are licensed in any state;⁷⁴ Section 407, which authorizes the Department of Veterans Affairs to enter into agreements with tribal health programs to receive reimbursement for health services to eligible Indian veterans;⁷⁵ Section 409, which allows tribes carrying out ISDEAA contracts or compacts to purchase health insurance coverage for its employees through the Federal Employees Health Benefits Program;⁷⁶ and revisions to Title VII to authorize new and expanded services for behavioral health services.⁷⁷

In addition to permanently re-enacting the IHCA, the Affordable Care Act included several Indian-specific provisions, including Section 2901(b), which provides that the Indian Health Service and tribal health programs are the payor of last resort;⁷⁸ Section 2902, which permanently preserved the ability of the IHS and tribal health programs to bill for all Medicare Part B Services by striking a 5-year sunset provision in prior law;⁷⁹ and Section 9021, which excludes health benefits provided by the IHS and tribal health programs to eligible individuals from taxable gross income.⁸⁰ The Affordable Care Act also included a number of special protections for Indians enrolling in a health insurance Marketplace, such as special monthly enrollment periods, and cost sharing exemptions.⁸¹ These provisions were designed to encourage Indian enrollment and otherwise expand the financial resources available to IHS and tribal health programs serving Indians. They have allowed tribes to expand and improve health care programs and services in impressive ways, and may tribal health programs today have become key service providers for Indians and non-Indians alike in remote and rural areas where access to primary and specialty health care is otherwise lacking.⁸²

⁷³ 25 U.S.C. § 1616l.

⁷⁴ 25 U.S.C. § 1621t.

⁷⁵ 25 U.S.C. § 1647.

⁷⁶ 25 U.S.C. § 1647b.

⁷⁷ 25 U.S.C. §§ 1665-1665m, § 1667e.

⁷⁸ 25 U.S.C. § 1623(b).

⁷⁹ 42 U.S.C. § 1395qq(e)(1)(A).

⁸⁰ 26 U.S.C. § 139D.

⁸¹ 42 U.S.C. § 18031(c)(6)(D); 42 U.S.C. § 18071(d).

⁸² Other federal laws have occasionally provided additional relevant authorities and protections. Section 5506 of the American Recovery and Reinvestment Act of 2009, for example, instituted new protections for Indians enrolled in State Medicaid programs and the Children's Health Insurance Program (CHIP), including: premium and cost sharing protections; certain property exemptions (including trust property) for purposes of eligibility resource considerations; and new requirements that State Medicaid or CHIP managed care programs permit any Indian enrolled in a non-IHS or tribal managed care entity to continue to receive covered services from an IHS or tribal program for which he or she is otherwise eligible, and to designate the IHS or tribal health program as his or her primary care provider, among other things. American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5, § 5006(a), 123 Stat. 115 (2009). These protections make Medicaid and CHIP more accessible to beneficiaries of the Indian Health Service and tribal health programs, resulting in increased Medicaid and CHIP reimbursements to those programs. In addition, Section 5006(e) of the ARRA mandated that States consult with Indian health

III. Current Legal Framework

The rise in sophisticated, tribally-operated health care programs and services that benefit both Indians and non-Indians alike has begun to raise questions about the extent of tribal authority to design and implement those programs and services free from state interference. As a matter of tribal law, tribes retain inherent sovereignty to self-regulate these matters except to the extent limited by tribal customary, constitutional, or other law. Federal law, however, purports to limit inherent tribal sovereignty in many respects and in some cases recognizes state authority to regulate activity on tribal lands.

As a matter of federal common law, two lines of authority in particular bear on a tribe's ability to self-regulate health care services within its own territory. These lines of authority relate to, first, the application of state laws on tribal lands, and second, tribal jurisdictional authority over individuals and activities—in particular, non-Indians—on tribal lands. Where no Act of Congress applies to alter the jurisdictional division on tribal lands,⁸³ the framework set out by the Supreme Court generally precludes the exercise of state authority where that exercise would “infringe on the right of reservation Indians to make their own laws and be ruled by them” or where it is preempted by federal law.⁸⁴ As to the extent of tribal authority over non-Indians within reservation boundaries, at the very least tribes may exercise civil jurisdiction over such individuals where they have entered into “consensual relationships” with the tribe or its members or where the individual's conduct “threatens or has some direct effect on the political integrity, the economic security, or the health or welfare of the tribe,”⁸⁵ though tribal authority may be more extensive on trust as opposed to fee lands.

A. Preemption of State Law and Infringement on Tribal Government

Historically, the general rule has been that state laws do not apply on Indian tribal lands—at least not without an express Act of Congress—as Indian affairs is a matter of tribal and federal control.⁸⁶ As a general matter this rule still applies with respect to the property and

programs on a regular, ongoing basis on matters having a direct effect on Indians, Indian health programs, or Urban Indian Organizations. *Id.* at § 5006(e).

⁸³ For example, Public Law 280 confers jurisdiction on six “mandatory” states and several “optional states” over criminal and some civil matters on tribal lands within state borders. Act of Aug. 15, 1953, 67 Stat. 588 (codified as amended at 18 U.S.C. § 1162, 25 U.S.C. §§ 1321-1326, 28 U.S.C. §§ 1360, 1360 note). Jurisdiction statutes like Public Law 280 alter or add another layer to the jurisdictional analysis set out below. Civil jurisdiction under Public Law 280, however, is limited to the state providing a forum to settle disputes among private parties, *Bryan v. Itasca County*, 426 U.S. 373, 388 (1976), and whether a state law is criminal or civil for purposes of Public Law 280 depends on whether the law is considered civil/regulatory or criminal/prohibitory in nature. *See California v. Cabazon Band of Mission Indians*, 480 U.S. 202 (1987). Under that analysis, state regulatory laws such as licensing of health care professionals are unlikely to apply on tribal lands as a result of Public Law 280, but some related criminal penalties—such as for practicing without a license—could apply.

⁸⁴ *White Mountain Apache Tribe v. Bracker*, 448 U.S. 136, 142 (1980).

⁸⁵ *Montana v. United States*, 450 U.S. 544, 565–66 (1981) (internal citations omitted).

⁸⁶ E.g., *Worcester v. Georgia*, 31 U.S. 515 (1832) (holding the Cherokee Nation was “a distinct community ... in which the laws of Georgia can have no force”).

activities of Indians in Indian country.⁸⁷ However, where the actions of non-Indians are involved or state interests are particularly strong, the landscape is a bit more complicated, and over recent decades the courts have allowed for a greater intrusion of state authority on Indian reservations.⁸⁸

In *Williams v. Lee*, the Court affirmed that the “basic policy” of *Worcester v. Georgia* remained the law,⁸⁹ but re-framed the rule of State authority on tribal lands as follows: “Essentially, absent governing Acts of Congress, the question has always been whether the state action infringed on the right of reservation Indians to make their own laws and be ruled by them.”⁹⁰ The Court held in that case that to allow the exercise of state court jurisdiction over a civil suit brought by a non-Indian against Indian patrons of his store, which was located on the Navajo Indian Reservation and operated under a federal license required of persons conducting trade with Indians on Indian reservations, “would undermine the authority of the tribal courts over Reservation affairs and hence would infringe on the right of the Indians to govern themselves.”⁹¹

In addition to infringement on the right of tribal self-governance, State authority can also be precluded on tribal lands where it is preempted by federal law. In *White Mountain Apache Tribe v. Bracker*, the Court noted the distinction:

Congress has broad power to regulate tribal affairs under the Indian Commerce Clause, Art. 1, § 8, cl. 3. See *United States v. Wheeler*, *supra*, at 322-323, 98 S.Ct., at 1085-1086. This congressional authority and the “semi-independent position” of Indian tribes have given rise to two independent but related barriers to the assertion of state regulatory authority over tribal reservations and members. First, the exercise of such authority may be pre-empted by federal law. See, *e. g.*,

⁸⁷ See *McClanahan v. State Tax Comm’n of Arizona*, 411 U.S. 164, 170–71 (1973) (“State laws generally are not applicable to tribal Indians on an Indian reservation except where Congress has expressly provided that State laws shall apply.”); *White Mountain Apache Tribe v. Bracker*, 448 U.S. 136, 144 (1980) (“[w]hen on-reservation conduct involving only Indians is at issue, state law is generally inapplicable, for the State’s regulatory interest is likely to be minimal and the federal interest in encouraging tribal self-government is at its strongest.”).

⁸⁸ See, *e.g.*, *California v. Cabazon Band of Mission Indians*, 480 U.S. 202, 215 (1987). Quoting *New Mexico v. Mescalero Apache Tribe*, 462 U.S. 324, 331-32 (1983), the Court in *Cabazon* noted that States may assert authority over the activities of nonmembers in “certain circumstances,” and may also assert authority over on-reservation activities of tribal members in “exceptional circumstances.” The Court pointed to *Moe v. Confederated Salish and Kootenai Tribes*, 425 U.S. 463 (1976), and *Washington v. Confederated Tribes of Colville Indian Reservation*, 447 U.S. 134 (1980), as illustrative: in those cases, the Court permitted the State to require tribal smokeshops on Indian reservations to collect state sales taxes from non-Indian customers entering the reservation to purchase tobacco products, due to the State’s strong interest in assuring the collection of sales taxes from non-Indians utilizing state services and the “minimal burden” imposed on the tribal smokeshop operators.

