No. 05-16386

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

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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.

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

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# REPLY BRIEF OF FEDERAL APPELLANTS

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**MISCELLANEOUS**

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## INTRODUCTION

Arizona suggests that it is "clear" (Arizona Br. 26) that referred services are "received through an Indian Health Service facility" under the statute, even though such service are performed by non-IHS providers in non-IHS facilities over which the IHS has neither control nor responsibility[1] and for which the IHS does not

[1] Arizona incorrectly suggests that "IHS controls whether a referred service is provided." Arizona Br. 15. But it merely cites the affidavit of its own employee for this assertion, and even that document says only that the IHS controls whether to make a referral, not whether (or when, where, how, or by whom) the referred service is provided. See SER 3. Also citing only its own affidavit, Arizona says that "IHS initiated and approved all such services," id. at 16; accord id. at 17. But, quite to the

bill Medicaid. Similarly, Arizona suggests that the Secretary's contrary interpretation is "not reasonable." Arizona Br. 52-56.

Yet the interpretation that Arizona challenges as "not reasonable" and contrary to the "clear" meaning of the statute has been adhered to consistently not only by the Secretary but also by the courts of appeals, see North Dakota ex rel. Olson v. CMS, 403 F.3d 537 (8th Cir. 2005); Alaska Dep't of Health & Soc. Servs. v. CMS, 424 F.3d 931, 935 n.1 (9th Cir. 2005) (dictum), and by the States, including Arizona itself, which, for the first twenty years of the statute's existence either agreed with or acquiesced in the Secretary's interpretation, despite the enormous cost of doing so.[2] Arizona faces an uphill battle in demonstrating that the federal government, the States, and the courts of appeals all acted so unreasonably over such a long period of time on such an important issue. It seems far more likely that, as discussed in our opening brief, the Secretary, the States (including Arizona itself), and

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contrary, the affidavit says that Arizona (not IHS) has authority to require "prior authorization or medical review" for referred services under Arizona's own "rules and policies. SER 4.

[2] Arizona does not address the first twenty years of the IHCIA's existence, see Arizona Br. 15, thus leaving unchallenged the DAB's findings that: (1) Arizona conceded that in the "early years" of the IHCIA the Secretary concluded that the special 100% reimbursement rate did not apply to non-IHS providers, DAB Decision 16-17 (ER 39-40); (2) agency statements in the 1990s upon which Arizona places a contrary interpretation in fact "were clear in limiting the 100% FMAP rate to services billed by IHS facilities," id. at 16 (ER 39); and (3) "Arizona was notified of and long operated consistently with this interpretation," id. at 26 (ER 49).

these courts of appeals did in fact all act reasonably, and it is Arizona that now misreads the statute.

Arizona's position conflicts with the language, structure, and history of the Indian Healthcare Improvement Act (IHCIA), all of which make clear that services "received through an Indian Health Service facility," 42 U.S.C. § 1396d(b), does not encompass referred services provided by a non-IHS provider that is responsible for the service and bills Medicaid itself. While it is unclear whether the statutory phrase "received through an Indian Health Service facility," on its face encompasses referred services, Congress expressly stated that it viewed the services covered by the special 100% reimbursement rate as limited to those performed in IHS facilities, which unquestionably excludes referred services. Moreover, Congress also stated that the special 100% rate was intended to avoid new financial burdens to States accompanying the statute's provision making IHS facility services eligible for Medicaid reimbursement for the first time. Since referred services had always been eligible for Medicaid reimbursement, the purpose behind the 100% reimbursement rate would not be served by expanding it to cover referred services. Accordingly, the Secretary's interpretation of the statute is correct (as well as being entitled to Chevron deference) and there is no basis for this Court to go into conflict with the Eighth Circuit.

In attempting to refute these arguments, Arizona makes a number of mistakes. First, although the words used by Congress are susceptible of many meanings, Arizona unilaterally picks the meaning that benefits it without offering any independent justification for choosing that definition over the others. Second, from the premise that the special 100% reimbursement rate can apply to services performed physically outside of an IHS facility, Arizona jumps to the unwarranted and unsupported conclusion that the special rate must apply to the services at issue in this case. But it is obvious that not every service performed outside of an IHS facility is subject to the special rate. Indeed, the Secretary honors the clear and express intent of Congress by minimizing the circumstances in which services provided outside of an IHS facility are subject to the special 100% reimbursement rate, while Arizona makes no attempt to accommodate that intent. Third, Arizona cannot substantiate its allegation that the federal government paid for referred services before IHCIA was enacted. Arizona proffers nothing to support this claim, other than an erroneous inference drawn from the legislative history, which does nothing to negate the clear law demonstrating that payment for referred services was not wholly the federal government's responsibility.

