No. 11-16334

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

QUECHAN TRIBE OF THE FORT YUMA INDIAN RESERVATION,

Plaintiff-Appellant,

v.

UNITED STATES, et al.,

Defendants-Appellees.

On Appeal from the United States District Court
for the District of Arizona,
Case No. 10-2261

BRIEF FOR APPELLEES

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TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES

Cases: **Page**

Statutes:

Regulations:

Other Authorities:

JURISDICTIONAL STATEMENT

Plaintiff invoked the jurisdiction of the district court under 28 U.S.C. §§ 1331, 1361, and 1362 and the Administrative Procedure Act, 5 U.S.C. § 702. ER 15-16 (First Am. Compl. (FAC) ¶ 4).[1] The district court granted the United States's motion to dismiss on March 31, 2011. ER 39-40. Plaintiff filed a timely notice of appeal on May 27, 2011. ER 40. This Court has jurisdiction pursuant to 28 U.S.C. § 1291.

STATEMENT OF THE ISSUES

Plaintiff-appellant Quechan Tribe seeks declaratory, mandamus, and injunctive relief requiring the Indian Health Service ("IHS") to fund improvements in the IHS clinic that provides free outpatient care to the Tribe. The questions presented are:

1. Whether the district court correctly held that plaintiff failed to identify any legal basis for compelling the relief it seeks.

2. Whether the district court correctly held that the government's operation of the clinic does not implicate plaintiff's rights to due process or equal protection under the Constitution.

[1] Citations to "ER __" are to the plaintiff-appellant's excerpts of record.

PERTINENT STATUTORY PROVISIONS

Pertinent statutory provisions are reproduced in the addendum to this brief.

STATEMENT OF THE CASE

Plaintiff Quechan Tribe of the Fort Yuma Indian Reservation, a federally recognized Indian tribe, brought this suit challenging IHS's operation of a medical clinic that offers free services to all eligible American Indians and Alaska Natives (collectively, "eligible Indians"). The clinic is located at Fort Yuma, and members of the Quechan and Cocopah Tribes are the primary recipients of the clinic's services. Plaintiff principally asserted that IHS is violating a duty "to provide and allocate available funding to maintain and operate [the clinic's services and facilities] at or above minimum, generally accepted, standards of professional medical care," ER 27-28 (FAC ¶ 88), and sought declaratory relief, as well as a writ of mandamus and an injunction to compel IHS to "take sufficient measures" to meet such standards. ER 31 (FAC ¶ 112).

The district court dismissed plaintiff's claims. ER 13. The court held that neither the statutes cited by plaintiff nor trust doctrine imposes a legal duty supporting plaintiff's claims, ER 5-10, and that IHS's operation of the clinic does not offend the Constitution. ER 11-13. The court further concluded that

IHS's allocation of Congress's lump-sum appropriations for the agency's medical programs and facilities is committed to agency discretion and therefore not subject to judicial review under the Administrative Procedure Act ("APA"). ER 10-11.

STATEMENT OF FACTS

A. Statutory Background

Indian Health Service is an agency of the U.S. Department of Health and Human Services that provides health services to American Indians and Alaska Natives. 25 U.S.C. § 1661. Its authority derives from the Snyder Act of 1921, 25 U.S.C. § 13, and the Indian Health Care Improvement Act of 1976, as amended, 25 U.S.C. § 1601 *et seq.*

The Snyder Act authorizes IHS to "direct, supervise, and expend such moneys as Congress may from time to time appropriate, for the benefit, care, and assistance of the Indians throughout the United States" for purposes including "relief of distress and conservation of health." 25 U.S.C. § 13.[2]

The Indian Health Care Improvement Act ("IHCIA") authorizes a general fund to promote Indian health and establishes a number of specific programs. The first two sections of the Act set forth legislative findings and

[2] The Snyder Act originally addressed the Bureau of Indian Affairs under the supervision of the Secretary of the Interior. Congress has since transferred the Act's health services authorization to the Department of Health and Human Services, which established IHS. Transfer Act of 1954, 42 U.S.C. § 2001 *et seq.*

aims, and state that "it is the policy of this Nation" to seek "to ensure the highest possible health status for Indians . . . and to provide all resources necessary to effect that policy." 25 U.S.C. § 1602(1); *see id.* § 1601(3) (observing that "[a] major national goal of the United States is to provide the quantity and quality of health services which will permit the health status of Indians to be raised to the highest possible level").

Next, the Act authorizes the creation of a fund for health services, and states that the "Secretary [of Health and Human Services], acting through [IHS], is authorized to expend funds . . . for the purposes of"—among other objectives—"eliminating the deficiencies in health status and health resources of all Indian tribes." 25 U.S.C. § 1621(a)(1).