⁸⁹ The Court stated, “Over the years this Court has modified these principles in cases where essential tribal relations were not involved and where the rights of Indians would not be jeopardized, but the basic policy of *Worcester* has remained.” *Williams v. Lee*, 358 U.S. 217, 219 (1959). In *White Mountain Apache Tribe v. Bracker*, 448 U.S. 136, 141 (1980), however, the Court noted that “Long ago the Court departed from Mr. Chief Justice Marshall’s view that ‘the laws of [a State] can have no force’ within reservation boundaries,” quoting *Worcester v. Georgia*, 6 Pet. 515, 561 (1832), and citing to *Williams*.

⁹⁰ *Williams v. Lee*, 358 U.S. 217, 220 (1959).

⁹¹ *Id.* at 223.

Warren Trading Post Co. v. Arizona Tax Comm'n, 380 U.S. 685, 85 S.Ct. 1242, 14 L.Ed.2d 165 (1965); *McClanahan v. Arizona State Tax Comm'n*, *supra*. Second, it may unlawfully infringe “on the right of reservation Indians to make their own laws and be ruled by them.” *Williams v. Lee*, 358 U.S. 217, 220, 79 S.Ct. 269, 271, 3 L.Ed.2d 251 (1959). ... The two barriers are independent because either, standing alone, can be a sufficient basis for holding state law inapplicable to activity undertaken on the reservation or by tribal members.⁹²

The Supreme Court has summarized the preemption test as follows:

State jurisdiction is pre-empted by the operation of federal law if it interferes with or is incompatible with federal and tribal interests reflected in federal law, unless the state interests at stake are sufficient to justify the assertion of state authority.⁹³

This preemption doctrine is different from the general federal preemption of state law analysis that is applied outside the context of federal Indian law.⁹⁴ Specifically, “The tradition of Indian sovereignty over the reservation and tribal members must inform the determination whether the exercise of state authority has been pre-empted by operation of federal law[,]” and “traditional notions of Indian self-government” thus provide “an important backdrop” to the preemption analysis.⁹⁵ Due to the pervasive authority of Congress over Indian affairs, Congress need not have expressly spoken on the matter or expressed a specific intent to preempt state law in a given area.⁹⁶

Rather, in the context of Indian law, the preemption analysis involves a fact-specific balancing of federal, tribal, and state interests.⁹⁷ Due in part to its fact-specific nature, the outcome of the preemption test can be unpredictable. In general, the courts will usually find that State jurisdiction is preempted when the matter at issue involves the conduct of Indians on the reservation, or the activities of the tribal government itself.⁹⁸ The greater the involvement of non-Indians or non-Indian interests in the activity, however, the greater likelihood that the courts

⁹² *White Mountain Apache Tribe v. Bracker*, 448 U.S. 136, 142 (1980).

⁹³ *New Mexico v. Mescalero Apache Tribe*, 462 U.S. 324, 334 (1983).

⁹⁴ See, e.g., *Id.* at 332-33; *White Mountain Apache Tribe v. Bracker*, 448 U.S. 136, 143 (1980) (“The unique historical origins of tribal sovereignty make it generally unhelpful to apply to federal enactments regulating Indian tribes those standards of pre-emption that have emerged in other areas of the law. Tribal reservations are not States, and the differences in the form and nature of their sovereignty make it treacherous to import to one notions of pre-emption that are properly applied to the other.”).

⁹⁵ *Id.* See also, *McClanahan v. State Tax Comm'n of Arizona*, 411 U.S. 164, 172 (1973) (“The Indian sovereignty doctrine is relevant, then, not because it provides a definitive resolution of the issues in this suit, but because it provides a backdrop against which the applicable treaties and federal statutes must be read.”).

⁹⁶ *White Mountain Apache Tribe*, 448 U.S. at 144 (“We have thus rejected the proposition that in order to find a particular state law to have been preempted by operation of federal law, an express congressional statement to that effect is required.”); *Three Affiliated Tribes of Fort Berthold Reservation v. Wold Eng'g*, 476 U.S. 877, 885 (1986).

⁹⁷ E.g., *Cotton Petroleum Corp. v. New Mexico*, 490 U.S. 163, 176 (1989) (quoting *Ramah Navajo School Bd., Inc. v. Bureau of Revenue of New Mexico*, 458 U.S. 832, 838 (1982)).

⁹⁸ See *supra*, note 87.

will find that State regulation is not preempted.⁹⁹ For example, in *Cotton Petroleum Corp. v. New Mexico*, the Court upheld a severance tax on non-Indian oil and gas producers located on-reservation, even though the Tribe imposed its own tax and despite the existence of a federal statute governing oil and gas leases on Indian lands.¹⁰⁰ The Court, emphasizing that the preemption analysis is “flexible,” and “sensitive to the particular state, federal, and tribal interest involved,”¹⁰¹ found “no history of tribal independence from state taxation” of mineral leases under federal law.¹⁰² It also found that the burden on the Tribe was minimal when weighed against the State’s legitimate interest in the tax arising from its provision of services to both the Tribe and the mineral lessee, as well as its role in regulating oil and gas drilling on the reservation.¹⁰³ In contrast, in *New Mexico v. Mescalero Apache Tribe*, the Court held that New Mexico could not apply its fishing and hunting laws to non-members on the tribe’s reservation because the state hunting and fishing laws at issue were incompatible with “the comprehensive scheme of federal and tribal management established pursuant to federal law[.]”¹⁰⁴ and because the State could not identify any regulatory function or service it provided or off-reservation effects that would justify the assertion of its authority over hunting and fishing on the Tribe’s reservation.¹⁰⁵

In an outlier case, *Rice v. Rehner*, the Supreme Court held that state liquor licensing laws could be applied to an individually-owned retail establishment operated by a tribal member on the reservation, in part because (in the Court’s view) there was no tradition of tribal sovereign immunity or inherent self-government in favor of liquor regulation by Indians.¹⁰⁶ Regulation of liquor sales presents a unique case: such regulation has been pervasive in Indian country since colonial times, so tribal sovereignty with respect to liquor has long been impaired—as the Court noted, “in addition to the congressional divestment of tribal self-government in this area, the States have also been permitted, and even required, to impose regulations related to liquor transactions.”¹⁰⁷ The *Rice* decision departed from the Supreme Court’s ordinary infringement and preemption analysis in its narrow interpretation of the “backdrop” of tribal sovereignty, focusing on the tribe’s traditional lack of control over liquor regulation specifically rather than its tradition of self-government in general.

In a later case commonly cited for its preemption analysis, *California v. Cabazon Band of Mission Indians*, the Supreme Court took a less restrictive approach and held that the application

⁹⁹ *Washington v. Confederated Tribes of the Colville Reservation*, 447 U.S. 134 (1980) (upholding requirement that Tribe collect and remit State taxes on cigarette sales to non-Indians); *Moe v. Salish and Kootenai Tribes*, 425 U.S. 463 (1976) (same).

¹⁰⁰ *Cotton Petroleum Corp. v. New Mexico*, 490 U.S. 163 (1989).

¹⁰¹ *Id.* at 184.

¹⁰² *Id.* at 182.

¹⁰³ *Id.* at 185.

¹⁰⁴ 462 U.S. 324, 338, 343-44 (1983).

¹⁰⁵ *Id.* at 341-42.

¹⁰⁶ *Rice v. Rehner*, 463 U.S. 713, 725 (1983).

¹⁰⁷ *Id.* at 723.

of California gaming laws to the tribe's high stakes bingo operation on tribal lands was precluded.¹⁰⁸ In *Cabazon*, noting that the case involved "a state burden on tribal Indians in the context of their dealings with non-Indians" coming from off-reservation, the Court described the preemption test as follows:

Decision in this case turns on whether state authority is pre-empted by the operation of federal law; and "[s]tate jurisdiction is pre-empted ... if it interferes or is incompatible with federal and tribal interests reflected in federal law, unless the state interests at stake are sufficient to justify the assertion of state authority." *Mescalero*, 462 U.S., at 333, 334, 103 S.Ct., at 2385, 2386. The inquiry is to proceed in light of traditional notions of Indian sovereignty and the congressional goal of Indian self-government, including its "overriding goal" of encouraging tribal self-sufficiency and economic development. *Id.*, at 334-335, 103 S.Ct., at 2386-2387.¹⁰⁹

In applying that test, the Court noted that in addition to the "important federal interests" of tribal self-sufficiency and economic development, the federal government actively approved of and promoted tribal bingo enterprises in specific ways: for example, the Secretary of the Interior had made grants and guaranteed loans for the purposes of constructing bingo facilities, and had approved the tribal ordinances establishing and regulating the very gaming activities that the State sought to regulate.¹¹⁰ The tribes' interests, the Court further noted, were "obviously parallel" to the federal interests, in that the bingo enterprises provided the sole source of revenue for tribal government and services, and were a major source of employment on the tribes' reservations.¹¹¹ Nor were the tribes "merely marketing an exemption from state gambling laws," as the Court had found in some cases involving state taxation on the sale of tobacco products on tribal lands:¹¹²

Here, however, the Tribes are not merely importing a product onto the reservations for immediate resale to non-Indians. They have built modern facilities which provide recreational opportunities and ancillary services to their patrons, who do not simply drive onto the reservations, make purchases and

¹⁰⁸ 480 U.S. 202, 221-22 (1987).

¹⁰⁹ *Id.* at 216.