## ARGUMENT

### I. BECAUSE CONGRESS DID NOT INTEND THE SPECIAL 100% RATE TO APPLY TO REFERRED SERVICES PERFORMED BY NON-IHS PROVIDERS, REVERSAL IS NECESSARY AT STEP ONE OF THE CHEVRON ANALYSIS.

A. Statutory Language

As shown in our opening brief, the word "through" has many meanings. Arizona picks a particularly favorable definition and argues that the special 100% reimbursement rate must apply whenever the IHS acts as an "intermediary" - a term which is obviously not contained in the statute and which even Arizona does not attempt to define. See Arizona Br. 20-21.[3] But, as we explained on pages 20-23 of our opening brief, Arizona cannot resolve statutory ambiguity by fiat, and Arizona does not deny that some definitions of "through" (e.g., "by" or "by means of") clearly support the Secretary's statutory interpretation by requiring some direct action (as opposed to vague intermediary status). Indeed, the Eighth Circuit has already rejected Arizona's approach to the statutory language here. North Dakota ex rel. Olson v. CMS, 403 F.3d 537, 540 (8th Cir. 2005) ("[T]he statutory language is susceptible to multiple interpretations and does little to resolve the present controversy."); id. at 539 (statutory language "does not compel any particular interpretation"); see also DAB Decision 9

[3] The district court, upon which Arizona relies so heavily in other respects never articulated a definition of "received through," relying solely on its conclusion that the phrase must be something other than "provided in." See District Court Op. 9-12 (ER 65-68).

(ER 32) ("While 'through' includes the meanings listed by Arizona, the term has other definitions.").

Arizona argues at length that, because the phrase "provided in" appears elsewhere within the IHCIA, the phrase "received through" must be interpreted to mean something other than "provided in." See Arizona Br. 22-23, 49-50. This is a red herring. The Secretary agrees that the special 100% reimbursement rate can apply outside the physical confines of an IHS facility. See CMS Br. 27 & n.9; DAB Decision 26 (ER 49) (holding that a Medicaid service is "received through" an IHS facility, when that facility "offers, is responsible for and bills Medicaid for the services provided"). The question in this case is thus not whether "received through" is a different concept than "provided in," but rather, whether it is so broad as to encompass the referred services at issue. See North Dakota, 403 F.3d at 540 ("[E]ven if 'received through' has a broader connotation than 'provided in,' the statute does not specify how far 'received through' should extend."). Nothing on pages 22 to 23 or 49 to 50 of Arizona's brief provides any assistance in answering that question. Accordingly, in order to resolve this case, this Court must look elsewhere within the statute and to the legislative history for additional guidance.[4]

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[4] Arizona also suggests that the statutory phrase at issue here should be interpreted in light of other statutory phrases in other parts of the Medicaid scheme. Arizona Br. 23 & n.6 (citing various parts of 42 U.S.C. § 1396d. But since none of these statutory provisions was a part of the IHCIA, their use of

The statute's emphasis on the role of an IHS facility does help resolve this dispute. The special 100% reimbursement rate applies to services "received through an Indian Health Service facility." 42 U.S.C. § 1396d(b) (emphasis added). Arizona proposes defining such services with reference to the IHS as a whole but without reference to the involvement of any IHS facility at all. See Arizona Br. 16. By contrast, as noted on pages 29 to 30 of our opening brief, the Secretary's interpretation of the statute gives meaning and importance to the word "facility," because an IHS facility must bill for a service in order for that service to qualify for the 100% reimbursement rate. This requirement also fits into the overall statutory scheme. The statute made an IHS "facility" eligible to receive Medicaid payments for the first time, provided that Medicaid payments to such facilities would be used to improve them, and then created a special 100% reimbursement rate applicable to IHS "facilities", so that this new eligibility would not impose a new financial burden on the States. IHCIA § 402(c) (codified at 25 U.S.C. § 1642 and 42 U.S.C. §§ 1396d(b) & 1396j). All this was done specifically to avoid "burden[ing] a State Medicaid program with costs which normally would have been borne by the Indian Health Service." H.R.