The remaining sections of the IHCIA address a variety of standards and initiatives—from establishing a loan repayment program for certain health care professionals employed by IHS, 25 U.S.C. § 1616a, to requiring certain steps be taken before IHS may construct a new facility, 25 U.S.C. § 1631. As discussed below, none of these provisions, 25 U.S.C. §§ 1611-1683, are at issue in this case.

Pursuant to the Snyder Act and the IHCIA, Congress annually appropriates funds to IHS principally in two lump sums—for services and for facilities. *See, e.g.*, Consolidated Appropriations Act, 2014, Pub. L. No. 113-76,

128 Stat. 5, 328-30. These appropriations generally do not earmark funds for particular tribes or IHS facilities. *See ibid.*

Although Congress generally does not earmark funds for particular new facility construction projects, it is aware of IHS's needs; the agency informs Congress of its construction project priorities, *see* 25 U.S.C. § 1631(c). The sum cost of all the agency's priority projects, however, far exceeds the funding appropriated by Congress. *See, e.g.*, Indian Health Serv., *Report to Congress on Estimated Need for Tribal and Indian Health Service Health Care Facilities* 5-6 (2011), http://www.ihs.gov//newsroom/includes/themes/newihstheme//display_objects/documents/RepCong_2012/47447-1_IHS_Facilities_Final_Report_3-22-11_640pm.pdf (explaining that 22 of the 61 IHS health centers nationwide were more than 40 years old). As of 2011, the cost of the agency's seventeen priority projects totaled $2.5 billion (and the agency's total facilities need totaled $8.4 billion). *Id.* at 8, 13. Congressional funding for construction, however, has averaged $63 million per year in the past five years. Dep't of Health & Human Servs., *Fiscal Year 2015 Indian Health Service: Justification of Estimates for Appropriations Committees* 152-53 (2014), http://www.ihs.gov/budgetformulation/includes/themes/newihstheme/documents/FY2015CongressionalJustification.pdf. For the upcoming fiscal year, the IHS budget justification contains $46 million for construction of a new Fort Yuma facility. *Id.* at 153-54.

B. Factual Background

IHS delivers free health services to 2.2 million eligible Indians through three mechanisms. First, tribes and tribal organizations can contract with IHS to independently operate health care delivery programs under the Indian Self-Determination and Education Assistance Act. Second, IHS provides health care services directly, either at its own facilities or through the purchase of care from third party providers. As particularly relevant here, IHS administers health care services at 123 of its own facilities (28 hospitals, 61 health centers, and 34 health stations) across the country. Each of these facilities is operated by an IHS "service unit," an administrative entity with responsibility for planning, managing, and evaluating the IHS programs serving a defined geographic area. Third, IHS offers resource centers and health care programs for urban Indians. *See* Indian Health Serv., *IHS Year 2014 Profile* (Jan. 2014), http://www.ihs.gov/newsroom/factsheets/ihsyear2014profile/; Dep't of Health & Human Servs., *Indian Health Service Circular No. 88-02* (Mar. 25, 1988), http://www.ihs.gov/ihm/index.cfm?module=dsp_ihm_circ_main&circ=ihm_circ_8802.

One of IHS's service units, the Fort Yuma Service Unit, operates an ambulatory care clinic, the Fort Yuma Indian Health Center, which serves members of the federally recognized Quechan and Cocopah Tribes, as well as other eligible Indians seeking services at the clinic. ER 17-18 (FAC ¶ 15-16);

ER 22 (FAC ¶ 44). As an ambulatory care facility, the Fort Yuma Indian Health Center ("the clinic") is open during normal business hours, and the services offered include primary medical care, diagnostic testing, simple radiography, pharmacy services, dental services, health education, and behavioral health. IHS purchases more advanced care for tribe members at a nearby nonfederal facility, the Yuma Regional Medical Center. If needed, patients may also obtain care at other IHS facilities, such as the Phoenix Indian Medical Center, an IHS-operated hospital that provides a comprehensive range of specialty services. *See* Indian Health Serv., *Phoenix Area: Fort Yuma Service Unit*, http://www.ihs.gov/Phoenix/index.cfm?module=dsp_phx_hf_ftYuma; *see also* ER 21 (FAC ¶ 38).