¹¹⁰ *Id.* at 217-18 ("Under the Indian Financing Act of 1974, 25 U.S.C. § 1451 *et seq.* (1982 ed. and Supp.III), the Secretary of the Interior has made grants and has guaranteed loans for the purpose of constructing bingo facilities. See S.Rep. No. 99-493, p. 5 (1986); *Mashantucket Pequot Tribe v. McGuigan*, 626 F.Supp. 245, 246 (Conn.1986). The Department of Housing and Urban Development and the Department of Health and Human Services have also provided financial assistance to develop tribal gaming enterprises. See S.Rep. No. 99-493, *supra*, at 5. Here, the Secretary of the Interior has approved tribal ordinances establishing and regulating the gaming activities involved. See H.R.Rep. No. 99-488, p. 10 (1986). The Secretary has also exercised his authority to review tribal bingo management contracts under 25 U.S.C. § 81, and has issued detailed guidelines governing that review.)

¹¹¹ *Id.* at 218-19.

¹¹² See *Washington v. Confederated Tribes of the Colville Indian Reservation*, 447 U.S. 134, 155-57 (1980) (upholding state cigarette sales tax deemed to fall on the non-Indian purchasers of cigarettes on tribal lands, finding that the value marketed to those purchasers was not generated on the reservation and citing the State's strong interest in assuring the collection of sales taxes from non-Indians utilizing state services).

depart, but spend extended periods of time there enjoying the services the Tribes provide. The Tribes have a strong incentive to provide comfortable, clean, and attractive facilities and well-run games in order to increase attendance at the games. The tribal bingo enterprises are similar to the resort complex, featuring hunting and fishing, that the Mescalero Apache Tribe operates on its reservation through the “concerted and sustained” management of reservation land and wildlife resources. *New Mexico v. Mescalero Apache Tribe*, 462 U.S., at 341, 103 S.Ct., at 2390.¹¹³

The Court thus concluded, “the Cabazon and Morongo Bands are generating value on the reservations through activities in which they have a substantial interest.”¹¹⁴ In contrast, the Court determined that the State’s asserted interest in preventing the infiltration of tribal bingo by organized crime was weak in light of the fact that the State permitted the play of charity bingo games within the State.¹¹⁵ As a result, the Court held, state regulation was preempted.¹¹⁶

B. Tribal Authority over Non-Indians on Tribal Lands

Apart from the preemption of state law, in order to realistically and successfully self-regulate the provision of health care services on tribal lands, tribes need to exercise civil regulatory and perhaps adjudicatory power over non-Indians. The question here is the extent to which federal law continues to recognize a tribe’s inherent authority to do so.

Montana v. United States is considered a critically important precedential decision on the scope of tribal civil jurisdiction over non-Indians.¹¹⁷ *Montana* involved the question of whether the Crow Tribe could regulate hunting and fishing by nonmembers on non-Indian fee land within the boundaries of the Crow Indian Reservation. Reversing the Court of Appeals, which held that such regulatory power was an incident of the Tribe’s inherent sovereignty over its reservation, the Supreme Court instead held that: “As a general proposition, the inherent sovereign powers of an Indian tribe do not extend to the activities of nonmembers of the tribe.”¹¹⁸ The Court continued, however, stating:

To be sure, Indian tribes retain inherent sovereign power to exercise some forms of civil jurisdiction over non-Indians on their reservations, even on non-Indian fee lands. A tribe may regulate, through taxation, licensing, or other means, the activities of nonmembers who enter consensual relationships with the tribe or its members, through commercial dealing, contracts, leases, or other arrangements. A tribe may also retain inherent power to exercise civil authority over the conduct of non-Indians on fee lands within its reservation when that conduct threatens or has

¹¹³ Id. at 219-20 (internal footnotes omitted).

¹¹⁴ Id. at 220.

¹¹⁵ Id. at 221.

¹¹⁶ Id. at 221-22.

¹¹⁷ 450 U.S. 544 (1981).

¹¹⁸ 450 U.S. at 565.

some direct effect on the political integrity, the economic security, or the health or welfare of the tribe.¹¹⁹

Thus, *Montana* establishes that one of these two exceptions must be met before a tribe may regulate the activities of non-members on non-Indian fee lands within reservation boundaries. In that case, the Court found that neither exception applied, and that the Crow Tribe therefore could not impose its hunting and fishing regulations on non-Indians on the fee lands at issue.

In a later case, *Brendale v. Confederated Tribes and Bands of the Yakima Indian Nation*,¹²⁰ the Court applied its *Montana* analysis to hold that tribal zoning and land use laws did not apply to non-Indian fee land within the tribe's reservation. The Court interpreted *Montana*'s second exception quite narrowly to allow tribal regulation only when the impact of the non-Indian conduct is "demonstrably serious" and "imperils" the political integrity, the economic security, or the health or welfare of the tribe.¹²¹ The Supreme Court has further emphasized the narrow nature of the *Montana* exceptions in subsequent cases. In *Strate v. A-1 Contractors*, for example, the Court held that a car accident on a State highway running through the Tribe's reservation did not fall within either exception for purposes of establishing tribal court jurisdiction over tort claims brought by a non-Indian reservation resident injured in the accident, even though the defendant (A-1 Contractors) was engaged in contract work for the Tribe on the reservation.¹²² With respect to the first exception, the Court held that although A-1 Contractors had a "consensual relationship" with the Tribe, the plaintiff was not a party to the contract and the Tribe was not involved in the accident, so the relationship was not of the "qualifying kind" to establish jurisdiction.¹²³ As for the second exception, the Court stated: "Undoubtedly, those who drive carelessly on a public highway running through a reservation endanger all in the vicinity, and surely jeopardize the safety of tribal members. But if *Montana*'s second exception requires no more, the exception would severely shrink the rule."¹²⁴

While the Court in *Strate* was faced with the scope of the Tribe's adjudicative jurisdiction (specifically, the ability of the tribal court to hear tort claims brought against a non-Indian defendant), the Court nevertheless employed the *Montana* analysis. The *Strate* majority explained:

While *Montana* immediately involved regulatory authority, the Court broadly addressed the concept of "inherent sovereignty." Regarding activity on non-Indian fee land within a reservation, *Montana* delineated—in a main rule and

¹¹⁹ *Montana v. United States*, 450 U.S. 544, 565–66 (1981) (internal citations omitted).

¹²⁰ 492 U.S. 408 (1989).

¹²¹ *Brendale*, 492 U.S. at 431.

¹²² *Strate v. A-1 Contractors*, 520 U.S. 438 (1997).

¹²³ *Id.* at 457.

¹²⁴ *Id.* at 457–58. See also, *Atkinson Trading Co. v. Shirley*, 532 U.S. 645, 655 (2001) (stating, "The consensual relationship must stem from 'commercial dealing, contracts, leases, or other arrangements,' [*Montana*, 450 U.S. at 565,] and a nonmember's actual or potential receipt of tribal police, fire, and medical services does not create the requisite connection. If it did, the exception would swallow the rule[.]"); *Plains Commerce Bank v. Long Family Land and Cattle Co.*, 554 U.S. 316, 330 (2008).

exceptions—the bounds of the power tribes retain to exercise “forms of civil jurisdiction over non-Indians.” As to nonmembers, we hold, a tribe’s adjudicative jurisdiction does not exceed its legislative jurisdiction.¹²⁵

The Court further held that the right-of-way held by the State rendered the State highway on which the underlying accident occurred “equivalent, for nonmember governance purposes, to alienated, non-Indian land[,]” even though the accident occurred within the borders of the reservation.¹²⁶

Montana, *Brendale*, and *Strate* thus all addressed tribal jurisdictional authority over non-Indians on fee land or its “equivalent” within reservation boundaries. The extent to which the same analysis—with its broad general rule against tribal authority and two narrow exceptions—applies to tribal trust land is still not completely clear. Less than one year after *Montana*, the Court in *Merrion v. Jicarilla Apache Tribe* upheld the Tribe’s ability to tax non-Indian oil and gas producers on tribal lands as an exercise of “the tribe’s general authority, as sovereign, to control economic activity within its jurisdiction” and “a necessary instrument of self-government and territorial management.”¹²⁷ Alternatively, the Court reasoned, the Tribe had authority to impose the tax by virtue of its power to exclude non-members—a power that “necessarily includes the lesser power to place conditions on entry, on continued presence, or on reservation conduct, such as a tax on business activities conducted on the reservation.”¹²⁸ The Court in *Merrion* reached these conclusions without ever suggesting that *Montana* might pose any bar to the Tribe’s exercise of such authority or that the Tribe was required to meet one of the two *Montana* exceptions in order to do so. Indeed, in *Montana* itself the Court expressly “agreed” with the Court of Appeals that, “on land belonging to the Tribe or held by the United States in trust for the Tribe,” a tribe may regulate activities of nonmembers.¹²⁹

However, in *Nevada v. Hicks* the Supreme Court held that a tribal court lacked jurisdiction over civil claims against state officials who had entered tribally-owned land to execute a warrant against a tribal member for an off-reservation violation of State law.¹³⁰ In so holding, the Court stated that Indian land ownership does not suspend “the ‘general proposition’ ... that ‘the inherent sovereign powers of an Indian tribe do not extend to the activities of nonmembers of the tribe’ except to the extent ‘necessary to protect tribal self-government or to

¹²⁵ *Strate*, 520 U.S. at 453 (quoting *Montana v. United States*, 450 U.S. at 563, 565) (internal citations omitted).

¹²⁶ *Id.* at 454.

¹²⁷ *Merrion v. Jicarilla Apache Tribe*, 455 U.S. 130, 137 (1982).

¹²⁸ *Id.* at 144.

