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No. 05-16386

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM, et al.,

Plaintiffs-Appellees,

v.

MARK B. MCCLELLAN, in his official capacity as the Administrator of the Centers for Medicare and Medicaid Services, et al.,

Defendants-Appellants.

ON APPEAL FROM THE UNITED STATES
DISTRICT COURT FOR THE DISTRICT OF ARIZONA

BRIEF OF FEDERAL APPELLANTS

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

STATUTES and REGULATIONS

MISCELLANEOUS

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STATEMENT OF JURISDICTION

The district court's final judgment was entered on May 18, 2005. The federal defendants filed a timely notice of appeal on July 13, 2005. The district court had jurisdiction as described in Bowen v. Massachusetts, 487 U.S. 879, 885 (1988). This Court has jurisdiction under 28 U.S.C. § 1291.

STATEMENT OF THE ISSUE ON APPEAL

A special federal reimbursement rate applies to State Medicaid payments for "services which are received through an Indian Health Service facility." 42 U.S.C. § 1396d(b). Does this special rate apply to services that were not provided or billed by an Indian

Health Service (IHS) facility but were provided by a non-IHS entity to whom the patient was referred by the IHS?

STATEMENT OF THE CASE

A. Nature of the Case, Course of Proceedings, and Disposition in the Court Below

This case involves Arizona's claims for federal Medicaid payments. Under the federal Medicaid program the federal government reimburses certain state expenditures on medical services for the needy. The federal reimbursement rates for eligible expenses under that program differ from State to State but are generally in the range of 50% to 80%. A special statutory provision, however, provides for 100% federal reimbursement for "medical assistance for services which are received through an Indian Health Service facility."

The services at issue here are not provided in or by an IHS facility. Instead, they "are provided as a result of a referral from an IHS facility by private health care providers who bill the state Medicaid program for those services." District Court Opinion of March 24, 2005 (Docket Entry 32) at 7 (Excerpts of Record 63). For over fifteen years, Arizona (like every other State containing an IHS facility) sought and received reimbursement for its payments for such services at the standard Medicaid rate. See Departmental Appeals Board (DAB) Decision of Aug. 7, 2001 ("DAB Decision") at 16 (ER 39) (noting that "Arizona did not identify a single instance - over 20 years, between 1976 and 1997 - where Arizona or any other

state sought the 100% FMAP rate for a claim of the kind it now puts forward."). But in 1999, for the first time, Arizona sought reimbursement for these payments at the special 100% rate. These claims were disallowed by CMS, see DAB Decision 1-2 (ER 24-25), and Arizona sought administrative review of that decision before the Department of Health and Human Service's (HHS) Departmental Appeals Board (DAB). The DAB (on behalf of the Secretary) issued a lengthy decision, ER 24-50, holding that the special 100% reimbursement rate does not apply to this situation.

The DAB first noted that the statutory phrase "received through an Indian Health Service facility" was ambiguous based on definitions of "through" that included "in" and "within". It accordingly held that, "[t]he phrase 'received through' an IHS facility is thus susceptible to either the reading that the services be obtained by the agency of an IHS facility or that they be obtained in an IHS facility." DAB Decision 8 (ER 32). The DAB noted that there was no evidence of any State ever claiming 100% reimbursement under the circumstances that Arizona did in this case for the first twenty years the statute was in effect and concluded that the agency's longstanding interpretation of the statute (as applicable solely to State Medicaid payments to IHS facilities) was fully consistent with the legislative history and most compatible with IHS's contract care program. Accordingly, it held that the 100% reimbursement rate was limited to services "'received through'

an IHS facility which offers, is responsible for and bills Medicaid for the services provided." Id. at 26 (ER 49). As a result of this ruling, the federal government reimbursed Arizona for these services at its generally applicable Medicaid reimbursement rate, which was 62.5% in 1999 and 65.92% in 2000. See Id. at 3 n.2 (ER 26). The difference between the amount sought by Arizona in this case and the amount paid by the federal government totals approximately $36.6 million. District Court Op. 2 (ER 26).[1]

Arizona then brought this lawsuit to challenge the DAB's decision. Ruling on the basis of cross-motions for summary judgment, the district court applied the analysis of Chevron U.S.A., Inc. v. Natural Res. Def. Council, Inc., 467 U.S. 837 (1984). At step one of the Chevron analysis, the district court held that the statute is "clear and unambiguous and that the phrase 'received through' is properly interpreted as pertaining [to] services that are provided as a result of a referral from an IHS facility by private health care providers who bill the state Medicaid program for those services." District Court Op. 11-12 (ER 67-68). Although the district court never articulated a specific definition of "received through," it concluded that Arizona's expansive interpretation of the statute was "more persuasive,"

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[1] That amount includes approximately $2.5 million from a subsequent claim by Arizona covering the first quarter of 2001. The DAB rejected this claim for the reasons set forth in its opinion covering the same issue for 1999 and 2000. See DAB Decision of Oct. 25, 2001 (ER 51-52).

primarily because "received through" had to mean something different than "provided by" or "provided in," since those different phrases were used elsewhere in the Medicaid statute. Id. 9-12 (ER 65-68) In reaching this conclusion, the district court relied heavily upon, quoted from, and expressly concurred with, two district court decisions from outside this Circuit, both of which were subsequently reversed. See Id. 11-12 & n.4 (ER 67-68) (citing North Dakota ex rel. Olson v. CMS, 286 F. Supp. 2d 1080 (D.N.D. 2003), rev'd, 403 F.3d 537 (8th Cir. 2005), and Ellenbecker v. CMS, 335 F. Supp. 2d 999 (D.S.D. 2003), rev'd, 403 F.3d 537 (8th Cir. 2005)).[2]

Although the court below concluded that the statutory language was dispositive, it went on to assert, in dictum, that the legislative history supported Arizona's interpretation of the statute. It rejected the legislative history that "repeatedly refers to services covered by the 100% [special reimbursement] rate as services provided 'in IHS facilities'" on the basis that this language differed from the language enacted in the statute. District Court Op. 16-17 (ER 72-73). Instead, again quoting extensively from the subsequently-reversed opinion of the district court in North Dakota, the court below concluded that "'responsibility for referred health care services is one

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[2] The district court below cited an unpublished version of the South Dakota district court opinion.

traditionally borne by the federal government which Congress sought to keep a federal responsibility'" through the special 100% reimbursement rate. Id. at 16 (ER 72) (quoting North Dakota, 286 F. Supp. 2d at 1086).