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different language does not help interpret the IHCIA. See United , Inc., 359 U.S. 29, 38 (1959) (noting that even the same "word need not mean the same thing in different statutes").

Rep. No. 94-1026 ("IHCIA House Report"), pt. 1, at 108 (1976), reprinted in 1976 U.S.C.C.A.N. 2652, 2746. The Secretary's statutory interpretation fits with this scheme by applying the 100% rate only to IHS facility services, which were the only services for which the IHS was previously responsible. By contrast, appellees would also shift the costs of referred services performed by non-IHS providers, which clearly are not IHS facility costs and were not the responsibility of the IHS prior to the enactment of the IHCIA.

B. Legislative History

1. The parties both rely upon the legislative history of the IHCIA in interpreting the scope of the special 100% reimbursement rate. Indeed, Arizona itself relies heavily and repeatedly on various portions of the legislative history throughout pages 28-42 of its brief. But in doing so, it discusses at great length the legislative history on tangential (or wholly irrelevant) issues, such as the distinction between Native Americans living on or near a reservation and "urban" Native Americans, see Arizona Br. 28-30, while minimizing the legislative history that directly addresses the scope of the special 100% reimbursement rate. Such selective use of legislative history is improper. See, e.g., Exxon Mobile Corp. v. Allapattah Servs., Inc., 125 S. Ct. 2611, 2626 (2005); United States v. Boos, 127 F.3d 1207, 1211 (9th Cir. 1997), cert. denied, 522 U.S. 1066 (1998). When directly on-point legislative

history exists, a reviewing court ought to look to that legislative history first. Congress specifically stated that "the 100 percent matching is limited to services in IHS facilities." IHCIA House Report (pt. 3), at 21, 1976 U.S.C.C.A.N. 2782, 2796 (emphasis added); accord id. (pt. 1), at 108, 1976 U.S.C.C.A.N. 2652, 2746 (statute "would provide 100% Federal Medicaid matching funds for services provided to any Indian in an IHS facility," if Indian were eligible for both Medicaid and IHS services) (emphasis added); id. (pt. 3), at 7, 1976 U.S.C.C.A.N. 2782, 2782 (statute provides for "Federal matching rate for Medicaid services provided to Indians in IHS facilities of 100 percent") (emphasis added). Congressional intent that the special 100% reimbursement rate not apply to the referred services at issue in this case, which were provided by non-IHS providers in non-IHS facilities, could scarcely be more clear. See North Dakota, 403 F.3d at 540 ("The legislative history . . . is clear and consistent when it discusses the scope of the 100 percent FMAP. Nowhere does it suggest that the 100 percent FMAP applies to services provided outside of IHS facilities, such as the referrals at issue in this case.").

Arizona suggests (as did the district court) that this clear legislative history should be ignored because it differs from the enacted language describing the scope of the special 100% reimbursement rate. Arizona Br. 47-48. But, as noted on pages 28 to 29 of the our opening brief, this argument misses the point of

legislative history entirely. Legislative history is used to clarify ambiguous statutory language. See, e.g., Underwood Cotton Co. v. Hyundai Merch. Marine (Am.), Inc., 288 F.3d 405, 412-13 (9th Cir. 2002); United States v. Sablan, 92 F.3d 865, 867-68 (9th Cir. 1996). It would be useless for this purpose if it were identical to the language it was meant to clarify; it is the difference in language that allows for clarification. See, e.g., Davis v. United States, 495 U.S. 472, 481 (1990) (using legislative history to interpret statutory phrase "'for the use of'" as conveying a similar meaning as 'in trust for.'").[5]

Arizona also suggests that this legislative history should be ignored because, in what Arizona acknowledges to be an "uncommon scenario," the Secretary's interpretation of the special 100% reimbursement rate would make that rate applicable to services performed outside the physical confines of an IHS facility, so long as the IHS facility was responsible for the service and billed the State Medicaid Program. Arizona Br. 48. But this also misses the point of legislative history. The Secretary has interpreted the statutory phrase "received through an IHS facility" in a way that most closely matches the language of the legislative history - "in

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[5] Arizona badly mischaracterizes Davis, asserting that the decision was based on the "context" of the ambiguous statutory language, Arizona Br. 26 (citing Davis, 495 U.S. at 479), despite the fact that Supreme Court clearly relied on legislative history (specifically citing and quoting legislative hearings and reports) to clarify the ambiguous statutory language. See Davis, 495 U.S. at 480.