¹²⁹ 450 U.S. at 557. Likewise, the second exception itself refers to “civil authority over the conduct of non-Indians on fee lands within [the tribe’s] reservation[.]:” *Id.* Subsequent decisions of this Court have also seemed to confirm this understanding of the scope of the *Montana* rule and its exceptions. See *Strate v. A-1 Contractors*, 520 U.S. 438, 453 (1997) (describing *Montana* and its exceptions as “[r]egarding activity on non-Indian fee land”); *Atkinson Trading Co. v. Shirley*, 532 U.S. 645, 654 (2001) (referring to “*Montana*’s general rule that Indian tribes lack civil authority over nonmembers on non-Indian fee land”).

¹³⁰ *Nevada v. Hicks*, 533 U.S. 353 (2001).

control internal relations.”¹³¹ The Court explained: “The ownership status of the land, in other words, is only one factor to consider in determining whether regulation of the activities of nonmembers is ‘necessary to protect tribal self-government or to control internal relations.’”¹³²

Hicks itself arguably addressed only a narrow question arising from an extreme set of facts—i.e. a tribe’s ability to regulate state law enforcement’s execution of a search warrant relating to off-reservation violations of state law.¹³³ Under the unique facts of that case, the Court held that tribal court jurisdiction was precluded because “the principle that Indians have the right to make their own laws and be governed by them requires an accommodation between the interests of the Tribes and the Federal Government, on the one hand, and those of the State, on the other.”¹³⁴ At the same time, the Court recognized that in the ordinary case the status of the land in question is “significant” or even “dispositive” to the underlying question of whether the exercise of tribal authority is “necessary to protect tribal self-government or to control internal relations.”¹³⁵

Hicks, therefore, did not fully answer the question of the applicability of the *Montana* rule and its narrow exceptions to tribal authority over non-members on tribal lands. The Court in *Hicks* also employed the *Montana* analysis while noting that it remains an “open question” whether tribal court jurisdiction over non-Indian defendants in general is *as broad* as the Tribe’s regulatory jurisdiction, or whether there are additional limitations on that adjudicatory jurisdiction.¹³⁶ After granting a writ of certiorari in a recent case that could potentially have resolved those questions, an equally divided Court affirmed the Court of Appeals with no explanation.¹³⁷ A fair reading of the Court’s precedent as a whole, however, and the most consistent with the history of federal Indian law and policy dating back to *Worcester v. Georgia*, is that tribes retain broader latitude to regulate and adjudicate the conduct of nonmembers on tribal lands than on non-Indian fee lands, because a Tribe’s interests in self-government and territorial management are strongest on its own lands and because the Tribe also retains its

¹³¹ *Id.* at 359 (also noting that it was “impl[ie]d that the general rule of *Montana* applies to both Indian and non-Indian land.”)

¹³² *Id.* at 360.

¹³³ *Id.* at 358 n.2 (“Our holding in this case is limited to the question of tribal-court jurisdiction over state officers enforcing state law.”)

¹³⁴ 533 U.S. at 362. The Court accordingly held that “tribal authority to regulate state officers in executing process related to the violation, off reservation, of state laws is not essential to tribal self-government or internal relations[.]” *Id.* at 364.

¹³⁵ *Id.* at 370-71. In response to criticism by Justice O’Connor in her concurring opinion that the Court did not sufficiently consider the status of the land at issue, the *Hicks* majority further stated: “To the contrary, we acknowledge that tribal ownership is a factor in the *Montana* analysis, and a factor significant enough that it ‘may sometimes be ... dispositive[.]’ ... We simply do not find it dispositive in the present case, when weighed against the State’s interest in pursuing off-reservation violations of its laws.” *Id.* at 370.

¹³⁶ *Id.* at 357-58 & n.2. The Court determined it did “not have to answer that open question” since it determined that the Tribe lacked regulatory jurisdiction over the State officials in any event. *Id.*

¹³⁷ See *Dollar Gen. Corp. v. Mississippi Band of Choctaw Indians*, 136 S. Ct. 2159 (2016) (affirming, by an equally divided Court, *Dolgencorp, Inc. v. Mississippi Band of Choctaw Indians*, 746 F.3d 167 (5th Cir. 2014) (upholding tribal court jurisdiction, on the basis of *Montana*’s consensual relations exception, over non-Indian corporation that operated a store on the Tribe’s reservation).

inherent authority to exclude nonmembers from its lands altogether.¹³⁸ Nevertheless, the safest way for Tribes to ensure that tribal jurisdiction over non-Indians will be upheld under federal law is by obtaining explicit consent to jurisdiction under *Montana*'s first exception where possible.

IV. Practical Issues Related to Tribal Self-regulation of Health Care Delivery

On the basis of inherent tribal authority, federal common law, and the federal statutory framework provided by the ISDEAA, the IHCIA, and other federal laws, tribes and tribal health programs across the country have begun to move beyond just the operation of federal Indian health programs to the development and implementation of robust, tribally driven programs that address local needs in new and innovative ways. These programs are still supported by and consistent with federal law and policy goals, and often rely to a significant degree on federal funding. However, as tribes themselves begin to play a larger role in the design and implementation of Indian health care services, and as tribal health programs begin to serve a broader base of individuals on tribal lands, tribal self-regulation in the health care field becomes increasingly significant. This is especially true where existing federal programs are insufficient and where state regulation works at cross-purposes with tribal and local community needs. While the existing legal framework recognizes and allows for such tribal self-regulation of health care, in some areas that framework could be improved to further encourage and foster innovation in tribal health care consistent with the federal trust responsibility.

To begin with, the potential regulatory matters that arise in the design and implementation of tribal health care programs and services are many. They could include, for example, the application of state and/or tribal licensing requirements to, and the ongoing regulation of, health care professionals, facilities, and services, as well as enforcement jurisdiction, including for private claims such as medical torts. These regulatory matters raise jurisdictional questions that, for the most part, currently must be resolved under the Supreme Court's preemption/infringement analysis, outlined above. Beyond such jurisdictional questions, tribes must also consider the availability of federal resources to support tribal programs. Specifically, existing provisions of federal health care law that serve to implement the federal trust responsibility by funneling federal resources into the Indian health system were largely designed with the assumption that tribes would implement existing federal programs, with perhaps some modifications. There has been movement toward increased tribal flexibility in recent decades, however, including for example greater freedom for tribes to serve non-beneficiaries without losing benefits and protections available under their ISDEAA contract.

¹³⁸ *Montana*, 450 U.S. at 557 (distinguishing land owned by or held in trust for the Tribe from fee land owned by nonmembers and agreeing that the Tribe may prohibit or regulate hunting and fishing on such tribal lands); *Merrion*, 455 U.S. at 138, 141-42 (upholding a Tribe's power to tax nonmember activity on tribal lands and observing that a Tribe's interests in levying taxes is strongest when the taxed activity takes place on tribal lands). Under this theory, Tribes must meet one of *Montana*'s two exceptions on non-Indian fee land because, under such circumstances, those exceptions exclusively define the scope of tribal authority "necessary to protect tribal self-government or control internal relations." See, e.g., *Atkinson Trading Co.*, at 651 ("Although we extracted from our precedents the general proposition that the inherent sovereign powers of an Indian tribe do not extend to the activities of nonmembers of the tribe, we nonetheless noted in *Montana* two possible bases for tribal jurisdiction over non-Indian fee land. ...") (internal quotations and citations omitted). However, on tribal trust lands, the exceptions may be more flexibly applied or may not be the only means of establishing tribal authority that is "necessary to protect tribal self-government or control internal relations."

These recent updates to the legal framework have allowed for significant advancements in the tribal health care system, and provide a roadmap for future improvement through increased support for tribal self-regulation.

A. *Regulatory and Preemption Issues: Licensing, Regulatory, and Enforcement Authority*

As a matter of federal law under the IHCIA, licensed health professionals employed by a tribal health program are exempt from the licensing requirements of the State in which the tribal health program is located, provided they are licensed in any other State.¹³⁹ When a tribe or tribal organization provides services pursuant to an ISDEAA contract or compact,¹⁴⁰ these federal licensing rules preempt state licensing requirements. Where a tribe operates a health care program or provides health care services outside of an ISDEAA contract, however, or where the tribe regulates but does not itself operate the program or service, the application of state licensure laws would be subject to the preemption/infringement analysis discussed in Section III.A above.

Where a tribe has adopted a comprehensive regulatory framework for licensure and regulation of health care professionals, there is a good argument against state interference under the preemption/infringement analysis. As in *New Mexico v. Mescalero Apache Tribe*, where the Supreme Court held that the state could not apply its hunting and fishing laws to non-Indians on the reservation because the Tribe had its own comprehensive program of fish and game management,¹⁴¹ application of state licensure requirements are likely to be inconsistent with tribal requirements and would interfere with tribal self-government in the field. Further, despite the fact that the federal government as a general matter does not regulate licensure of health care professionals or license health care facilities, but rather leaves such regulation to the states, federal interests nevertheless strongly support the development of robust tribal health programs according to tribal priorities and without state interference. This interest is clearly reflected in the ISDEAA and the IHCIA, special Medicare and Medicaid and other federal health care program provisions for American Indians and Alaska Natives, and regulations across the federal government—from the IHS to the Internal Revenue Service to the Centers for Medicare and Medicaid Services—implementing federal statutory law, the federal trust responsibility to improve the health status of Indian people, and tribal self-determination policy. In this sense, the argument for preemption of state licensing and regulation of health care professionals tracks the Supreme Court’s reasoning in *Cabazon* in holding that state gaming regulation was

¹³⁹ 25 U.S.C. § 1621t. This provision states: “Licensed health professionals employed by a tribal health program shall be exempt, if licensed in any State, from the licensing requirements of the State in which the tribal health program performs the services described in the contract or compact of the tribal health program under the Indian Self-Determination and Education Assistance Act[.]” In addition, for purposes of participation as a provider of health care services under a Federal health care program (such as Medicare, Medicaid, and CHIP), entities operated by the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization are deemed to have met state licensing requirements if they meet all the applicable standards for such licensure, regardless of whether they actually obtain the license. 25 U.S.C. § 1647a.