In further dictum, the district court analyzed the reasonableness of the Secretary's interpretation of the statute under step two of Chevron. It concluded that although the DAB decision was the type of formal adjudication entitled to Chevron deference, the statutory interpretation adopted by the DAB was unreasonable because (1) it does not account for the use of the phrases "provided in" and "provided by" elsewhere in the Medicaid statute, (2) it failed to distinguish between Native Americans living on or near reservations and urban Native Americans, (3) it yielded arbitrary results depending on the ability of an IHS facility to provide a service directly, and "it is contrary to the intent shown by the legislative history in that it would shift a financial burden previously borne by the federal government to the states." District Court Op. 18 (ER 74). Yet again, the court below quoted from the reversed decision of the district court in North Dakota to support its conclusion. Id. at 19 (ER 75) (quoting North Dakota, 286 F. Supp. 2d at 1085). This appeal followed.

B. Statutory Background

The Medicaid program, established by Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 et seq., is a cooperative effort by

the federal government and the States to provide medical care to individuals "whose income and resources are insufficient to meet the costs of necessary medical services." 42 U.S.C. § 1396. To participate in the Medicaid program, a state develops a plan that specifies the categories of individuals who will receive medical assistance under the plan and the specific kinds of medical care and services that will be covered. See 42 U.S.C. § 1396a. Once the Secretary has approved a State's plan, the State may seek federal reimbursement for a specified percentage (usually between fifty and eighty percent) of the amounts "expended . . . as medical assistance under the State plan." Id. § 1396b(a)(1); see id. § 1396d(b).

Native Americans are eligible to receive Medicaid benefits on the same basis as others. Native Americans are also eligible to receive treatment from Indian Health Service (IHS) facilities. Those facilities are often the only available means for Native Americans to receive healthcare. See H.R. Rep. No. 94-1026 ("IHCIA House Report"), pt. I, at 107 (1976), reprinted in 1976 U.S.C.C.A.N. 2652, 2745. Before 1976, however, IHS facilities, like all federal providers, were not eligible for Medicaid payments and therefore, as a practical matter, many Native Americans could not receive all of the benefits of the Medicaid program. Id.

The IHS uses contract health services to help ensure that Native Americans have access to medical services not provided by

IHS facilities. See 42 C.F.R. pt. 136, subpt. C (2003) (formerly codified at 42 C.F.R. pt. 36, subpt. C). Under the program, IHS acts as a residual payor (also called the payor of last resort) for services provided to Native Americans by non-IHS facilities. See 42 C.F.R. § 136.61. This means that under appropriate circumstances, IHS pays for a non-IHS facility to provide a Native American with medical services. However, the program is not an entitlement, and, importantly, IHS will only pay if (1) there is no other source of payment, including the Medicaid program, and (2) contract health services funds are available. Id.; id. § 136.23(e); see also IHS Contract Health Services, 55 Fed. Reg. 4,606 (Feb. 9, 1990) (explanation and justification). As this Court put it, "Congress . . . contemplated that the IHS would aid Indians in taking advantage of state and local programs, with the federal government meeting health care needs not met under these programs." McNabb v. Bowen, 829 F.2d 787, 794-95 (9th Cir. 1987).

As part of its program, IHS contracts with non-IHS providers to accept referrals from IHS facilities and to provide services at reduced rates. See Reimbursement Rates for Health Care Services Authorized Under the IHS Contract Health Service Regulations, 51 Fed. Reg. 23,540 (June 30, 1986). IHS is not responsible for the

conduct of providers who participate in the contract health services program.[3]

Thus, before 1976, IHS facilities themselves provided limited services and were not eligible for Medicaid payments. Under the referral program, the IHS could refer a Native American to a non-IHS provider for services. That provider agreed to limits on its fees, and the IHS agreed to serve as a payor of last resort for those fees under specified circumstances. However, by definition, as payor of last resort under the contract health service program, the IHS was not responsible for payment for Medicaid-covered services; the non-IHS providers of those services would bill Medicaid in the usual way and would receive payment from the State Medicaid program, which would, in turn, receive the usual federal reimbursement of approximately 50% to 80%.

In 1976, Congress enacted the Indian Health Care Improvement Act (IHCIA), Pub. L. No. 94-437, 90 Stat. 1400 (1976). The stated

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[3] As a technical matter, the regulations use the phrase "contract health services" to refer only to those services for which the IHS actually pays. See 42 C.F.R. § 136.21(e) ("Contract health services means health services provided at the expense of the Indian Health Service from public or private medical or hospital facilities other than those of the Service."). In other words, under the nomenclature used by the regulations, the referred services at issue in this case are not "contract health services" because Medicaid funds were available to pay for them, and therefore the IHS, as payor of last resort, was not financially responsible. We will call such services "referred services." We use the phrase "referral program" to mean the process by which IHS refers patients to non-IHS providers who have promised the IHS to charge limited rates for those services.

primary purpose of Title IV of the IHCIA was "to remove a current prohibition against [Medicaid] reimbursement for services performed in IHS facilities." IHCIA House Report (pt. I) at 107, reprinted in 1976 U.S.C.C.A.N. at 2665. The statutory language accomplishes this goal, making a "facility of the Indian Health Service" eligible to receive Medicaid payments (so long as it meets the general conditions for receiving such payments). IHCIA § 402(a) (codified at 42 U.S.C. § 1396j(a)). In connection with this new eligibility, Congress also provided for a special 100% reimbursement rate:

> the Federal medical assistance percentage 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 . . . .