C. District Court Proceedings

1. In 2010, plaintiff Quechan Tribe brought this suit alleging that IHS is violating a legal duty to provide a certain level of health services and facilities to the Tribe. ER 31 (FAC ¶ 112). Plaintiff claimed that such an obligation arises from the Snyder Act, the IHCIA, and the general trust relationship between the federal government and Indian tribes. ER 25 (FAC ¶ 66). Plaintiff also claimed that the United States breached duties to maintain trust property and to fulfill a fiduciary patient-physician relationship. ER 26-27 (FAC ¶¶ 74-84). In addition to alleging violations of the Administrative Procedure Act, plaintiff also alleged

violations of Tribe members' rights to due process and equal protection. ER 27-29 (FAC ¶¶ 85-103). Plaintiff sought a writ of mandamus, a declaratory judgment, and an injunction ordering the United States to improve the services and facilities offered at Fort Yuma. ER 31-32 (FAC ¶ 112).

2. Plaintiff's complaint broadly challenges the adequacy of services provided by the clinic. The complaint's only specific allegation supporting these claims describes an isolated event in 2009 when IHS became aware that certain instruments at the clinic had been sterilized using an improper technique. ER 24 (FAC ¶ 58). IHS immediately corrected the instrument treatment techniques. The agency also contacted and offered testing to all patients who might have been exposed to any contagion. Defs.' Mot. Dismiss First Am. Compl. 3 n.2. It is undisputed that no patient tested positive, and there are no continuing allegations of improper sterilization.

Plaintiff's complaint also challenges the adequacy of the clinic's facilities, asserting the following concerns: the building's age and size, the building's potential exposure to earthquakes, the clinic's lack of a CT scan machine, and floors that are allegedly difficult to keep sanitized. ER 20-22 (FAC ¶¶ 32-43). The complaint does not allege, however, that any of these concerns violate any express requirements of federal law, and the clinic maintains accreditation from the Accreditation Association for Ambulatory Health Care. Accreditation Ass'n

for Ambulatory Health Care, Inc., *Accredited Organization Detail*, http://eweb.aaahc.org/eweb/Dynamicpage.aspx?site=aaahc_site&webcode=accred_org_detail&org_cst_key=d89154b7-d9ad-46e1-a23f-1dc19c4411c9.

3. The district court dismissed plaintiff's claims. The court noted that "[t]he general trust relationship between the United States and Indian tribes, alone, is insufficient to create legal obligations" unless a statute "establishes specific legal duties." ER 6-7. The court held that neither the Snyder Act nor the IHCIA established such duties. The Snyder Act, the court found, "consists of extremely broad language" authorizing expenditures, and that providing a specific level of facilities, equipment, or services is "not a legal obligation" under that Act. ER 7. Similarly, the court found that the "broad policy language" of the IHCIA "does not . . . impose any specific duties on defendants." ER 8. The court recognized that "[w]ithout specific statutory entitlement, there is no claim." ER 8-9. The court examined the particular provisions of the IHCIA cited by the plaintiff, but found that those did not impose mandatory duties and, in any event, were not alleged to have been violated. ER 9 & n.2. Finally, the court also rejected plaintiff's claims that IHS breached fiduciary obligations to preserve trust property and to serve as a health care provider. ER 9. The court explained that the IHS's Fort Yuma

clinic is not a tribal asset held in trust, and that IHS does not have a physician-patient relationship with the Tribe. ER 9-10.

The court observed that "plaintiff is really challenging defendants' lack of funding at Ft. Yuma." ER 11. The court explained: "There is no statutory mandate that defendants provide a certain minimal level of health care to Indians. Congress appropriates what it wants to and commits to agency discretion how to distribute [those funds for different services and facilities]." *Ibid.* (noting IHS's expertise in evaluating health care facilities). Citing *Lincoln v. Vigil*, 508 U.S. 182 (1993), and *Norton v. Southern Utah Wilderness Alliance*, 542 U.S. 55 (2004), the court concluded that "plaintiff's claims fall outside the scope of judicial review under the APA." ER 11. Likewise, because IHS is not under a "mandatory, nondiscretionary duty to provide a minimal level of health care, plaintiff's request for a writ of mandamus [was] denied." *Ibid.*

The court also dismissed plaintiff's constitutional claims. It noted that due process only requires the government to provide health services "[i]n limited circumstances where a special relationship exists," an exception that generally "applies only when the government has placed a person in custody." ER 12. The court noted that "[n]o such special relationship exists here," *ibid.*, and explained that "[t]he government has broad discretion to allocate funds for discretionary programs without violating equal protection rights." ER 13.