¹⁴⁰ Section 1621t applies to “tribal health programs,” defined under the IHCIA as “an Indian tribe or tribal organization that operates any health program, service, function, activity, or facility funded, in whole or in part, by the [Indian Health] Service through, or provided in, a contract or compact with the Service under the [ISDEAA].” 25 U.S.C. § 1603(25).

¹⁴¹ *New Mexico v. Mescalero Apache Tribe*, 462 U.S. 324, 338 (1983).

preempted on tribal lands: the “important federal interests” and express federal support for tribal health care programs; parallel federal and tribal interests; and the value generated by the development of tribal health programs all weigh in favor of tribal self-regulation.

In order to enforce its licensure and regulatory scheme against non-Indian practitioners, however, a tribe would have to establish jurisdiction over those individuals under the *Montana/Merrion/Hicks* line of cases, as discussed above. Due to the narrow way in which the Supreme Court has framed the *Montana* exceptions, and to the extent those exceptions apply with the same force on tribal lands, the courts may not be willing to apply the second “health or welfare of the Tribe” exception to establish tribal jurisdiction over non-Indians involved in health care on tribal lands, even though there is clearly a rational argument that the regulation of health care programs and services in fact goes to the very heart of the “health and welfare” of the tribe. Regardless, there are various ways that tribes may seek to affirm jurisdiction to license and regulate non-Indian health care professionals under the second “consensual relationship” exception, including through written acknowledgement of tribal jurisdiction as a prerequisite to employment in a tribal health program or entry onto tribal lands for purposes of providing health care services, or on the basis of the Tribe’s right to self-govern and exclude individuals from tribal lands under *Merrion*.¹⁴²

A similar analysis, for both preemption of state law and tribal regulatory jurisdiction, would apply to the regulation of health care facilities and practices (such as the use of traditional, alternative, or complimentary medicine), and to tribal court jurisdiction over medical torts such as malpractice claims arising on tribal lands. These questions involve not only health care practitioners, who may enter into specific employment, licensing, or other types of agreements with the tribe in order to provide health care services on tribal lands, but also patients (both Indian and non-Indian) and other individuals present on tribal lands coming into contact with health care providers and program administrators. With respect to the preemption/infringement analysis, the determination in each case is fact-specific and would depend to some extent on the type of tribal regulatory scheme at issue, specific federal laws and regulations that may be relevant, and the state interest at issue. The federal government’s trust responsibility to provide for Indian health care, its policy in support of tribal self-determination, and the comprehensive federal scheme reflected in the ISDEAA and the IHCIA, among other federal laws, should all play a role in this analysis. With respect to tribal jurisdiction, to the extent a tribe can secure specific agreement to tribal civil jurisdiction, such as through a land or building lease or patient consent forms, the jurisdictional analysis is simplified. In the absence of written agreement,

¹⁴² While the regulation of health care professionals by tribes in the manner contemplated here is relatively new, there are many parallels in tribal regulation of legal professionals practicing in tribal courts—something that is quite common. Many tribes require membership in a tribal court bar and may impose various requirements on admission, including in some cases separate bar exams. See, e.g., Arizona State University Sandra Day O’Connor School of Law, *Arizona Tribal Courts* (2011), <https://web.law.asu.edu/Portals/13/Files/RossBlakleyLawLibrary/>

2011%20Arizona%20Tribal%20Court%20List.pdf (listing admission requirements for tribal courts in Arizona); State Bar of Arizona Ethics Opinion 99-13 (1999), <http://www.azbar.org/Ethics/EthicsOpinions/>

ViewEthicsOpinion?id=507 (finding that attorney’s supervision of non-lawyer paralegal’s representation of clients in tribal court was not in violation of Arizona lawyer’s duty not to assist in the unauthorized practice of law, where paralegal was a licensed tribal court advocate, because tribal court’s rules governed the conduct and it was not “unauthorized” under those rules).

tribes should be able to advance the argument that their interests in self-government and territorial management under *Merrion*, or one of the *Montana* exceptions, justifies tribal jurisdiction over individuals entering onto tribal lands for purposes of providing or obtaining health care services, particularly on tribal trust (as opposed to fee) lands.

B. Federal Benefits and Protections for Tribal Health Programs

Apart from such jurisdictional questions, another important consideration for tribes is the extent to which they may self-regulate health care services and implement innovative new health care programs on tribal lands while still maintaining the many special federal benefits and protections available to tribes and tribal organizations implementing federal programs under the ISDEAA.¹⁴³ These benefits and protections serve to maintain the federal government's trust responsibility to provide for health care to Indian people even as tribes themselves exercise more control over the design and implementation of specific programs and services. They also serve to assist tribes in addressing the chronic resource shortage that still exists throughout Indian Country today as a direct result of historical federal policies dispossessing tribes of resources as well as control over those resources that remained in tribal possession.

One important benefit extended to tribal contractors under the ISDEAA is coverage under the Federal Tort Claims Act (FTCA).¹⁴⁴ In the FTCA, the United States waived its immunity and consented to be sued for money damages for injury or loss of property caused by the negligent or wrongful acts or omissions of federal employees acting within the scope of their employment.¹⁴⁵ So long as they are performing services under an ISDEAA contract or compact, the FTCA also covers a tribe's permanent or temporary employees, volunteers, and federal employees assigned to the contract to work for the tribe.¹⁴⁶ Coverage extends to individuals providing health services to the tribal contractor under personal services contracts in facilities operated under ISDEAA contracts or compacts,¹⁴⁷ and also to tribal employees paid from tribal funds other than those provided through the contract or compact, as long as the services or activities from which the claim arose were performed in carrying out the contract or compact.¹⁴⁸ For covered categories of claims, an FTCA claim against the United States is the exclusive remedy, meaning that any employee or personal services contractor for the tribe, acting within the scope of his or her employment in carrying out an ISDEAA contract, will be shielded from liability by the FTCA.¹⁴⁹ FTCA coverage was extended to tribes under the ISDEAA because

¹⁴³ See, e.g., Starla K. Roels & Liz Malerba, *New Opportunities for Innovative Healthcare Partnerships with Indian Tribes and Tribal Organizations*, ABA Health Lawyer V.28 No. 1 (Oct. 2015).

¹⁴⁴ 25 U.S.C. § 5321(d) (Title I); 25 U.S.C. § 5396(a) (Title V). See also 25 C.F.R. Part 900, Subpart M (Title I); 42 C.F.R. § 137.220 (Title V).

¹⁴⁵ 28 U.S.C. § 1346(b). Pursuant to the FTCA, as amended by the Federal Employees Liability Reform and Tort Compensation Act, an action against the United States is the exclusive judicial remedy for such claims. 28 U.S.C. § 2679(b)(1).

¹⁴⁶ 25 C.F.R. § 900.192; 25 C.F.R. § 900.206.

¹⁴⁷ 25 C.F.R. § 900.193.

¹⁴⁸ 25 C.F.R. § 900.197.

¹⁴⁹ 25 C.F.R. § 900.190; 25 C.F.R. § 900.204. FTCA coverage does not extend to: (1) claims against most subcontractors; (2) claims for injuries covered by workmen's compensation; (3) breach of contract (as opposed to

Congress recognized that the diversion of program funds to purchase liability insurance led to a decrease in funding for direct services, putting contracting tribes at a disadvantage and contravening the federal trust responsibility.¹⁵⁰

Other provisions applicable to tribal health care programs operated under the ISDEAA are specifically intended to supplement inadequate IHS funding by leveraging or providing access to other federal or private insurance funding. For example, tribal health programs operating under the ISDEAA are specifically authorized to seek reimbursements for services from Medicare, Medicaid, the Children's Health Insurance Program (CHIP), as well other third-party payors, such as private health insurance companies.¹⁵¹ Under the authority of the Public Health Service Act, the IHCIA and other federal law and policy, tribal health programs billing for Medicare and Medicaid may collect at what is known as the IHS "encounter rate" (also called the "OMB rate"), which the Department of Health and Human Services publishes in the Federal Register each year, for certain inpatient and outpatient medical services.¹⁵² Additionally, section 1905(b) of the Social Security Act provides that the Federal medical assistance percentage (in other words, the cost share paid by the federal government for Medicaid services) "shall be 100 per centum with respect to amounts expended as medical assistance for services which are received through an Indian Health Service facility whether operated by the Indian Health Service or by an Indian tribe or tribal organization[.]"¹⁵³ While not a direct benefit to tribal health providers per se, the federal government's promise to reimburse State Medicaid programs for 100% of services provided to IHS beneficiaries through the IHS or a tribal health facility

tort) claims; or (4) claims resulting from activities performed by an employee that are outside the scope of employment. 25 C.F.R. § 900.183.

¹⁵⁰ See, e.g., GAO/RCED-00-169, Federal Tort Claims Act: Issues Affecting Coverage for Tribal Self-Determination Contracts 6 (2000), <https://www.gao.gov/new.items/rc00169.pdf>.