§ 402(e) (codified at 42 U.S.C. § 1396d(b)). Congress also mandated that Medicaid payments to IHS facilities be placed in a special fund and used exclusively to improve IHS facilities in order to bring them into compliance with general Medicaid requirements. IHCIA § 402(c) (codified at 25 U.S.C. § 1642(a)).[4]

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[4] The other provisions of this same section (1) authorized the Secretary to enter into agreements allowing the receipt of Medicaid payments by IHS facilities; (2) gave IHS facilities that did not meet general Medicaid conditions up to 18 months to come into compliance, during which time they would remain eligible for Medicaid payments; and (3) decreed that the Medicaid payments under this section will not be "considered in determining appropriations for the provision of health care and services to Indians." IHCIA § 402.

In enacting this section, Congress intended to improve the access of Native Americans to healthcare. It specifically intended that the Medicaid funding "be used to expand and improve current IHS health care services and not to substitute for present expenditures." IHCIA House Report (pt. I), 1976 U.S.C.C.A.N. at 2746. Congress explained the purpose of the special 100% reimbursement rate in this way:

> In adopting the 100% Medicaid reimbursement formula, the Committee took the view that it would be unfair and inequitable to burden a State Medicaid program with costs which normally would have been borne by the Indian Health Service. . . . "The Committee wishes to assure that a State's election to participate in the Medicaid program will not result in a lessening of Federal support of health care services for this population group, or that the effect of Medicaid coverage be to shift to the States a financial burden previously borne by the Federal Government."

Id. (quoting with approval report accompanying H.R. 3153, 93d Cong. (1993)).

This Court recently summarized the special 100% reimbursement rate as follows:

> Historically, Indian Health Service ("IHS") facilities were funded directly and entirely by the federal government and did not participate in Medicaid reimbursement. To improve services, Congress in 1976 amended the Medicaid Act to permit reimbursement of state expenditures on behalf of eligible Native Americans at IHS facilities. Pub.L. No. 94-437, 90 Stat. 1400 (1976). But, because services at these facilities previously were funded wholly by the federal government, this

> amendment provided for 100% FMAP so that no additional burden would fall on the states.

Alaska Dep't of Health & Soc. Servs. v. CMS, 424 F.3d 931, 935 n.1 (9th Cir. 2005).

C. Factual Background

Within months after the IHCIA was enacted, the federal agency responsible for implementation of the Medicaid program (now called the Centers for Medicare and Medicaid Services (CMS)) noted that the special 100% reimbursement rate for Medicaid "services which are received through an Indian Health Service facility," applied only to payments by a State Medicaid program to an IHS facility. See Department of Health, Education, and Welfare Memorandum dated November 26, 1976, at 1 (ER 53). In other words, CMS determined that Medicaid services "received through" the IHS facility are services for which that facility bills the State Medicaid program. During the administrative process, Arizona admitted that this was the federal government's contemporaneous interpretation See DAB Decision at 16-17 (ER 39-40). CMS reiterated this view when subsequently asked by Arizona to clarify rules for the special 100% reimbursement rate. See Jan. 28, 1993 letter from Medicaid Associate Regional Director for Region IX to Leonard J. Kirschner of the Arizona Health Care Cost Containment System 1 (ER 21) (specifically stating that to receive the special 100% reimbursement rate, "IHS must be in control of or responsible for the services, i.e., claim them as part of its facility services").

No State challenged this interpretation for over twenty years. CMS is aware of no instance during the two decades after the enactment of the IHCIA in which any State sought the 100% reimbursement rate for services for which the State Medicaid program paid an entity other than an IHS facility.

Nonetheless, starting in 1999 - over twenty years after enactment of the IHCIA - Arizona, for the first time, sought reimbursement from the federal government at the 100% rate for Medicaid payments to non-IHS providers. See District Court Op. 5 (ER 61) ("It is undisputed that prior to 1999, [Arizona] did not claim the 100% [special reimbursement] rate for Medicaid services provided to Native Americans through the contract care program.").[5]

As noted above, in formal administrative proceedings under 42 U.S.C. § 1316(d), 42 C.F.R. § 430.42, and 45 C.F.R. pt. 16, first the CMS Regional Administrator and then the Departmental Appeals Board (DAB) adhered to the Department's longstanding reading of the statute as providing a 100% reimbursement rate only for Medicaid payments made to IHS facilities. This legal challenge followed.

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[5] This is not the only attempt a State has made to improperly profit from the special 100% reimbursement rate applicable to services received through an IHS facility. For example, Alaska devised a scheme to dramatically increase the Medicaid payments to certain Native American health facilities and have 90% of the increase then returned to local and/or state governments. Just last month, in Alaska Dep't of Health & Soc. Servs. v. CMS, 424 F.3d 931 (9th Cir. 2005), this Court refused to disturb CMS's rejection of that scheme.

Around the same time that Arizona started seeking the special 100% reimbursement rate for referred services, two additional States also sought such increased reimbursements for the first time. The Eighth Circuit recently rejected the suggestion that referred services are eligible for the special 100% reimbursement rate. North Dakota ex rel. Olson v. CMS, 403 F.3d 537 (8th Cir. 2005). The Eighth Circuit denied a petition for rehearing in that case, and a writ of certiorari was not sought.

SUMMARY OF THE ARGUMENT

Congress has created a special 100 % Medicaid reimbursement for services "received through an Indian Health Service facility." The issue here is whether Arizona can claim this special reimbursement rate for services provided, supervised, and billed by non-IHS providers, simply because the IHS referred patients to those providers. Relying on authority that has since been reversed, the district court concluded that the statutory language unambiguously applied and that any contrary reading violated both the plain language and intent of the statute. It is wrong on both counts.

Standing alone, the statutory phrase at issue, "services which are received through an Indian Health Service facility," is ambiguous. It could be read narrowly to include only services provided by IHS employees in an IHS facility, or it could be read more broadly to encompass services for which the IHS facility is

responsible and bills the relevant state Medicaid program (which is the agency's interpretation), or it could be read even more broadly to encompass all services to which the IHS has any relationship (which appears to be Arizona's interpretation). Thus the phrase, standing by itself, neither requires nor forecloses the agency's interpretation, and the district court ruling to the contrary is incorrect.