The court concluded by observing that, at bottom, plaintiff's complaint "raise[s] … policy issues as to the proper allocation of resources for Indian health care." ER 13. The court noted that plaintiff is one of many tribes "competing for [these] scarce resources," and that the "political process"—not the courts—is ultimately best suited to address plaintiff's concerns and interests.[3]

SUMMARY OF ARGUMENT

1. Plaintiff alleges that IHS has not met an obligation to provide services and facilities at "minimum, generally accepted standards" at the Fort Yuma medical clinic, and seeks an injunction and mandamus to compel the agency to "take sufficient measures" to meet these standards. ER 31 (FAC ¶ 112).

The district court properly held that plaintiff had identified no legal basis to support such relief. Plaintiff presents the type of broad challenge and requests the type of relief precluded by *Norton v. Southern Utah Wilderness Alliance*, 542 U.S. 55 (2004), in which the Supreme Court made clear that a plaintiff seeking to compel agency action must identify "a *discrete* agency action that [the agency] is *required to take*." *Id.* at 64. Plaintiff identifies no such discrete action required by federal law that IHS has failed to take at Fort Yuma.

[3] The court also distinguished the Tribe's present suit from potential suits by Tribe members in the event of medical malpractice; the court explained that such suits would arise under the Federal Tort Claims Act and raise the question of a duty of care under the "law of the place." *See* ER 10, 13.

The district court also correctly recognized that the reordering of IHS's budgetary priorities, which plaintiff seeks to compel, is not authorized by the APA. *See Lincoln v. Vigil*, 508 U.S. 182, 191-93 (1993). Congress has committed to IHS's discretion the allocation of resources across the agency's services by appropriating lump-sum funds under a broad statutory mandate to provide health services to Indians. Plaintiff identifies no other pertinent constraint on IHS's discretion that Congress has authorized courts to apply.

Plaintiff's invocation of the Snyder Act, the IHCIA, and the general federal-Indian trust relationship is unavailing. As the district court held, none of these sources of law establish any discrete and mandatory agency action that IHS has failed to take and that a court could compel.

2. The district court also correctly held that the Due Process and Equal Protection Clauses of the Constitution do not entitle plaintiff to the requested relief. Due process creates no affirmative obligation to provide government-funded health care in a certain manner in this case, where no custodial relationship exists. *See DeShaney v. Winnebago Cnty. Dep't of Soc. Servs.*, 489 U.S. 189, 196-98 (1989). And, as the district court explained, IHS has "broad discretion to allocate funds for discretionary programs without violating equal protection rights." ER 13 (rejecting plaintiff's contention that it is irrational to allocate varying funds for health care services and programs to different tribes).

STANDARD OF REVIEW

This Court reviews *de novo* a district court's dismissal for lack of subject matter jurisdiction and for failure to state a claim on which relief may be granted. *See Ctr. for Policy Analysis on Trade & Health v. Office of U.S. Trade Representative*, 540 F.3d 940, 944 (9th Cir. 2008); *Coto Settlement v. Eisenberg*, 593 F.3d 1031, 1034 (9th Cir. 2010).

ARGUMENT

I. THE DISTRICT COURT CORRECTLY CONCLUDED THAT IT COULD NOT COMPEL THE AGENCY ACTION PLAINTIFF SEEKS.

A. A Court May Compel Agency Action Only To Enforce a Legal Duty That Is Both Discrete and Mandatory.

1. Plaintiff's complaint broadly alleges that IHS has failed "to ensure that the health care services provided within the Fort Yuma Service Unit do not fall below the minimum, generally accepted, standards of professional medical care." ER 31 (FAC ¶ 112); *see, e.g.*, ER 28 (FAC ¶ 89) (alleging that failure to allocate more money to the Fort Yuma Service Unit was arbitrary and capricious).[4] Citing the age and size of the clinic, the lack of a CT scan machine, and the potential for damage by earthquakes, plaintiff claims that the current facilities are unsafe and inadequate, and complains of IHS's "failure to

[4] Plaintiff challenges only the direct services offered by the Fort Yuma Service Unit at the Fort Yuma Indian Health Center, not the services provided by third party providers and paid for by IHS.

construct a new adequate facility." ER 21-22 (FAC ¶¶ 34, 41, 43, 49). Plaintiff also asserts that "[t]he United States fails to adequately staff, train, and supervise personnel" at the clinic. ER 24 (FAC ¶ 56).

The relief requested is equally broad: plaintiff has asserted that "the Tribe is entitled to seek a declaratory order defining IHS's minimum duties and obligations with respect to its provision of health-care on the Fort Yuma Indian Reservation," and is "also entitled to pursue appropriate equitable relief to ensure the United States' compliance with its duties." Plaintiff-Appellant's Brief ("Pl. Br.") 25-26. Plaintiff asked the district court to invoke its equitable and mandamus powers to compel IHS "to take sufficient measures" to ensure that the facilities and services at Fort Yuma comport with plaintiff's asserted standards—"minimum, generally accepted, standards of professional medical care." ER 31 (FAC ¶ 112); *see* ER 23 (FAC ¶ 52).