¹⁵¹ Historically, the ability to collect Medicare and Medicaid depended in large part on provider type, facility type, and the program at issue, and before 1976, tribally operated health programs could not collect reimbursements from Medicare or Medicaid. After 1976, provisions under the Social Security Act and the IHCIA, as amended over several years, generally authorized certain "facilities of the IHS," whether operated by the IHS or by a tribe or tribal organization, to collect Medicare and Medicaid reimbursements. See, e.g., 42 U.S.C. §§ 1395qq, 1396j; 25 U.S.C. § 1642. See also "Memorandum of Agreement Between the Indian Health Service and the Health Care Financing Administration" (1996) (hereinafter "1996 MOA"). The Health Care Financing Administration is now called the "Centers for Medicare and Medicaid Services." When the IHCIA was reauthorized in 2010, the new Section 401 of the Act significantly revised the old language regarding authority to collect such payments: Section 401(d) authorizes tribal health programs to elect to "directly bill for, and receive payment for, health care items and services provided by such programs for which payment is made under [Medicare, Medicaid and CHIP] or from any other third party payer." 25 U.S.C. § 1641.

¹⁵² See, e.g., 82 Fed. Reg. 5585 (Jan. 18, 2017). Under Section 1905(1)(2)(B) of the Social Security Act, outpatient health programs or facilities operated by a Tribe or Tribal organization under the ISDEAA are by definition Federally Qualified Health Centers (FQHCs) and thus may instead elect to bill Medicaid as FQHCs if they prefer. 42 U.S.C. § 1396d(l)(2)(B). See also 1996 MOA (affirming that tribal facilities could choose to be designated as an IHS provider, allowing them to collect at the IHS encounter rate for payment of Medicaid services provided to eligible Indian beneficiaries on or after July 11, 1996).

¹⁵³ 42 U.S.C. § 1396d(b).

provides an important incentive for States to work with Tribes to maximize the availability of Medicaid services to IHS beneficiaries served by tribal health programs.¹⁵⁴

Another example is access to pharmaceuticals for eligible Indian beneficiaries at a discount from the Federal Supply Schedule (FSS). Section 105(k) of the ISDEAA authorizes Indian tribes and tribal organizations to utilize the FSS for purposes of carrying out ISDEAA contracts and compacts and deems the tribes and tribal organizations to be part of the IHS and their employees to be federal employees for this purpose.¹⁵⁵ Section 105(k) specifically includes acquisitions from prime vendors:

For purposes of carrying out such contract, grant or agreement [under the ISDEAA], the Secretary shall, at the request of an Indian tribe, enter into an agreement for the acquisition, on behalf of the Indian tribe, of any goods, services, or supplies available to the Secretary from the General Services Administration or other Federal agencies that are not directly available to the Indian tribe under this section or under any other Federal law, *including acquisitions from prime vendors*. All such acquisitions shall be undertaken through the most efficient and speedy means practicable, including electronic ordering arrangements.¹⁵⁶

This includes the VA prime vendor program, which makes certain listed federal agencies (including the IHS) eligible to purchase drugs from the FSS at discounts determined under agreements between the manufacturers and the Secretary of Veterans Affairs.¹⁵⁷

Questions over the scope of these provisions may arise when tribes choose to design and implement a tribal health care program outside the scope of an ISDEAA contract—perhaps in order to address a local health care need that is not adequately addressed by any existing federal program. In some cases, federal law has evolved to support tribal innovation by affording tribes greater flexibility than the IHS in the implementation of federal programs under the ISDEAA, at least to some degree—thereby avoiding those questions. This is the case, for example, with respect to who may be considered eligible for health care programs and services. The IHS’s federal regulations define who is eligible for health care services directly from the IHS and for

¹⁵⁴ A recent change to the Center for Medicare and Medicaid Service’s interpretation of section 1905(b) increases that incentive. Previously, CMS interpreted section 1905(b) to exclude services rendered by outside providers through the Purchased/Referred Care (PRC) program administered by the IHS and tribes. In a February 26, 2016 letter to State Health Officials, however, CMS announced that it would update its interpretation of section 1905(b) to extend 100% FMAP to services rendered by a non-IHS or non-tribal provider so long as that care is provided pursuant to a care coordination agreement meeting certain requirements. Letter from Department of Health and Human Services, Center for Medicare & Medicaid Services, to State Health Officials, SHO #16-002 (February 26, 2016), <https://www.medicaid.gov/federal-policy-guidance/downloads/sho022616.pdf>. It is up to the IHS or tribal health program to enter into these care coordination agreements, which render the State eligible for 100% FMAP for Medicaid services provided thereunder.

¹⁵⁵ 25 U.S.C. § 450j(k). Section 105(k) is specifically made applicable to Title V compacts and funding agreements by § 516(a) of Title V, 25 U.S.C. § 458aaa-15(a).

¹⁵⁶ 25 U.S.C. § 450j(k) (emphasis added).

¹⁵⁷ 38 U.S.C. § 8126.

services the IHS must purchase from non-IHS providers (called “Purchased/Referred Care” or “PRC,” and formerly known as “contract health services”).¹⁵⁸ The general rule is that the IHS will provide direct services at IHS facilities to “persons of Indian descent belonging to the Indian community served by the local facilities and program.”¹⁵⁹ In its direct-operated facilities, the IHS itself follows an “Open Door Policy” under which the facility will serve any eligible Indian beneficiary presenting for available services regardless of where that person resides. Eligibility for PRC from the IHS is directly tied to being eligible for direct care services under the IHS regulations, and also requires either (1) residence within the United States and on a reservation located in a defined health care delivery area; or (2) residence within the United States outside of the reservation but within a defined health care delivery area and either (a) membership in the tribe or tribes located on that reservation (or for which the reservation was established) or (b) maintenance of “close economic and social ties with that tribe or tribes.”¹⁶⁰

As a general rule, tribal health programs must also make eligibility determinations for direct care and PRC subject to the IHS’s eligibility regulations.¹⁶¹ For direct care services, a tribal ISDEAA contractor would thus provide direct care to “persons of Indian descent belonging to the Indian community served” by that tribal program’s facilities.¹⁶² However, tribes operating their own health care programs under an ISDEAA contract or compact are not required to follow the IHS’s Open Door policy unless they specifically agree to do so.¹⁶³

Further, under section 813 of the IHCA, as revised under the 2010 permanent reauthorization, tribes and tribal organizations operating under an ISDEAA contract or compact can elect to serve non-beneficiaries (i.e., individuals who would not otherwise be eligible for IHS services) based on a determination that the provision of those services will not result in a denial or diminution of services to eligible Indian beneficiaries.¹⁶⁴ In making that determination, tribes and tribal organizations can consider that payment could be required from such individuals for services received. Indeed, it may make good business sense – as well as fill a community need – for tribal health programs to serve non-beneficiaries as well as tribal members and other IHS beneficiaries within their geographic area. Importantly, where a tribe decides to serve non-beneficiaries under a section 813 resolution, the statute specifically provides that “Any services

¹⁵⁸ 42 C.F.R. Part 136, Subparts B and C.

¹⁵⁹ 42 C.F.R. § 136.12(a). Services may also be provided to a non-Indian woman pregnant with an eligible Indian’s child for a certain time period, and to non-Indian members of an eligible Indian’s household if the IHS determines that such care is necessary to control a public health hazard or an acute infectious disease. *Id.* Other non-Indians may be provided direct care services by the IHS in certain limited circumstances. *See* 25 U.S.C. § 1680c(a), (b), (d); 42 C.F.R. § 136.14(a).

¹⁶⁰ 42 C.F.R. § 136.23(a). Other groups also have limited PRC eligibility, such as students and transients, foster children and persons who leave their PRC health service delivery area. *Id.* § 136.23(b)-(d).

¹⁶¹ Sections 105(g) and 517(e) of the ISDEAA, 25 U.S.C. §§ 5324(g), 5397(e).

¹⁶² 42 C.F.R. § 136.12(a). In situations of doubt as to whether a person is eligible for care, the regulations allow for input from the Bureau of Indian Affairs about each individual’s “continuing relationship to the Indian population served by the local program.” 42 C.F.R. § 136.12(b).

¹⁶³ Under the ISDEAA, tribal contractors are not bound by IHS policies or guidance unless they specifically agree. 25 U.S.C. § 5329(c) (Title I model agreement, at Sec. 1(b)(11)); 25 U.S.C. § 458aaa-16(e) (Title V).

¹⁶⁴ 25 U.S.C. § 1680c.

provided by the Indian tribe or tribal organization pursuant to a determination made under this subparagraph shall be deemed to be provided under the agreement entered into by the Indian tribe or tribal organization under the Indian Self-Determination and Education Assistance Act.”¹⁶⁵ This provision ensures that, so long as services to non-beneficiaries are included in the tribe’s scope of work for its ISDEAA agreements, the tribe will not lose the benefits and protections otherwise available to it under those agreements as a result of its sovereign decision to extend services to non-Indians.