The legislative history, however, provides unmistakable evidence of congressional intent. The fundamental innovation of the IHCIA in this area was to make IHS facilities eligible to receive state Medicaid payments. Previously, IHS facilities, like all federal facilities, had been ineligible for Medicaid payments. The relevant legislative history states that the sole and exclusive purpose of the special 100% reimbursement rate was to ensure that this new statutory provision (allowing IHS facilities to receive Medicaid payments) did not impose a <u>new</u> financial burden on the States. The Secretary has fully implemented this intent by concluding that Medicaid payments made to IHS facilities under IHCIA, and only such payments, are subject to the special 100% reimbursement rate. At the same time, the IHCIA provisions allowing IHS facilities to receive state Medicaid payments did not affect the pre-existing contract care program. If a patient referred by the IHS to a non-IHS facility was not covered by any other source (including Medicaid), then the IHS could pay for that

service under the contract care program, both before and after IHCIA was enacted. The IHCIA did not change that. Similarly, both before and after IHCIA was enacted, if a patient referred by the IHS to a non-IHS facility was covered by some other source (including Medicaid), that other source would have to pay for those services. Arizona's interpretation of the statute, under which the special 100% reimbursement rate applies to payments that would have previously been the responsibility of the State Medicaid program (and only partially reimbursed by the federal government) is directly contrary to the clear legislative history demonstrating that the purpose of the special 100% reimbursement rate was only to avoid placing new financial burdens on the States, not to shift to the federal government financial responsibilities previously borne by the States.

Even if the legislative history left any doubt, the agency's reasonable interpretation here must be upheld under Chevron U.S.A. Inc. v. Natural Res. Def. Council, Inc., 467 U.S. 837 (1984). The agency articulated its interpretation in a formal adjudication entitled to Chevron deference. And the agency interpretation is clearly reasonable, following several of the many dictionary definitions of "through" and implementing the clear congressional intent to avoid shifting costs previously borne by the federal government onto the States. That reasonableness is underscored by the fact that the agency has consistently maintained the same

interpretation since the enactment of the statute, and, despite significant sums at stake, no State challenged that interpretation for over twenty years. There is no legitimate basis for refusing to defer to the agency's interpretation here.

ARGUMENT

THE SPECIAL 100% REIMBURSEMENT RATE DOES NOT APPLY TO REFERRED SERVICES.

A. CMS's Construction of the Medicaid IHS Reimbursement Provision is Governed by Chevron.

This case involves judicial review of the construction of a federal statute by the agency charged with the administration of that statute. The framework for such a judicial review is the familiar one of Chevron U.S.A., Inc. v. Natural Res. Def. Council, Inc., 467 U.S. 837 (1984):

> [I]f a court determines that Congress has directly spoken to the precise question at issue, then that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress. If, however, the agency's statutory interpretation fills a gap or defines a term in a way that is reasonable in light of the legislature's revealed design, we give [that] judgment controlling weight.

United States v. Haggar Apparel Co., 526 U.S. 380, 392 (1999) (internal quotation marks and citation omitted). In determining congressional intent, a court uses "traditional tools of statutory construction," which include looking to both the "statute" and the "legislative history." Chevron, 467 U.S. at 837, 843 n.9, 845; Irvine Med. Ctr. v. Thompson, 275 F.3d 823, 829 n.3 (9th Cir. 2002)

("[W]e 'cautiously adhere' to the practice of consulting legislative history in attempting to ascertain a clear congressional directive under Chevron.") (quoting American Rivers v. FERC, 201 F.3d 1186, 1196 n.16 (9th Cir. 2000)). In other words, the issue at step one of the Chevron analysis is "whether the purpose and legislative history of the statutory provision plainly establishes that the [Secretary]'s interpretation is untenable." Newman v. Apfel, 223 F.3d 937, 946 n.4 (9th Cir. 2000).

As we now show, Congress has "directly spoken to the precise question at issue" here. While the statutory language is itself ambiguous, congressional intent is clear from the legislative history, and that intent would be thwarted under Arizona's interpretation of the statute. See North Dakota ex rel. Olson v. CMS, 403 F.3d 537, 540 (8th Cir. 2005) (affirming the Secretary's interpretation of the statute "[b]ased on the legislative history alone"). But to the extent this Court concludes that Congress has failed to speak to this issue with sufficient clarity, the Court must give controlling weight to the agency's interpretation, since that interpretation defines a term (the word "through") in a way that is reasonable in light of the statutory design.

This court reviews the district court's Chevron analysis in its grant of summary judgment de novo. Balint v. Carson City, 180 F.3d 1047, 1050 (9th Cir. 1999) (en banc). "The appellate court

must determine, viewing the evidence in the light most favorable to the nonmoving party, whether the district court correctly applied the relevant substantive law and whether there are any genuine issues of material fact." Id.

B. Congressional Intent that the Special 100% Rate not Apply to Referred Services is Clear.

1. The Statutory Language Is Ambiguous, Although it Tends to Support the Agency's Interpretation.

The district court held that the word "through" as used in the statutory phrase "services which are received through an Indian Health Service facility," was clear and unambiguous on its face such that the statute could only be read to apply the special 100% reimbursement rate to the referred services at issue here. See District Court Op. 11 (ER 67).[6]

That conclusion is wrong. As an initial matter, this Court recently characterized the relevant statutory scheme in a way that is inconsistent with that of the district court, stating that the special 100% reimbursement rate applies to "state expenditures on

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[6] Specifically:

> The Court . . . concludes as a matter of law that the language of § 1396d(b) at issue is clear and unambiguous and that the phrase "received through" is properly interpreted as pertaining [to] services that are provided as a result of a referral from an IHS facility by private health care providers who bill the state Medicaid program for those services.

District Court Op. 11-12 (ER 67-68).

behalf of eligible Native Americans at IHS facilities." Alaska Dep't of Health & Soc. Servs. v. CMS, 424 F.3d 931, 935 n.1 (9th Cir. 2005) (emphasis added). To be sure, this characterization is in dictum, but the fact that a unanimous panel of this Court would read the statutory language differently than the district court below did is an extremely strong indication that the statutory language is ambiguous. Moreover, this is not the only court of appeals to interpret the statutory language differently from the district court below; the Eighth Circuit, applying step one of the Chevron analysis, recently held that the statutory language at issue is ambiguous and that the same interpretation adopted by the district court here must be rejected as inconsistent with congressional intent. North Dakota ex rel. Olson v. CMS, 403 F.3d 537 (8th Cir. 2005). Thus the district court's conclusion that the plain language of the statute compels a finding for the plaintiffs here is highly suspect in that it flatly contradicts the opinions of this Court and the only other court of appeals to address the question.