Because federal law does not supply such standards, plaintiff has suggested that the district court fashion the standards that IHS must meet. Pl. Br. 4-5 (requesting an injunction ordering IHS to meet "appropriate minimum standards of care to be determined at trial," and suggesting that "[a]ppropriate relief may include" ordering repair of floor tiles, seismic retrofitting, and recruiting of new personnel); *see id.* at 50 (urging a remand to allow the district court to "take evidence on what minimum standards of care apply, and to

determine whether the United States' practices at [Fort Yuma] meet those standards and what corrective action may be appropriate").

2. The Administrative Procedure Act, 5 U.S.C. § 706(1), authorizes courts to "compel agency action unlawfully withheld or unreasonably delayed." The Supreme Court has stressed the limits of this authority, explaining that courts may only order action where an agency has "failed to take a *discrete* agency action that it is *required to take*." *Norton v. Southern Utah Wilderness Alliance*, 542 U.S. 55, 64 (2004) (emphasis in original) (describing such actions as "ministerial or non-discretionary"). As the Court has emphasized, under the APA courts are not "empowered to enter general orders compelling compliance with broad statutory mandates." *Id.* at 66.

Thus, as this Court has repeatedly observed, "[e]ven if a court believes that the agency is withholding or delaying an action the court believes it should take, the 'ability to compel agency action is carefully circumscribed to situations where an agency has ignored a specific legislative [or regulatory] command.'" *Gardner v. U.S. Bureau of Land Management*, 638 F.3d 1217, 1221-22 (9th Cir. 2011) (quoting *Hells Canyon Preservation Council v. U.S. Forest Serv.*, 593 F.3d 923, 932 (9th Cir. 2010) ("*Hells Canyon*")); *see, e.g.*, *Zixiang Li v. Kerry*, 710 F.3d 995, 1004 (9th Cir. 2013) (explaining that there is no judicial authority to compel agency action "merely because the agency is not doing something [the plaintiff

or the court] may think it should do"); *Our Children's Earth Found. v. EPA*, 527 F.3d 842, 851 (9th Cir. 2008) ("To compel agency action . . . , [plaintiff] must point to a nondiscretionary duty that is readily-ascertainable, and not only ... the product of a set of inferences based on the overall statutory scheme." (internal quotation marks omitted)).

This limitation on judicial review—derived from "the traditional limitations upon mandamus"—aims "to protect agencies from undue judicial interference with their lawful discretion, and to avoid judicial entanglement in abstract policy disagreements which courts lack both expertise and information to resolve." *Southern Utah Wilderness Alliance*, 542 U.S. at 66; *see also Hells Canyon*, 593 F.3d at 932 ("[T]he purportedly withheld action must not only be 'discrete,' but also 'legally *required*'—in the sense that the agency's legal obligation is so clearly set forth that it could traditionally have been enforced through a writ of mandamus.").

Moreover, even when a litigant challenges a final agency action that would generally be subject to judicial review, the APA precludes review where the "agency action is committed to agency discretion by law." 5 U.S.C. § 701(a)(2). *See California v. United States*, 104 F.3d 1086, 1093-94 (9th Cir. 1997). The Supreme Court has explained that where a "statute is drawn so that a court would have no meaningful standard against which to judge the agency's

exercise of discretion," "the statute ('law') can be taken to have 'committed' the decisionmaking to the agency's judgment absolutely." *Heckler v. Chaney*, 470 U.S. 821, 830 (1985) (citation omitted).

As particularly relevant here, the Supreme Court has held that the APA "gives the courts no leave to intrude" when an agency "allocates funds from a lump-sum appropriation to meet permissible statutory objectives." *Lincoln v. Vigil*, 508 U.S. 182, 193 (1993) (citing 5 U.S.C. § 701(a)(2)). Such allocation decisions require the agency to consider, for instance, "whether [the agency's] resources are best spent on one program or another . . . [and] whether the agency has enough resources to fund a program at all." *Ibid.* (citation omitted) (internal quotation marks omitted). For these considerations, "the agency is far better equipped than the courts to deal with the many variables involved in the proper ordering of its priorities." *Ibid.* (citation omitted) (internal quotation marks omitted); *see Los Coyotes Band of Cahuilla & Cupeño Indians v. Jewell*, 729 F.3d 1025, 1038 (9th Cir. 2013).