This authority for tribes to determine whether to serve non-beneficiaries in the operation of tribal health programs without losing the benefits and protections available under their ISDEAA contract is thus an existing example of how federal laws can support tribal health programs even when they extend beyond mere implementation of a parallel federal program. The model—i.e., deeming those services to be performed under an ISDEAA contract—is relatively straightforward under the existing legal framework, and could be applied elsewhere with relatively minor adjustments to existing federal laws. The issue becomes more complicated, however, where the tribe regulates but does not itself operate a health care program or facility. As one example, Medicare and Medicaid laws and regulations require that health care providers and facilities be state licensed as a condition of reimbursement.¹⁶⁶ Under the IHClA, tribal health programs are deemed to have met state licensing requirements for such purposes if they meet all the applicable standards for licensure, regardless of whether they actually obtain the license.¹⁶⁷ However, if a tribe licenses a non-tribal provider on tribal lands and does not require parallel state licensing, Medicare and Medicaid reimbursements to that facility could be jeopardized. In some ways, then, existing federal laws lag behind tribal innovation in the provision of health care to tribal communities.

V. Case Study: The Swinomish Tribe’s Dental Therapist Program

While there are certainly ways to further strengthen the legal framework, then, there is a strong basis for tribal self-regulation of health care in existing federal law—and good reasons for tribes to take advantage. Indeed, Indian tribes are beginning to implement self-regulation of health care services, through the exercise of inherent tribal sovereignty, in new and innovative ways in order to address pressing health concerns that are not adequately addressed through existing federal programs or that can be better implemented through tribal authority. In 2016, in a powerful example of how tribal self-regulation can be used to address local community needs while at the same time driving the evolution of state and federal law, the Swinomish Indian Tribal Community became the first tribal community outside of Alaska to employ a dental therapist to provide basic oral health services to community members under a tribal licensing and regulatory scheme.

¹⁶⁵ 25 U.S.C. § 1680c(c)(2).

¹⁶⁶ 42 U.S.C. § 1395x(e)(7), (r), (aa)(2)(B) (requiring that hospital providers and other providers such as physicians and rural health clinics be state licensed for purposes of Medicare reimbursement); 42 C.F.R. § 440.10(a)(3)(ii), (iii) (federal Medicaid regulations requiring that hospitals providing inpatient services be state licensed); 42 C.F.R. § 440.20(a)(3)(i), (ii) (federal Medicaid regulations requiring that hospitals providing outpatient services be state licensed).

¹⁶⁷ 25 U.S.C. § 1647a.

Dental therapists are primary oral health care professionals who work under the general supervision of a licensed dentist to provide basic clinical dental treatment and preventive services. Dental therapists have been providing such services within the Indian health care system in Alaska for many years—the Alaska dental therapy program is part of the federally-authorized Community Health Aide Program, which was initially created in Alaska over 50 years ago to respond to poor health status in isolated, rural communities that lacked basic and preventive care,¹⁶⁸ and is now operated under specific authority in the IHCIA.¹⁶⁹ The Alaska Community Health Aide Program includes dental health aide/therapists as well as community health aide/practitioners and behavioral health aide/practitioners—all three classes of which are certified by the Alaska Community Health Aide Program Certification Board (CHAPCB), a federally authorized and created entity charged with maintaining training and practice standards and policies, as well as certification of training centers and individual health aides, for the community health aide program in Alaska.¹⁷⁰ In Alaska, there are five levels of dental health aides: Primary Dental Health Aide levels 1 and 2, Expanded Function Dental Health Aide levels 1 and 2, and dental health aide therapists (DHATs). The training curriculum for DHATs includes education and practical experience components and takes three academic years completed over two calendar years.¹⁷¹ The scope of practice for each type of dental health aide provider is different, but depending on their level of certification, dental health aides can provide an array of services including diagnosis and treatment; basic hygiene; infection control; pediatric services; uncomplicated extractions; planning and prevention; radiographs; restorative services; and urgent care, as well as clinic management and equipment repair and maintenance. The certification program operated by the Alaska CHAPCB under the federal community health aide program has been held to preempt Alaska state licensure requirements.¹⁷²

When the Swinomish Tribe launched its dental therapist program, the State of Washington did not allow for dental therapist or midlevel dental health services to be provided within the state.¹⁷³ While federal law, as part of the 2010 amendment and reauthorization of the IHCIA, authorizes the expansion of the Alaska Community Health Aide Program nation-wide, the IHCIA specifically excludes DHAT services from such tribal programs unless the tribe or tribal organization is located in a state (other than Alaska) where DHAT services or midlevel

¹⁶⁸ Sarah Shoffstall-Cone and Mary Williard, “*Alaska Dental Health Aide Program*,” *International Journal of Circumpolar Health* (Aug. 5, 2013), available at www.tandfonline.com/doi/full/10.3402/ijch.v72i0.21198 (last visited on Nov. 3, 2017).

¹⁶⁹ 25 U.S.C. § 1616l.

¹⁷⁰ See Alaska Community Health Aide Program, <http://www.akchap.org/html/chapcb.html>.

¹⁷¹ See Community Health Aide Program Certification Board Standards and Procedures, § 2.30.610 (Dental Health Aide Therapist Training and Education Requirements) (Jan. 26, 2017), http://www.akchap.org/resources/chap_library/CHAPCB_Documents/CHAPCB_Standards_Procedures_Amended_2017-01-26.pdf.

¹⁷² *Alaska Dental Society v. State of Alaska*, 3 AN-06-4797CI (June 27, 2006).

¹⁷³ See Julie Ralston Aoki, Christina Peters, Laura Platero, & Carter Headrick, *Maximizing Community Voices to Address Health Inequities: How the Law Hinders and Helps*, 45 *J. of Law, Medicine & Ethics* 11, 12 (2017) (discussing the decision by the Swinomish Tribe to act in the absence of Washington law authorizing DHATs).

dental health provider services are authorized under state law.¹⁷⁴ The only option for the Swinomish Tribe, at that time then, was to implement a dental therapist program under its own sovereign authority.

The Swinomish Tribe saw a clear need for such a program. In announcing the employment of the first dental therapist on the Swinomish Reservation, a press release from the Tribe stated that “too many Swinomish Tribal members – particularly children – [suffer] unnecessarily and potentially [face] life-threatening conditions because they lack access to dental care[.]”¹⁷⁵ The press release cited disturbing statistics on oral health in Indian Country:

Oral health research shows that historical traumas have caused Indians to lead the nation in oral disease rates. By age five, 75 percent of American Indians and Alaska Natives experience tooth decay. Recent Federal statistics for Washington, Oregon and Idaho show that Indian children suffer tooth decay at three times the national average. Low-dentist-to-patient ratios in Indian Country mean that many Indians lack access to regular dental treatment and prevention services. Turnover among providers in Indian Country interrupts continuity of care and inhibits the delivery of culturally competent services.¹⁷⁶

The Tribe’s Chairman said of the dental therapist program, “We have developed a tribal approach to solve a tribal issue. This solution will help our people immediately address their oral health needs in ways that have not been possible until today.”¹⁷⁷

The Swinomish Tribe’s dental therapist program was patterned after the Alaska Area DHAT program and designed specifically to improve access to quality dental health services within the Tribe’s community. The Tribe enacted its own dental provider licensure code that establishes a Dental Health Provider Licensing Board and sets the Tribe’s own dental health provider licensing qualifications and standards that must be met in order to obtain and maintain a tribal license, not only for tribally-hired DHATs, but other of the Tribe’s dental providers as well, such as its dentists and dental hygienists.¹⁷⁸ The Swinomish Dental Health Provider Licensing Code not only covers qualifications and standards for licensure, but also addresses continuing education requirements; discipline, suspension and revocation of the licenses;

¹⁷⁴ 25 U.S.C. § 1616(d).

¹⁷⁵ Press Release: Swinomish become first tribe in the Lower 48 to use dental therapists to address oral health crisis in Indian Country (Jan. 4, 2016), <http://www.swinomish-nsn.gov/media/49613/20160104-pressrelease-swinomishhirefirstdentalhealthaidetherapist.pdf>.

¹⁷⁶ *Id.* (citing Phipps KR, Ricks, TL. The oral health of American Indian and Alaska Native Children Aged 1-5 Years: Results of the 2014 IHS Oral Health Survey. Indian Health Service data brief. Rockville, MD: Indian Health Service (2015)).

¹⁷⁷ *Id.* See also, Aoki et al., *supra* note 173, at 13 (describing benefits realized since implementation of the Swinomish DHAT program, including decreased patient wait times and the ability of all levels of dental providers within the Tribe’s program “to focus their skills and expertise more efficiently – to work at the top of their licenses.”)