At any rate, it should be obvious that the word "through," by itself, is susceptible of many meanings, see, e.g., Random House Dictionary of the English Language 1977 (2d ed.); Webster's Third New International Dictionary 2384 (1967) (containing twenty-nine definitions of "through"), and is therefore ambiguous standing alone. North Dakota, 403 F.3d at 540 (holding that "the statutory

language is susceptible to multiple interpretations and does little to resolve the present controversy"); id. at 539 (holding that the statutory language at issue here "does not compel any particular interpretation").[7]

Whatever the degree of ambiguity inherent in the word, it is clear that the Secretary's interpretation encompasses a legitimate reading. For example, Webster's Third New International Dictionary 2384 (1967) contains the following definitions and examples, among many others:

> **2a**(1): by means of : by the help or agency of <he educated himself ~ correspondence courses - Current Biog.> <this idea is somewhat more difficult to present ~ statistics - N.R. Heiden> (2): by the intermediary of : in the person of <speaking ~ the chairman of its committee on economic policy - Collier's Yr. Bk.> <speaking ~ an interpreter>

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[7] The Eight Circuit's conclusion in this regard is hardly anomalous. Courts frequently find that general undefined terms in statutes are ambiguous. See, e.g., National Cable & Telecomm. Ass'n v. Brand X, 125 S. Ct. 2688 (June 27, 2005) (holding that the statutory term "offer" is ambiguous); Breuer v. Jim's Concrete of Brevard, Inc., 538 U.S. 691, 694-95 (2003) (holding statutory term "maintain" is ambiguous); Davis v. United States, 495 U.S. 472, 479 (1990) (finding statutory phrase "for the use of" ambiguous); Buckley v. Valeo, 424 U.S. 1, 77 (1976) (finding statutory phrase "'for the purpose of . . . influencing' the nomination or election of candidates for federal office" ambiguous); Hawaii ex rel. Attorney Gen. v. FEMA, 294 F.3d 1152, 1161 (9th Cir. 2002) (finding statutory word "available" ambiguous); Forbes v. Napolitano, 236 F.3d 1009, 1013 (9th Cir. 2000) (finding statutory words "experimentation," "investigation," and "routine" ambiguous); United States v. 313.34 Acres of Land, 923 F.2d 698, 702 (9th Cir. 1991) (finding statutory word "suitable" ambiguous).

The word "by" is a synonym for "through." Id. at 307; Random House Dictionary at 287, 1997. Thus, one meaning of the phrase "through an Indian Health Service facility" is by or by means of an IHS facility, meaning that the IHS facility provided and was responsible for the services at issue (rather than merely referred the patient to some other entity that provided the services).

To demonstrate this meaning, it is helpful to look to the dictionary's examples. One such example is "speaking [through] the chairman of its committee on economic policy." Webster's Third New International Dictionary 2384 (1967). This phrase means that the chairman is doing the speaking. It would not apply if the chairman had been asked to speak but referred the matter to an assistant who actually did the speaking.[8] Accordingly, this definition comports with the agency's interpretation of the statute but conflicts with

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[8] A hypothetical involving this use of the word "through" in a more familiar legal context may be helpful. Suppose that a litigant with an immigration case before this Court seeks assistance from attorney A. A tells the litigant that his firm cannot help him and refers the litigant to B, an attorney at a different law firm who specializes in immigration law and who has agreed to charge reduced rates for services provided to litigants referred by A. B then represents the litigant in the immigration matter before this Court, including filing a notice of appearance and a brief and appearing at oral argument.

In these circumstances, did the litigant appear before (or litigate in) this Court "through" A? Most people would reject that characterization and say instead that the litigant appeared before (or litigated in) this Court "through" B. That is because the word "through" as used in this context is commonly understood to mean "by," "by means of" or "in the person of" and not to encompass an entity whose only role was to refer the litigant to the counsel who actually provided the representation.

plaintiffs' interpretation. Because, as the Eighth Circuit put it, "the statutory language is susceptible to multiple interpretations," North Dakota, 403 F.3d at 540, and because some of those meanings are entirely consistent with the Secretary's reading of the statute, the district court erred in concluding that the text foreclosed the Secretary's interpretation.

Put another way, the dictionary contains definitions that support both the agency's interpretation and plaintiffs' interpretation. This situation is similar to that in Davis v. United States, 495 U.S. 472, 479 (1990), where the Supreme Court (citing an earlier version of Webster's New International Dictionary) held that the statutory phrase "for the use of" could support both the government's interpretation and a contrary interpretation. The Supreme Court resolved the issue in Davis by referring to the legislative history. 495 U.S. at 479-83; see also Intercounty Constr. Corp. v. Walter, 422 U.S. 1 (1975) (resolving ambiguity in statutory language by reference to legislative history in the form of congressional reports). As we now demonstrate, the legislative history of the IHCIA strongly supports the agency's statutory interpretation.

2. The Legislative History and Statutory Context Demonstrate That Congress Intended the 100% Reimbursement Rate to Apply Only to Services That Would Previously Have Been Funded Entirely by the Federal Government.

The specific statutory phrase to be interpreted here, "received through an Indian Health Service facility," was enacted by Congress in section 402 of the IHCIA. In that same section, Congress also provided, for the first time, that IHS facilities would be eligible to receive Medicaid funds. See IHCIA § 402(a) (codified at 42 U.S.C. § 1396j(a)). Congress clearly explained that these two provisions of the same statutory section were directly related. First, section 402(a) was intended to remove the previous prohibition against Medicaid payments to IHS facilities. IHCIA House Report (pt. I), at 26, 1976 U.S.C.C.A.N. at 2665. This effectively increased the overall IHS budget, allowing IHS facilities to provide better care, and particularly more Medicaid-covered services to more Native Americans. Id.; id. at 108, 1976 U.S.C.C.A.N. at 2746. At the same time, Congress recognized that IHS facilities had previously provided some Medicaid-covered services to Native Americans, and that when they had done so, the federal government (through the IHS budget) had funded the entire cost. Accordingly, it enacted the language at issue here in section 402(e) (codified at 42 U.S.C. § 1396d(b)) expressly in order to avoid burdening the States with such "costs which normally would have been borne by the Indian Health Service." IHCIA House Report (pt. I), at 108, 1976 U.S.C.C.A.N. at 2746; accord id.