B. Plaintiff Does Not Seek Specific Enforcement of a Clear Statutory Duty, and the Grounds on Which Plaintiff Relies Do Not Furnish a Basis for Its Suit.

1. Plaintiff here seeks the type of relief precluded by the Supreme Court's decision in *Southern Utah Wilderness Alliance*. Plaintiff does not identify any discrete, legally required action that IHS has failed to take at Ft. Yuma.

Rather than point to a "specific legislative command," *Hells Canyon*, 593 F.3d at 932, plaintiff asks for programmatic improvement and suggests that the district court fashion relevant standards. *E.g.*, Pl. Br. 4-5.

Plaintiff's claims likewise disregard the principles emphasized in *Lincoln*, which preclude a court from reordering budget priorities. IHS receives its annual appropriations principally in two lump sums for facilities and services, and the agency allocates these funds in a manner consistent with its general mandate to promote Indian health throughout the United States to the greatest degree practicable. *See* 25 U.S.C. § 13; *see also* 25 U.S.C. § 1601(3). Plaintiff's request for an order requiring IHS to furnish new (or renovated) facilities, equipment, personnel, and services at Fort Yuma ignores both Congress's decision to commit allocation determinations to agency discretion and the complexity of those determinations given the limited funds "Congress may from time to time appropriate," 25 U.S.C. § 13. *See supra* 5 (describing limited funds). As the district court emphasized, there is no suggestion here that IHS is allocating available funds for "things other than Indian health care." ER 11; *see Lincoln*, 508 U.S. at 193 (requiring only that an agency allocate lump sum appropriations consistent with "permissible statutory objectives").

Moreover, as a threshold matter, the district court correctly held that plaintiff failed to identify a "substantive source of law that mandates [the]

declaratory and equitable relief" it seeks. Pl. Br. 20; *see* ER 7-9, 11. Plaintiff maintains that the Snyder Act and the Indian Health Care Improvement Act, "as supported by the [government's] special fiduciary trust obligations to Indians," obligate the United States "to ensure Indians receive health care," Pl. Br. 19, and urges that the United States's "[i]mplicit" duty to "conform[] to baseline, minimum standards of care" is sufficient to compel the specific relief the Tribe seeks, *id.* at 18-19.

But even accepting plaintiff's suggestion of a general assumed obligation to support the health care of all Indians, none of the grounds plaintiff invokes, whether taken individually or together, obligate IHS to establish and maintain a clinic at Fort Yuma, let alone create a "nondiscretionary or ministerial" obligation, *Southern Utah Wilderness Alliance*, 542 U.S. at 64, to "take sufficient measures" to meet as-yet undefined standards for the Ft. Yuma clinic's facilities, equipment, services and personnel. ER 31 (FAC ¶ 112); *see* Pl. Br. 4-5, 50 (suggesting that the district court may determine the "minimum standards of care," and then compel IHS to comply with the court-determined standards).[5]

[5] As the district court explained and as we discuss below, no "standards of care" can be identified and enforced under the Snyder Act or IHCIA. The court properly recognized that such a concept sounds in tort, and an individual tribe member injured by medical malpractice may pursue relief under the Federal Tort Claims Act. ER 10. But even in such an action, a court could not order the kind of reordering of agency budgeting priorities that plaintiff seeks here. *See* 28 U.S.C. 2680(a).

As the district court observed, the Supreme Court's 1993 decision in *Lincoln v. Vigil* is particularly instructive. There, the plaintiffs challenged IHS's decision to discontinue a health services program for handicapped Indian children, and argued that the decision violated the same three sources of law cited by plaintiff here—the Snyder Act, the IHCIA, and general principles derived from the federal government's trust relationship with Indians. Rejecting these contentions, the Supreme Court held that the statutes conferred broad discretion on IHS and that judicially enforceable, "legally binding" programming obligations could not be inferred—regardless of legislative history or any general trust relationship. *Lincoln*, 508 U.S. at 192, 194-195.