an Indian Health Service facility." By interpreting the statutory language to refer to services for which an IHS facility is responsible and bills Medicaid, the Secretary is true to the statutory language, while also reducing to a negligible amount the "uncommon scenario[s]" in which a service could be "received through" an IHS facility without also being provided "in" such a facility. This properly harmonizes the ambiguous statutory language with its legislative history. In contrast, Arizona makes no attempt to harmonize its interpretation of the ambiguous statutory language with the legislative history. To the contrary, Arizona proposes an interpretation of the unclear statutory language under which it would be extremely common, rather than uncommon, for services not provided in an IHS facility to nonetheless be deemed "received through" such a facility. Indeed, that description would apply to all referred services, over half a billion dollars annually.[6] It simply makes more sense to interpret ambiguous statutory language in a way that coincides with the legislative history in all but a few "uncommon scenario[s]," as the Secretary does, than to interpret ambiguous statutory language in a way that departs from the legislative history in a huge number of scenarios involving vast sums, as Arizona does.

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[6] In 2003, Congress budgeted $467,046,000 just for referred services for Native Americans without Medicaid or other alternative funding sources. See, e.g., Pub. L. No. 108-108, 117 Stat. 1241, 1293 (2003).

2. A second part of the legislative history also sheds light on the scope of the special 100% reimbursement rate, albeit less directly than that discussed above. This legislative history states that the special 100% reimbursement rate was intended to avoid "burden[ing] a State Medicaid program with costs which normally would have been borne by the Indian Health Service," or "shift[ing] to States a financial burden previously borne by the Federal Government," IHCIA House Report (pt. 1), at 108, 1976 U.S.C.C.A.N. 2746, and is discussed on pages 33 to 43 of Arizona's brief. Our opening brief spells out the simple logic that leads to the conclusion that the services at issue in this case (referred services for Medicaid-covered Native Americans) were not a financial burden previously "borne by the Indian Health Service," but rather were borne by State Medicaid programs, with the IHS acting only as an (unnecessary, in these cases) payor of last resort. See CMS Br. 7-9, 25-26; see also DAB Decision 11-12 (ER 34-35). Because Arizona concedes the existence of the referred services program, Arizona Br. 35 (acknowledging the program's existence at least back to 1956), and does not question the existence of the well-documented payor of last resort rule, see McNabb v. Bowen, 829 F.2d 787, 789 (9th Cir. 1987) (citing 42 C.F.R. § 36.23(f), now moved to 42 C.F.R. § 136.61), it is difficult to see how it can deny the fact that State Medicaid Programs (not the IHS) were responsible for the costs of these

services. See also DAB Decision 12 (ER 35) (because prior to the IHCIA, services provided to Medicaid-eligible Native Americans were paid for by State Medicaid Programs, "the costs claimed by Arizona here . . . are not the costs referred to as 'normally borne by' the federal government prior to the IHCIA").

Arizona incorrectly suggests that the legislative history is contrary to this conclusion. The specific legislative history Arizona relies upon is quoted on pages 37-38 of Arizona's brief. In sum, this legislative history says that many Native Americans lacked access to Medicaid because their only source of healthcare was an IHS facility that, as a Federal facility, could not receive Medicaid funds. See IHCIA House Report (pt. 1), at 107, 1976 U.S.C.C.A.N. at 2745 (emphasis added).

> [T]he IHS, as a Federal facility, cannot, under existing law, receive payments from Medicare or reimbursements for services provided under Medicaid. As a result, Indian citizens are unable to receive Medicare or Medicaid payments for necessary care.

Id. This Court has already explained this point more fully:

> 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 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) (emphasis added). In sum, the special 100% reimbursement rate was enacted because IHS facility services were previously funded wholly by the federal government, and that, in turn, was because IHS facilities, as Federal facilities, were ineligible to receive Medicaid funding.

The same reasoning simply does not apply to referred services. As Arizona concedes, referred services are provided by "non-IHS providers," i.e., non-Federal facilities. Arizona Br. 14, 35. Referred services have thus always been eligible for Medicaid reimbursement, and, under the payor of last resort rule, 42 C.F.R. § 136.61, must be paid by Medicaid funds (rather than IHS funds) whenever Medicaid funds are available. The IHCIA made no changes with respect to referred services. In sum, the special 100% reimbursement rate was meant to offset a new cost that States would have otherwise incurred because the IHCIA made IHS facilities eligible to receive Medicaid payments for the first time. Because the IHCIA did not change referred service providers' eligibility to receive Medicaid payments, there was no new cost to the States associated with referred services in the IHCIA and accordingly no reason to make costs associated with referred services subject to the IHCIA's special 100% reimbursement rate.