(intent was to avoid shifting "to States a financial burden previously borne by the Federal Government") (quoting Report accompanying H.R. 93-3153 (1993)).

The Congressional intent is thus clear: the 100% reimbursement rate applies only to "costs which normally would have been borne by the Indian Health Service." The statute must be interpreted in light of this clear congressional intent. See, e.g., Davis, 495 U.S. at 480 (using intent gleaned from congressional reports to interpret facially ambiguous statutory phrase). Implementing this congressional intent is straightforward here. It is only necessary to determine whether the costs at issue in this case would have been borne by the IHS at the time that Congress enacted the IHCIA.

3. At the Time the IHCIA Was Enacted, Medicaid Payments of the Type at Issue in This Case Were not Paid by the IHS, but Were Shared by the State and Federal Governments.

As described above, the costs at issue in this case are costs of Medicaid services provided to Native Americans by third-party providers to whom the Native Americans were referred by the IHS. In other words, these are the costs for referred services for which the patient has an alternative source of funding (namely, Medicaid). Under IHS's contract health service program (as it existed from before the enactment of the IHCIA to the present day) the IHS is the payor of last resort. 42 C.F.R. § 136.61; 55 Fed. Reg. 4,606, 4,608 (Feb. 9, 1990) (explaining that IHS has been the

payor of last resort since 1956). That means that if any alternate form of funding is available - including Medicaid funding - the IHS is not financially responsible. In other words, at the time Congress enacted the IHCIA with its special 100% reimbursement rate for "costs which normally would have been borne by the Indian Health Service," the regulations provided that the Medicaid program - not the IHS - was responsible for the type of costs at issue here. Because those costs were paid by the Medicaid program (ultimately shared by the federal and state governments) - and not by IHS - Congress clearly did not intend that they be covered by its special 100% reimbursement rate.

It is on this point that the district court below primarily erred. Rather than supply its own reasoning, it simply quoted a lengthy portion of the opinion of the district court in North Dakota. See District Court Op. 15-16 (ER 71-72) (quoting North Dakota ex rel. Olson v. CMS, 286 F. Supp. 2d 1080 (D.N.D. 2003), rev'd, 403 F.3d 537 (8th Cir. 2005). The reasoning of the quoted portions of the North Dakota opinion is, frankly, obscure. What is clear is that (1) the court below did not engage in any independent analysis of this issue other than quoting the North Dakota court and (2) the decision of the North Dakota district court was subsequently reversed by the Eighth Circuit, based on "the legislative history's unequivocal stance" against including referred services. North Dakota, 403 F.3d at 540.

4. Applying the Special 100% Reimbursement Rate Only to Services Provided and Billed for by IHS Best Comports with Additional Indicators of Congressional Intent.

The legislative history contains additional evidence of how Congress viewed the special 100% reimbursement rate, all of which support the agency's interpretation. For example, no fewer than three times, the congressional reports refer to the 100% reimbursement rate as applying to services provided "in an Indian Health Service facility." IHCIA House Report (pt. I), at 108, 1976 U.S.C.C.A.N. 2652, 2746 (emphasis added); accord id. (pt. III), at 7, 1976 U.S.C.C.A.N. at 2782 (special 100% reimbursement rate applies to Medicaid services provided to Indians "in IHS facilities") (emphasis added); id. (pt. III), at 21, 1976 U.S.C.C.A.N. at 2796 (same).

To be sure, the legislative history does not use exactly the same words as the statute, and it may be that some very small category of services are "received through" an IHS facility even though they are not "provided in" such a facility.[9] Nevertheless, the Secretary's interpretation of the ambiguous statutory phrase ("received through") is fundamentally compatible with the legislative history. Under the Secretary's interpretation, the overwhelming majority of services "received through" an IHS facility are also "provided in" such a facility, thus harmonizing,

[9] An IHS facility may, for example, conduct a clinic off-site, or provide emergency care to someone who collapses outside the actual facility.

to the extent the statutory language allows, the statutory interpretation with the legislative history. Under the Secretary's interpretation, Congress' reference to services "provided in" an IHS facility in the legislative history can be seen for what it is: a highly accurate shorthand for the services to which the special 100% reimbursement rate applies.

By contrast, Arizona urges an interpretation of the ambiguous statutory phrase ("received through") under which hundreds of millions of dollars in referred services are considered "received through" an IHS facility even though they are not "provided in" such a facility.[10] In other words, Arizona has interpreted the ambiguous statutory phrase in the way that departs dramatically from the legislative history. It cannot explain this radical departure from clear and obvious congressional intent. Cf. North Dakota, 403 F.3d at 540 ("Given the legislative history's unequivocal stance, we conclude that Congress's use of "received through" rather than "provided in" does not cover referred services such as those at issue in this appeal.").

The district court below erred by inferring that the legislative history can be completely ignored whenever its language is not identical to the language used in the statute. See District Court Op. 16-17 (ER 72-73). This approach makes no sense and would

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[10] The services at issue in this case alone cost approximately $100 million and represent only two and one-quarter years' worth of services in a single State.

render legislative history useless, since the only point of referring to legislative history is to elucidate the otherwise unclear statutory language. Moreover, the Supreme Court has used legislative history in precisely the way rejected by Arizona and the district court here. See Davis v. United States, 495 U.S. 472, 481 (1990) (in light of legislative history, holding that ambiguous statutory phrase "for the use of" should be interpreted as conveying a similar meaning to the different, non-statutory phrase "in trust for").