In holding the agency's decision unreviewable, the *Lincoln* Court explained that "the appropriations Acts for the relevant period do not so much as mention the program, and both the Snyder Act and the Improvement Act [IHCIA] likewise speak about Indian health only in general terms." 508 U.S. at 193-94. The Court emphasized that Congress required only that IHS serve a broad "statutory mandate to provide health care to Indian people," and plaintiffs did "not seriously contend" that the agency had conducted itself otherwise. *Id.* at 194. In addition, the Court held that "[w]hatever the contours of [the federal-Indian trust] relationship, . . . it could not limit the Service's discretion to reorder its priorities" by shifting funds to a particular group of

Indian beneficiaries. *Id.* at 195; *see id.* at 194-95 (expressly rejecting the appellate court's view that the general trust relationship "imposed a separate limitation on [IHS's] discretion" and citing *Hoopa Valley Tribe v. Christie*, 812 F.2d 1097, 1102 (9th Cir. 1986) (explaining that where the United States has a fiduciary obligation, it is one "owed to all Indians" generally, not to be discharged by an agency to the benefit of a particular tribe or group at the expense of others)).

The Supreme Court's analysis in *Lincoln* applies with full force here. The balancing of nationwide Indian health needs and priorities involved in the budgeting decisions at issue here has been committed to agency expertise and discretion. IHS's programs and services promote the agency's broad mandate and therefore fall within the only relevant limit Congress has placed on the agency's discretion. ER 11 (explaining that "'as long as the agency allocated funds from a lump-sum appropriation to meet permissible statutory objectives … courts [have] no leave to intrude'" (quoting *Lincoln*, 508 U.S. at 193)). As the district court recognized, plaintiff "does not allege that defendants are using money appropriated [by Congress] for things other than Indian health care." *Ibid.* Absent any discrete, nondiscretionary legal requirement for IHS to provide the various programmatic improvements (e.g., renovated facilities, additional

equipment, expanded services) that plaintiff requests, plaintiff fails to state a claim for relief.[6]

Below we address each of the potential sources of substantive law plaintiff invokes—the Snyder Act, the IHCIA, and trust doctrine—in turn.

2. Although plaintiff urges that the Snyder Act creates an "affirmative duty" that has been violated by IHS, Pl. Br. 20, the Act simply authorizes IHS to "expend such moneys as Congress may from time to time appropriate" for a variety of purposes, including the "relief of distress and conservation of health." 25 U.S.C. § 13. As this Court has explained, this "broad language" authorizes "IHS activity in the Indian health area," but does not require any discrete agency conduct. *McNabb v. Bowen*, 829 F.2d 787, 792 (9th Cir. 1987) (finding that the Act provides only a general mandate). It thus does not create any judicially enforceable obligation. *See also Vigil v. Andrus*, 667 F.2d 931, 934 (10th Cir. 1982) (finding that the language of the Snyder Act "is too broad to support" a legal obligation to provide a particular service). *See generally, e.g.*, *Sea*

[6] In addition to the APA, plaintiff invokes the Declaratory Judgment Act as an alternate cause of action. ER 30 (FAC ¶¶ 104-106). This does nothing to advance its case because "[t]he availability of [declaratory] relief presupposes the existence of a judicially remediable right." *Schilling v. Rogers*, 363 U.S. 666, 677 (1960); *see also, e.g.*, *N. Cnty. Commc'ns Corp. v. Cal. Catalog & Tech.*, 594 F.3d 1149, 1161 (9th Cir. 2010); *Fiedler v. Clark*, 714 F.2d 77, 79 (9th Cir. 1983). Further, as explained, the trust relationship supplies no free-floating cause of action here. *See, e.g.*, *Lincoln*, 508 U.S. at 194-195; *Marceau v. Blackfeet Housing Authority*, 540 F.3d 916, 927 (9th Cir. 2008).

Hawk Seafoods, Inc. v. Locke, 568 F.3d 757, 767 (9th Cir. 2009) (explaining that authority to take action or even a requirement that an agency consider taking action is not sufficiently "discrete or legally required" to be compelled).

Similarly, in *Southern Utah Wilderness Alliance*, the Supreme Court rejected the plaintiff's reliance on a statute that mandated that the Bureau of Land Management "preserve wilderness and manage public lands in accordance with land use plans," holding that "its mandates are not tantamount to a 'specific statutory command requiring' agency action." *Gardner*, 638 F.3d at 1222 (quoting *Southern Utah Wilderness Alliance*, 542 U.S. at 71). Likewise, this Court in *Gardner* held that other provisions of the same statute gave "authority and direction" to the Bureau of Land Management, but still were not sufficiently specific as to make agency inaction reviewable. *Id.* at 1220, 1221.

3. Compared with the Snyder Act, the Indian Health Care Improvement Act offers a "more detailed expression of congressional intent regarding Indian health care," *McNabb v. Bowen*, 829 F.2d 787, 792 (9th Cir. 1987), but—as the Supreme Court subsequently observed in *Lincoln*—even the IHCIA "speak[s] about Indian health only in general terms." *Lincoln*, 508 U.S. at 194.