In an attempt to avoid this result, Arizona lumps together IHS facility services and referred services. See, e.g., Arizona Br. 35

(suggesting that providers of referred services "were an integral part of the IHS service delivery system"). But Arizona cannot hide the indisputable and dispositive difference between IHS facility services and referred services; as even Arizona admits, "referred services [are] furnished by non-IHS providers." Arizona Br. 35. And, as noted above, they were therefore not subject to the rule regarding "Federal facilities" that, before the IHCIA, had prevented IHS facilities from receiving Medicaid payments, nor was their ability to receive such payments altered by the IHCIA. As this Court suggests in the passage quoted above from the Alaska case, this difference explains in full why Congress made the special 100% reimbursement rate applicable to Medicaid payments to IHS facilities (for IHS facility services) and not to Medicaid payments to non-IHS providers of referred services.

In another attempt to evade this result, Arizona cites the legislative history for the proposition that, at the time the IHCIA was enacted, Native Americans living on or near reservations were not enrolling in Medicaid, and therefore the IHS always paid for all referred services. Arizona Br. 38. Both the premise and conclusion of this argument are wrong. First, the legislative history, which is Arizona's sole source for this argument, does not say that no Native American living on or near a reservation had access to Medicaid. Rather, it says that "most" Native Americans "[i]n most cases," have "severely limited" access to Medicare and

Medicaid. IHCIA House Report (pt. 1), at 107, 1976 U.S.C.C.A.N. at 2745. Indeed, as the passage discussed above indicates, Congress attributed Native Americans' limited access to Medicaid entirely to the fact that IHS facilities (as Federal facilities) could not receive Medicaid payments. Native Americans with access to non-federal healthcare providers (e.g., referred providers) necessarily did have access to Medicaid. The only reasonable conclusion is that Native Americans with access to referred providers (like the Native Americans whose services are at issue in this case) were not among the majority of Native Americans that Congress described as lacking access to Medicaid.

At base, Arizona does not accept the facts as presented by this case. Arizona's argument boils down to the idea that the IHS paid for healthcare for Native Americans without access to Medicaid before the enactment of the IHCIA and therefore the special 100% reimbursement rate should apply to the referred services at issue in this case. But it is undisputed that the Native Americans at issue here do have access to Medicaid and therefore the proper question is whether the IHS paid for referred services for Native Americans with access to Medicaid when the IHCIA was enacted. And the answer to that is undisputable: by operation of the payor of last resort rule, the IHS did not pay for such services.[7]

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[7] Interestingly, Arizona cites this Court's decision in McNabb v. Bowen, 829 F.2d 787 (9th Cir. 1987), and suggests (without citation) that the federal government ought to pay for all

Arizona suggests that even if the above analysis is correct, a different rule should apply in Arizona than elsewhere because Arizona did not participate in the Medicaid program until after the enactment of the IHCIA. Arizona Br. 39-40. In other words, Arizona suggests that the statutory phrase "received through" means one thing in Arizona and something different everywhere else. But the Supreme Court has decreed that, absent evidence of contrary congressional intent, terms in federal statutes be given a single, nationwide definition. Mississippi Band of Choctaw Indians v. Holyfield, 490 U.S. 30 (1989). Arizona provides no basis to depart from Mississippi Band here and no reason why Congress would not have wanted the provisions of the IHCIA to function the same in each state.

3. Arizona suggests that in interpreting the IHCIA (passed by the 94th Congress in 1976), this Court should conform to the language of a bill that was considered (but not passed) by the 93d Congress in 1973. See Arizona Br. 40 (quoting from House Bill 3153 (1973)); id. at 42 (suggesting that it is appropriate in interpreting the IHCIA to "consider this prior legislative

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referred services as part of its "longstanding and unique federal obligation to Native Americans who lived on reservations." Arizona Br. 38. This suggestion is obviously wrong and was specifically rejected by this Court in McNabb. Instead, this Court noted that "Congress did not view the federal government as the exclusive provider of Indian health care benefits," rather, such benefits were the "shared responsibility" of state and federal governments. Id. at 792.