The specific statutory language also supports the agency's interpretation. The special 100% reimbursement rate applies to services "received through an Indian Health Service facility." (Emphasis added). Congress chose not to enact an enhanced rate for services provided to eligible Native Americans or services provided to eligible Native Americans who used IHS as their primary caregiver or even services provided by the IHS. Instead, Congress keyed the special 100% reimbursement rate to the involvement of an IHS facility. This chosen language does not square well with plaintiffs' view that the "facility" is irrelevant because all that is necessary is a referral from an IHS employee to the non-IHS provider that ultimately provides the services. On the other hand, the legislative history above makes it clear why the "facility" is crucial. The IHCIA made IHS "facilities" eligible to receive State Medicaid payments. The special 100% reimbursement rate is meant to

ensure that such newly-authorized payments did not create a new financial burden on the States, precisely because IHS facilities had previously been funded entirely by the federal government. And Congress mandated that such payments be set aside and used exclusively to improve IHS "facilities." IHCIA § 402 (codified at 25 U.S.C. § 1642(a)). Thus, the "facility" is key; the IHS "facility" is the entity that the statute allows (for the first time) to receive Medicaid funds; it is also the "facility" to which the special 100% reimbursement rate applies; and finally, it is the "facility" which those payments are used to improve.

By contrast, when a State Medicaid program payment is made to a non-IHS provider, the usual Medicaid reimbursement rate applies. Such services were always paid for by the State Medicaid program (and thus were only partially reimbursed by the federal government). And the restriction on the use of Medicaid payments to IHS facilities does not apply. Such Medicaid payments were made in the same way to the non-IHS providers for their services on behalf of patients referred to them by the IHS both before and after the enactment of the IHCIA.

C. The Agency's Interpretation must be Upheld Because it is Entitled to Chevron Deference and is Reasonable.

If congressional intent in enacting the special 100% reimbursement rate remained unknown or ambiguous despite the clear legislative history discussed above, then the second step of the Chevron analysis would apply, and this Court would determine

whether the Secretary's interpretation "is based on a permissible construction of the statute." Chevron USA, Inc. v. Natural Res. Def. Council, Inc., 467 U.S. 837, 843 (1984). Just last month, this Court reaffirmed that it "generally afford[s] Chevron deference to the Agency's interpretations of the Medicaid Act." Alaska Dep't of Health & Soc. Servs. v. CMS, 424 F.3d 931, 938 (9th Cir. 2005). Because the Secretary's statutory interpretation here is embodied in a formal adjudication authorized by statute, there is no question that it constitutes the type and form of agency decision entitled to Chevron deference. United States v. Mead Corp., 533 U.S. 218, 230 & n.12 (2001) (collecting eight other Supreme Court decisions); Alaska Dep't of Health, 424 F.3d at 938 (quoting Mead for the proposition that the results of formal adjudication are entitled to Chevron deference).

The discussion in Section I above demonstrates that the agency interpretation here is a reasonable and permissible construction of the statute. It employs a common and accepted dictionary definition for the word "through." Moreover, that definition gives the statute a scope that comports with the clearly expressed intent of Congress as stated in the official congressional reports. Given the strong deference that courts owe agencies at step two of the Chevron analysis, the agency's statutory interpretation here easily passes muster.

In addition, the Secretary's interpretation, unlike Arizona's, implements the statute in a logical and manageable way. The scheme is logical because it makes enhanced reimbursement dependent upon who performs, is responsible for, and bills the Medicaid Program for, the services. By contrast, Arizona's interpretation of the scheme makes enhanced reimbursement dependent upon the route a patient took to the provider: one reimbursement rate applies when a patient goes directly to the private provider while a different rate applies when that same patient first goes to the IHS and is referred to that same private provider. That is not the type of distinction that justifies a different federal payment.

Similarly, under the Secretary's interpretation, eligibility for the special 100% reimbursement rate is relatively straightforward to verify; state Medicaid payments to IHS facilities are reimbursed at the special rate, while all other state Medicaid payments are reimbursed at the lower regular rate. By contrast, Arizona's interpretation of the statute would be extremely complex, costly, and inaccurate because, for every single service, CMS and the State would have to verify, in addition to the Medicaid eligibility of the beneficiary, that: (1) the beneficiary was a Native American eligible for treatment by the IHS, (2) the beneficiary sought treatment at an IHS facility; (3) the IHS referred the beneficiary to a private provider; (3) the private provider to whom the beneficiary was referred performed the

services; (4) the services were within the scope of the referral; and (5) the services would have been covered by IHS's contract care program if the patient had not been eligible for Medicaid. These are inquiries that the Secretary has never made with respect to the special reimbursement rate and would add considerably (and unnecessarily) to the expense, bureaucracy, and accuracy of administration. There is no reason to construe the ambiguous statutory language to create such problems.

If any additional indication of the reasonableness of the agency's interpretation were necessary, such an indication is found in the conduct of the States, including Arizona, in not challenging that interpretation. From the enactment of the IHCIA in 1976 through at least 1997, neither Arizona nor any other State sought or received reimbursement at the special 100% rate for Medicaid payments for referred services provided and claimed by non-IHS providers, and Arizona did not seek such reimbursement until 1999. See District Court Op. 5 (ER 61); DAB Decision 5 (ER 28). Given the hundreds of millions (if not billions) of dollars at stake, one would expect that at least one State would have challenged the agency's interpretation at some point during that twenty-year period, if it thought that such a challenge might have even a remote chance of success. From the fact that no challenge was made during those twenty years, it is reasonable to conclude that every

single state containing an IHS facility understood that the special 100% reimbursement rate did not apply to referred services.