¹⁷⁸ Swinomish Indian Tribal Community Dental Health Provider Licensing and Standards Code, Title 15, Chapter 11 (Oct. 2017).

enforcement of the Licensing Board’s decisions; and the right of licensees to appeal the denial of a license application or disciplinary action to the Swinomish Tribal Court and Swinomish Tribal Court of Appeals.¹⁷⁹

The Tribe created the Swinomish Dental Health Provider Licensing Code under the authority of the Tribe’s constitution and bylaws, its inherent tribal sovereign authority as a federally-recognized Indian tribe, and the rights reserved to the Tribe in the “Treaty of Point Elliott.”¹⁸⁰ In adopting the code, the Tribe made several findings, not only about the Tribe’s sovereign “right and responsibility to promote, protect and improve the health and welfare of its members, and to enhance the quality of the lives of all of its members by providing a combination of economic opportunities and a safety net of social services,”¹⁸¹ but also based on documentary evidence of the poor quality of dental health among native children and adults and the significant dental health improvements made in Alaska under the Alaska DHAT program.¹⁸² Moreover, it was important to the Tribe that the Tribe’s own dental clinic “provide the highest quality dental services in the most culturally competent manner.”¹⁸³ To that end, all dental health aides, dentists, dental hygienists, and dental therapists licensed by the Tribe must demonstrate that they possess “formal education, training, and/or personal or professional experience that would be reasonably expected to result in cultural competency.”¹⁸⁴ This provision, which reflects uniquely tribal priorities and has no parallel in state licensing requirements, serves to ensure that providers practicing in the tribal community are meeting tribal needs. Since 2015, the Swinomish Division of Licensing has licensed dental health providers practicing at the Swinomish Dental Clinic, and in 2016, the Division licensed its first certified DHAT who is now providing services at the Tribe’s clinic and within its community.¹⁸⁵

The Tribe also adopted a tribal tort claims code to govern procedures for individuals who may be injured by tortious acts or omissions of the Tribe, its officers or employees in carrying out the scope of their duties or employment, and to seek compensation for the injury.¹⁸⁶ The Tribe’s Tort Claims Code provides for a limited waiver of tribal sovereign immunity for anyone who believes they are injured by the Tribe’s licensed dental providers (or otherwise by tribal officers, employees or agents, including tribal police officers) to file a claim for monetary damages in tribal court.¹⁸⁷ The Tort Claims Code limits monetary damages to the amount of funds available through the Tribe’s insurance coverage.¹⁸⁸

¹⁷⁹ *Id.*

¹⁸⁰ *Id.* Section 15-11.030.

¹⁸¹ *Id.* Section 15-11.040(A).

¹⁸² *Id.* Sections 15-11.040(C)-(F), (H)-(I).

¹⁸³ *Id.* Section 15-11.040(N).

¹⁸⁴ *Id.* Sections 15-11.150(G); 15-11.160(C); 15-170(C); 15-11.171(B).

¹⁸⁵ *Id.* Sections 15-11.040(O), (P).

¹⁸⁶ Swinomish Indian Tribal Community Tort Claims Code, Title 03, Chapter 08 (2015).

¹⁸⁷ *Id.* Section 3-08.060.

¹⁸⁸ *Id.* Section 3-08.060(E).

The broad scope of the Tribe’s Dental Health Provider Licensing Code and its Tort Claims Code was driven in part by the need to substitute for non-existent state law, to help head-off and minimize potential risk that the Tribe’s State-licensed dentists would be accused of conducting the unlawful practice of dentistry and violating their dental licenses by supervising otherwise un-licensed DHATs. As it turned out, the Swinomish Tribe was simply ahead of the curve with respect to the development of state law: as of July 23, 2017, Washington Substitute Senate Bill 5079 authorizes DHAT services as part of on-reservation tribal health programs within Washington State. Under this Washington law, DHAT services must be provided by a person who is “certified” as a DHAT by a federal community health aide certification board (*i.e.*, the CHAPCB) or by “[a] federally recognized Indian tribe that has adopted certification standards that meet or exceed the requirements of a federal community health aide program certification board.”¹⁸⁹ The Swinomish Tribe’s dental licensure program, which was already tribally designed to “meet or exceed” the CHAPCB certification requirements, is thus now also expressly consistent with the authorized certification of DHATs under Washington State law.

As a result of the success of Swinomish’s new DHAT program and the authorization of DHAT services in Washington and other states,¹⁹⁰ other tribal health programs have expressed a desire to hire, train and certify DHATs to work for their own tribal health programs—many such individuals have been hired and are currently undergoing the two-year DHAT training program in Alaska.¹⁹¹ However, not all of these tribes have been interested in developing and replicating the same comprehensive certification scheme put into place by Swinomish, as that could be resource intensive and cost prohibitive, create delays in being able to hire DHATs to begin providing services as quickly as possible, and create an environment for overlapping infrastructure and inconsistent regional implementation. Instead, some of these tribes are considering a different way of exercising their sovereign authority to self-regulate, by entering into intergovernmental agreements with the Swinomish Tribe pursuant to which the Swinomish Tribe’s certification program will serve as a region-wide certifying entity for all tribal DHATs within Indian country in the States of Oregon and Washington, for any such tribes who choose to have their DHATs licensed by Swinomish. Licensed DHATs may then carry out DHAT services within the tribal dental program that employs them, consistent with the Swinomish licenses.¹⁹²

¹⁸⁹ Washington Substitute Senate Bill 5079, §§ 2(1)(a)(i), (ii) (July 23, 2017). The law also requires that all of the DHAT services be performed as part of an Indian health program within the boundaries of an Indian reservation, and be provided in accordance with the certification standards and pursuant to any applicable written standing orders by a supervising dentist. *Id.* § 2(1)(b). Under the Washington law, the DHAT services may be provided only to members of federally recognized tribes or anyone else who is “eligible for services under Indian health service criteria” pursuant to the IHCA. *Id.*

¹⁹⁰ The State of Oregon has also approved an “Oregon Tribes Dental Health Aide Therapist Pilot Project,” which is authorized through 2021. Oregon Health Authority Dental Pilot Project Program, Dental Pilot Project # 100, “Oregon Tribes Dental Health Aide Therapist Pilot Project (Feb. 2017), *available at* <http://www.oregon.gov/oha/ph/PreventionWellness/oralhealth/DentalPilotProjects/Documents/100-abstract.pdf> (last visited Nov. 7, 2017).

¹⁹¹ *Id.* at 4. *See also* www.rasmuson.org/news/dhat-attracts-lower-48-trainees/ (last visited Nov. 7, 2017). For more information about the students from Oregon, Washington and Idaho tribes who are currently training to become DHATs, see the Northwest Portland Area Indian Health Board’s website covering its Native Dental Therapy Initiative at www.npaihb.org/ndti/ (last visited Nov. 7, 2017).

¹⁹² This approach is comparable in many ways to efforts by States to streamline multi-state licensure for medical professionals through interstate compacts adopted and implemented through state legislation. *See, e.g.*, American

To implement this arrangement, the Swinomish Dental Health Provider Licensing Code now authorizes the Tribe’s Division of Licensing and Dental Health Provider Licensing Board to license, oversee and discipline DHATs and other dental providers who are licensed by the Tribe but employed by other dental health programs of federally recognized tribes in Washington and Oregon State.¹⁹³ Under the Code, the dental provider must be an employee of a comprehensive tribal dental health program, and the tribe in question must enter into a Memorandum of Agreement with the Swinomish Tribe agreeing to the Swinomish Tribe’s oversight and disciplinary authority over the providers it licenses.¹⁹⁴ Licensees and their tribal employers must submit to the Swinomish Tribe’s licensing-related authorities, including agreeing to comply with the Swinomish Dental Health Provider Licensing Code and, specifically, with the authority of the Swinomish Tribal Court and the Swinomish Tribal Court of Appeals.¹⁹⁵ Tribes who wish to have their dental providers licensed by Swinomish must have their own tribal law in place prohibiting anyone from providing services as a DHAT without a valid license, and requiring licenses to be maintained in good standing.¹⁹⁶ DHATs licensed by Swinomish and employed by other tribal programs must “provide only certain dental services in accordance with his or her Swinomish license and applicable State law, and will be supervised by a licensed dentist who will provide the other, higher levels of dental care to the tribe’s patients.”¹⁹⁷

This exercise of inherent tribal sovereign authority among tribal governments has a strong potential for creating greater efficiency through consolidation of resources and expertise available to all tribes; consistency in implementation of DHAT programs throughout the region leading to better cooperation, identification and implementation of best practices; and reciprocity among different tribal programs. And now, this approach—shaped by tribes seeking to use their sovereign authority in a creative manner to effectively and efficiently address tribal needs—is supported by Washington state law, which recognizes that certification of DHATs for practice at tribal health programs can be carried out by a federally recognized Indian tribe that has adopted the appropriate certification standards. In this way, the exercise of tribal self-regulation in this instance has served not only to increase and improve services for tribal people throughout the region, but to drive advancements in state law as well.

VI. Conclusion

Existing federal programs and state laws regulating the health care field do not always meet local tribal needs. Where possible under the existing legal framework, tribal self-regulation of health care programs and services on tribal lands can offer solutions to fill the gaps, resulting

Dental Education Association, *ADEA State Update: States Enact Interstate Medical Licensure Compact and Trigger Commission*, <http://www.adea.org/Blog.aspx?id=27399&blogid=20132> (last visited January 17, 2018).

¹⁹³ Swinomish Indian Tribal Community Dental Health Provider Licensing and Standards Code, Title 15, Chapter 11, Section 15-11.370 (Oct. 2017).

¹⁹⁴ *Id.* Sections 15-11.370-15-11.410.

¹⁹⁵ *Id.* Section 15-11.370(A), (B).

¹⁹⁶ *Id.* Section 15-11.370(B)(4).

¹⁹⁷ *Id.* Section 15-11.370(B)(7).

in better health outcomes in local tribal communities while also developing and exercising tribal governing capacity. At the same time, tribal self-regulation can benefit non-Indian communities by driving innovation in health care policy at the state and federal level and, in some cases, increasing the availability of services even to non-Indians at the local level.

This process is already underway in some tribal communities, like Swinomish and other tribes in the Northwest implementing DHAT programs and services to address their dental health needs. Undoubtedly, more and more tribes will opt to follow this path as they outgrow the existing self-determination model of tribal implementation of federal health care programs and services, relying to an even greater degree on inherent tribal authority as well as tribal expertise and creative problem-solving abilities to improve access to quality health care for Indian people. Support for these tribally-driven efforts is consistent with the federal trust responsibility and government-to-government relationship underlying modern federal Indian law, and—most importantly—shows great promise for improving the health and wellbeing of tribal communities.