proposal"). Such an approach makes absolutely no sense, precisely because the broad 100% reimbursement rate contained in the 1973 bill was dramatically narrowed before it passed in the IHCIA in 1976. While the 1973 bill would have applied 100% reimbursement rate to "any individual who . . . resided on or adjacent to a Federal Indian reservation," and was eligible for IHS services, Arizona Br. 40 (quoting from H.R. 93-3153 (1973)), the IHCIA's special 100% reimbursement rate covers only services which are in fact "received through an Indian Health Service facility." 42 U.S.C. § 1396d(b). Had the 1973 bill passed, Arizona would likely be entitled to the costs at issue in this case. But the 1973 bill did not pass and is not the law.[8] Accordingly, this Court must give effect to Congress's decision to enact more narrow language, see 2A Norman J. Singer, Sutherland Statutory Construction § 48:18, at 484-85 (6th ed. 2000) ("Adoption of an amendment is evidence that the legislature intends to change the provisions of the original bill."), rather than ignore that decision, as Arizona proposes.[9]

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[8] As a result, Arizona's emphasis on the distinction between Native Americans living "on or near" reservations and "urban" Native Americans, see Arizona Br. 29-30, is misplaced. That distinction would have been crucial had the 1973 bill passed, but is essentially irrelevant to the inquiry facing this Court under the IHCIA as actually enacted.

[9] Neither case cited by Arizona supports its dubious proposition that a statute ought to be interpreted like an older bill, when Congress expressly changed the language of the bill on the issue in question. See Arizona Br. 42 n.10. United States v.

C. Eighth Circuit Decision

For the foregoing reasons, the language, structure, context, and history of the IHCIA demonstrate a clear congressional intent that the statute's special 100% reimbursement rate not apply to the referred services at issue in this case. Accordingly, this Court should follow the Eighth Circuit in holding, at step one of the Chevron analysis,[10] that Arizona's lawsuit must be dismissed. North Dakota ex rel. Olson v. CMS, 403 F.3d 537 (8th Cir. 2005).

Arizona suggests that this Court go into conflict with the Eighth Circuit, which, it alleges, decided North Dakota based on legislative history alone, and specifically "disregard[ed]" section 402(b) of the IHCIA. Arizona Br. 44-45. But the Eighth Circuit

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Enmons, 410 U.S. 396, 405 n.14 (1973), involved a case where the language in the earlier bill was "the very language subsequently enacted." Here, Arizona alleges only that the statute has "much in common" with the bill, Arizona Br. 41, and that assertion is highly questionable given the dramatically different language they employ. And in Planned Parenthood Fed'n of Am., Inc. v. Heckler, 712 F.2d 650, 658-59 (D.C. Cir. 1983), which is incorrectly characterized by Arizona, the court relied on legislative history of previous similar enacted statutes, not the language of a rejected bill.

[10] Arizona suggests that the Secretary "never raised" his Chevron step one argument "at the administrative level." Arizona Br. 51-52. This contention makes no sense, since the Chevron analysis governs "judicial review of administrative agency interpretations of federal law," The Wilderness Soc'y v. United States Fish & Wildlife Serv., 353 F.3d 1051, 1059 (9th Cir. 2003) (en banc) (emphasis added), and therefore has no effect "at the administrative level." At any rate, nothing in either brief filed by the Secretary in this case is in any way inconsistent with the DAB Decision, and, tellingly, Arizona cites nothing to support its baseless claim that the Secretary has changed his position. See Arizona Br. 51.

specifically (and correctly) relied on the statutory language, North Dakota, 403 F.3d at 539 ("The scope of the Medicaid services reimbursed at the 100 percent FMAP depends on the meaning of 'received through an Indian Health Service facility.'"), and only turned to the legislative history after concluding that "the statutory language is susceptible to multiple interpretations and does little to resolve the present controversy," id. at 540 (emphasis added). In the course of that analysis, the Eighth Circuit specifically addressed (and, indeed, quoted from) IHCIA 402(b) - the specific statutory provision Arizona accuses it of disregarding. See id. As is clear from the full context of the Eighth Circuit's language, because the legislative history was clear and unequivocal (even though the statutory language was not), the court could end its inquiry there and had no need to address the question of deference to the agency:

> Because our inquiry stops if the legislative history explains the statutory language, even when that language would otherwise be ambiguous, we do not reach the matter of what deference we might owe to the relevant agencies' interpretation of the statute. Based on the legislative history alone, we reverse the district courts' judgments.