Although not necessary to the conclusion that the agency's interpretation here is reasonable, it is worth noting that "[a]n agency's construction of a statute is entitled to greater deference when made contemporaneously to the statute's enactment." California State Legislative Bd. v. Mineta, 328 F.3d 605, 608 n.3 (9th Cir. 2003) (deferring to rule adopted within two years of relevant statutory enactment); accord Udall v. Tallman, 380 U.S. 1, 16 (1965) (deference particularly appropriate for contemporaneous agency construction of a statute when enacted) (citing Power Reactor Dev. Co. v. International Union of Electricians, 367 U.S. 396, 408 (1961)). Similarly, longstanding interpretations receive "particular deference." Barnhart v. Walton, 535 U.S. 212, 220 (2002) (citing North Haven Bd. of Ed. v. Bell, 456 U.S. 512, 522 n.12 (1982)). Here, the Secretary's interpretation was contemporaneous with the enactment of the IHCIA and has remained constant for almost 30 years. Within months after the IHCIA was enacted, the responsible federal agency clearly stated that the special 100% reimbursement rate applied only to payments by a State Medicaid program to an IHS facility. See Department of Health, Education, and Welfare Memorandum dated November 26, 1976, at 1 (ER 53). Indeed, Arizona conceded as much during the administrative proceedings. See DAB Decision 16-17 (ER 39-40)

(quoting Arizona's brief before the DAB). As the DAB noted, contrary to Arizona's assertions, the federal government maintained this position consistently through the years, including in responding to communications from the plaintiff in this case. See Jan. 28, 1993 letter from Medicaid Associate Regional Director for Region IX to Leonard J. Kirschner of the Arizona Health Care Cost Containment System 1 (ER 21) (specifically stating that to receive the special 100% reimbursement rate, "IHS must be in control of or responsible for the services, i.e., claim them as part of its facility services"). The facts that the agency's interpretation of this statute was initially made contemporaneously with the enactment of the statute and consistently held for decades, combined with the fact that although the States had significant incentives to challenge this interpretation, they did not do so for over twenty years, strongly support the reasonableness of the interpretation.

CONCLUSION

For the foregoing reasons, this Court should reverse the district court's summary judgment and remand with instructions to grant summary judgment to the federal defendants.[11]

Respectfully submitted,

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[11] Pursuant to Ninth Circuit Rule 28-2.6, there are no known related cases pending in this Court.

CERTIFICATE OF COMPLIANCE

Certificate of Compliance Pursuant to Fed. R. App. P. 32(a)(7)(C) and Circuit Rule 32-1 for Case Number 05-16386.

I certify that:

X 1. Pursuant to Fed. R. App. P. 32 (a)(7)(C) and Ninth Circuit Rule 32-1, the attached opening brief is

☐ Proportionately spaced, has a typeface of 14 points or more and contains _____ words (opening, answering, and the second and third briefs filed in cross-appeals must not exceed 14,000 words; reply briefs must not exceed 7,000 words),
or is

✗ Monospaced, has 10.5 or fewer characters per inch and contains 8,284 words.

Jonathan H. Levy
Attorney for the federal appellants

October 26, 2005

CERTIFICATE OF SERVICE

I hereby certify that on October 31, 2005, I served the foregoing BRIEF OF FEDERAL APPELLANTS by causing one original and fifteen copies to be sent by Federal Express overnight to the Court and two copies to be sent to the following counsel of record by the following methods:

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ADDENDUM

42 U.S.C.A. § 1396d:

. . .

(b) Federal medical assistance percentage; State percentage; Indian health care percentage

Subject to section 1396u-3(d) of this title, the term "Federal medical assistance percentage" for any State shall be 100 per centum less the State percentage; and the State percentage shall be that percentage which bears the same ratio to 45 per centum as the square of the per capita income of such State bears to the square of the per capita income of the continental United States (including Alaska) and Hawaii; except that (1) the Federal medical assistance percentage shall in no case be less than 50 per centum or more than 83 per centum, (2) the Federal medical assistance percentage for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa shall be 50 per centum, (3) for purposes of this subchapter and subchapter XXI of this chapter, the Federal medical assistance percentage for the District of Columbia shall be 70 percent, and (4) the Federal medical assistance percentage shall be equal to the enhanced FMAP described in section 1397ee(b) of this title with respect to medical assistance provided to individuals who are eligible for such assistance only on the basis of section

1396a(a)(10)(A)(ii)(XVIII) of this title. The Federal medical assistance percentage for any State shall be determined and promulgated in accordance with the provisions of section 1301(a)(8)(B) of this title. Notwithstanding the first sentence of this section, the Federal medical assistance percentage 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 (as defined in section 1603 of Title 25). Notwithstanding the first sentence of this subsection, in the case of a State plan that meets the condition described in subsection (u)(1) of this section, with respect to expenditures (other than expenditures under section 1396r-4 of this title) described in subsection (u)(2)(A) of this section or subsection (u)(3) of this section for the State for a fiscal year, and that do not exceed the amount of the State's available allotment under section 1397dd of this title, the Federal medical assistance percentage is equal to the enhanced FMAP described in section 1397ee(b) of this title.

42 U.S.C.A. § 1396j

(a) Eligibility for reimbursement for medical assistance

A facility of the Indian Health Service (including a hospital, nursing facility, or any other type of facility which provides services of a type otherwise covered under the State plan), whether operated by such Service or by an Indian tribe or tribal organization (as those terms are defined in section 1603 of Title 25), shall be eligible for reimbursement for medical assistance provided under a State plan if and for so long as it meets all of the conditions and requirements which are applicable generally to such facilities under this subchapter.

42 C.F.R. § 136.61 Payor of last resort.

(a) The Indian Health Service is the payor of last resort for persons defined as eligible for contract health services under the regulations in this part, notwithstanding any State or local law or regulation to the contrary.

(b) Accordingly, the Indian Health Service will not be responsible for or authorize payment for contract health services to the extent that:

(1) The Indian is eligible for alternate resources, as defined in paragraph (c) of this section, or

(2) The Indian would be eligible for alternate resources if he or she were to apply for them, or

(3) The Indian would be eligible for alternate resources under State or local law or regulation but for the Indian's eligibility for contract health services, or other health services, from the Indian Health Service or Indian Health Service funded programs.

(c) Alternate resources means health care resources other than those of the Indian Health Service. Such resources include health care providers and institutions, and health care programs for the payment of health services including but not limited to programs under titles XVIII or XIX of the Social Security Act (i.e., Medicare, Medicaid), State or local health care programs, and private insurance.

42 C.F.R. § 136.21 Definitions

. . .

(e) Contract health services means health services provided at the expense of the Indian Health Service from public or private medical or hospital facilities other than those of the Service.

. . .