Id. (citation omitted).

Arizona also criticizes the Eighth Circuit for not addressing the "burdenshifting" concept contained in the legislative history. Arizona Br. 45-46. As noted above, the burdenshifting concept is

highly supportive of the Secretary's interpretation of the statute, and therefore any omission of this concept is harmless. But, more importantly, the way the Eighth Circuit addressed the legislative history was entirely reasonable. It noted that the legislative history contains "unequivocal," "clear and consistent" statements that the special 100% reimbursement rate was limited to services provided in IHS facilities. 403 F.3d at 540. Because, in this case, following that clear, specific, and directly on-point legislative history was both dispositive and consistent with the otherwise ambiguous statutory language, there was simply no need to inquire into who paid for what a quarter of a century ago or, for that matter, how the distinction between Native Americans living on (or near) reservations and "urban" Native Americans might relate to the case at hand. The Eighth Circuit properly concluded that "unequivocal," "clear and consistent," and dispositive legislative history consistent with the statutory language was enough.

## II. ARIZONA FAILS TO DEMONSTRATE THAT THE SECRETARY'S INTERPRETATION IS UNREASONABLE.

Arizona suggests that, in determining the reasonableness of the Secretary's statutory interpretation (vis-a-vis Arizona's interpretation) this Court should not consider the agency's expert opinion that Arizona's interpretation of the statute would be inefficient, costly, and inaccurate. See Arizona Br. 53-54. Arizona's suggestion, unaccompanied by citation, is incorrect. See Verizon Communications, Inc. v. FCC, 535 U.S. 467, 501-02 (2002)

(suggesting that Chevron deference allows agencies to solve practical difficulties); Pension Benefit Guar. Corp. v. LTV Corp., 496 U.S. 633, 651-52 (1990) ("[P]ractical agency expertise is one of the principal justifications behind Chevron deference."); Eisinger v. FLRA, 218 F.3d 1097, 1105 (9th Cir. 2000) (suggesting, in case decided at Chevron step one, that Court would have considered "policy and practical considerations" in a Chevron step two inquiry); AT&T Corp. v. FCC, 220 F.3d 607, 630 (D.C. Cir. 2000) (finding statutory interpretation reasonable under Chevron because it was "the most efficient way to proceed").

While asking this Court to ignore the Secretary's practical concerns, Arizona suggests that this Court should consider its assertion that the Secretary's interpretation is "inescapably awkward in practice." Arizona Br. 31. But the Secretary has applied his interpretation for thirty years now, and no substantial practical problems have emerged, nor is any identified by Arizona. Instead, Arizona argues that it is "awkward" to have a different government payment scheme[11] for IHS facility services and referred services, when which of these types of services a particular Native American receives may be rooted, for example, in whether a particular IHS facility has a staff cardiologist. Arizona Br. 31-

[11] At issue in this case is only the relative burdens on the federal government and Arizona. There is no effect whatsoever on the Native American recipients of Medicaid-covered referred services.

32. But there is nothing remotely "awkward" or unfair about distinguishing between IHS facility services and referred services. IHS facility services, which are provided by the government itself, are, for that reason alone, different from referred services provided by non-governmental providers over which the federal government has no control. The distinction between the funding of such services is enshrined in the payor of last resort rule, which is over a half century old and has been endorsed by this Court, see McNabb v. Bowen, 829 F.2d 787, 792-93 (9th Cir. 1987). The distinction is also recognized by Congress, which separately appropriates funds for referred services provided to Native Americans without any other source of funding (like Medicaid). See, e.g., Pub. L. No. 108-108, 117 Stat. 1241, 1293 (2003), (establishing a $467,046,000 line item in the Indian Health Service budget specifically for referred services).

Arizona suggests that the Secretary's interpretation creates a perverse incentive for IHS facilities to refer services out rather than perform them. Arizona Br. 32. The incentives are, in fact, just the opposite. If an IHS facility performs a Medicaid-covered service in-house, it receives a payment from the State Medicaid Program, which, by law supplements the IHS budget and is used to improve IHS facilities, see IHCIA § 402(c) & (d), but Medicaid payments to the non-IHS referred services providers add nothing to the IHS budget. See DAB Decision 11 & n.5 (ER 34).

Finally, Arizona suggests briefly that the Secretary's interpretation is unreasonable because it is contrary to a position allegedly taken in a single phrase in a 1997 agency regional memorandum. Arizona Br. 15, 55-56. It is implausible on its face to think that the agency would announce an enormous and dramatic change of longstanding policy affecting millions of program dollars and all referred services in an offhand phrase in 4-page regional memorandum whose subject line reads "Provision of Non-Emergency Transportation to Native Americans in Arizona - INFORMATION," and which was only addressed to the associate regional Medicaid administrator for one of Medicaid's ten Regions. See 1997 Regional Memorandum (ER 17).[12]

Nonetheless, the DAB discussed this regional memorandum and related agency statements at length in its decision, see ER 37-49, and concluded that:

> (1) [The agency]'s reasonable and long-standing interpretation of the costs eligible for 100% FMAP was limited to those "received through" an IHS facility which offers, is responsible for and bills Medicaid for the services provided; (2) Arizona was notified of and long operated consistently with the interpretation; (3) [the agency] did not change this policy in its memorandum of May

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[12] Arizona admitted in agency proceedings that the Secretary had originally concluded that the special 100% reimbursement rate was not available for referred services. See DAB Decision 16-17 (ER 39-40) (referring to "services provided to Native Americans by providers other than the [IHS] itself"); Arizona Br. 35 (conceding that referred services are "furnished by non-IHS providers"); id. at 14 (same).

> 1997; (4) Arizona did not reasonably rely on an alternative interpretation; and (5) the costs disallowed here were not eligible for 100% FMAP rate under [the agency]'s interpretation.

DAB Decision 26-27 (ER 49-50). Arizona does not challenge these findings generally,[13] but relies (in a footnote) solely on its assertion that the DAB's linguistic analysis of the 1997 regional memorandum is faulty. See Arizona Br. 55 n.17. Not only is Arizona's narrow linguistic analysis erroneous, but Arizona simply and completely ignores the majority of the reasons the DAB gave for rejecting Arizona's reading of the 1997 regional memorandum. That analysis puts the 1997 regional memorandum in its proper context, not only as a memorandum addressing a very narrow issue (emergency transportation) in a single state (Arizona) but also as a memorandum that followed (and was succeeded by) years of clear statements by the agency, clearly understood by Arizona, that the

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[13] It does, however, simply make statements of fact contrary to the DAB's findings without citing any source. E.g., compare, Arizona Br. 56 (asserting, without citation, that, "the 1997 issuance [memorandum?] plainly represented a deliberate decision by the agency to expand its previous interpretation of the 100% FMAP provision.") and id. at 3 (asserting, without citation, that "CMS advised the State that after reevaluating the issue, the agency had decided that it no longer endorsed its policy announced in 1997 authorizing 100% reimbursement for IHS referred services") (emphasis added), with DAB Decision 22 (ER 45) ("The May 1997 HCFA Memorandum did not herald a change in policy on Medicaid payments to non-IHS contract care facilities") and id. (the 1997 memorandum was "consistent with HCFA's long practice") and id. at 26 (ER 49) (noting that the agency's longstanding policy excluded referred services from the special 100% reimbursement rate and that the agency "did not change this policy in its memorandum of May 1997").

special 100% reimbursement rate did not apply to referred services. See DAB Decision 14-26 (ER 37-49).[14] Nothing in the 1997 regional memorandum provides any indication whatsoever that the Secretary's interpretation of the IHCIA is unreasonable.

**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.

Respectfully submitted,

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[14] Arizona chides the Secretary for holding its years-long effort to change his interpretation against it. See Arizona Br. 54. But these efforts are important, as the DAB recognized, because they demonstrate that Arizona was well aware of the agency's position on this issue, rendering unreasonable its allegation that it believed that the 1997 regional memorandum had announced a reversal. See DAB Decision 24 (ER 47); accord id. at 21 (ER 44) (holding that "for many years prior to 1993 Arizona admittedly knew of [the agency]'s position that claims such as those at issue were not reimbursable [at the special 100% rate]," and that subsequent policy statements "reinforced rather than overturned the notice that Arizona had").

**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 reply 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 6,432 words.

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January 11, 2006

**CERTIFICATE OF SERVICE**

I hereby certify that on January 11, 2006, I served the foregoing REPLY 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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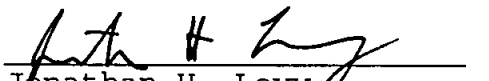

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