The first two sections of the IHCIA, which set out findings and declare a "national Indian health policy," 25 U.S.C. §§ 1601-1602, announce Congress's aim "to ensure the highest possible health status for Indians" and "to provide

all resources necessary to effect that policy." 25 U.S.C. § 1602(1). As the district court recognized, this "broad policy language . . . does not create a private right of action or impose any specific duties" that could be judicially enforceable. ER 8.[7]

The IHCIA authorizes IHS to establish a fund for health services (the Indian Health Care Improvement Fund), but does not thereby oblige IHS to provide specific services in a specific manner. *See* 25 U.S.C. § 1621. The Act neither promises congressional appropriations of any particular level, nor requires IHS to allocate monies to the Fund. Under this section, IHS "is authorized to expend funds" for purposes including "eliminating the deficiencies in health status and health resources of all Indian tribes." *Ibid.* Thus, like the Snyder Act, this provision allows spending consistent with broad

[7] *Marceau v. Blackfeet Housing Authority*, 540 F.3d 916 (9th Cir. 2008), cited by plaintiff for the proposition that congressional goals can create legal obligations, is inapposite. The statute in that case required the government agency to "exercise [its] powers . . . in such manner as will encourage and assist . . . the production of housing of sound standards of design, construction, livability, and size for adequate family life." *Id.* at 925 (quoting 42 U.S.C. § 1441). The Court stated that this specifically articulated standard (which has no counterpart in the IHCIA) bound the agency, *see ibid.*, but dismissed the plaintiff Indian tribe's claim that the agency had a responsibility to manage and maintain Indian housing because neither this standard nor any other statute clearly required the agency to do so. *Id.* at 927. *See generally, e.g.*, *Lyng v. Nw. Indian Cemetery Prot. Ass'n*, 485 U.S. 439, 455 (1988) (expression of congressional policy with respect to American Indian Religious Freedom Act insufficient to show Congress' "intent to create a cause of action or any judicially enforceable individual rights").

purposes, but does not mandate any discrete agency action that a court could compel. As the district court explained, the statute's general exhortation to improve Indian health does not provide judicial authority to order IHS to provide particular building renovations, equipment purchases, or other relief plaintiff seeks. *See* ER 8-9.

Nor do the two additional IHCIA provisions cited in plaintiff's complaint provide any grounds for relief. ER 19-20 (FAC ¶¶ 27-28). The first provision states that, before expending funds "appropriated for the planning, design, construction or renovation of facilities" under the Snyder Act, IHS shall consult with the affected Indian tribe and, "whenever practicable," a newly constructed or renovated building shall meet the standards of the Joint Commission on Accreditation of Health Care Organizations. 25 U.S.C. § 1631(a)(2). As the district court noted, plaintiff makes no allegations relevant to this provision, which—in any event—expressly affords the agency discretion. ER 9.

The second provision cited charges the Director of IHS with ensuring that "agency directors, managers, and chief executive officers" have appropriate qualifications "to competently fulfill the duties of the positions and the mission of the [Indian Health] Service." 25 U.S.C. § 1661(c)(2). This general provision

has no applicability to this case, where there are no allegations related to such personnel or to any failure by the Director with regard to such personnel. *Ibid.*[8]

4. The general federal-Indian trust relationship does not transform the broad provisions of the Snyder Act and the IHCIA into judicially enforceable requirements with regard to the operation of the Fort Yuma clinic. The trust relationship "does not impose a duty on the government to take action . . . 'unless there is a specific duty that has been placed on the government with respect to Indians'" by statute. *Gros Ventre Tribe v. United States*, 469 F.3d 801, 810 (9th Cir. 2006) (quoting *Morongo Band of Mission Indians v. FAA*, 161 F.3d 569, 574 (9th Cir. 1998)). Thus, "[t]he Government assumes Indian trust responsibilities only to the extent it expressly accepts those responsibilities by statute." *United States v. Jicarilla Apache Nation*, 131 S. Ct. 2313, 2325 (2011) ("*Jicarilla*").

To determine whether a statute imposes an actionable fiduciary obligation, "a court's analysis . . . 'must train on specific rights-creating or duty-imposing statutory or regulatory prescriptions.'" *Marceau v. Blackfeet Hous. Auth.*, 540 F.3d 916, 923 (9th Cir. 2008) (quoting *United States v. Navajo Nation*, 537 U.S. 488, 506 (2003) ("*Navajo Nation I*")) (dismissing trust claim). No such

[8] Plaintiff's brief cites a number of IHCIA provisions and implementing regulations setting out conditions or requirements not relevant here. *See* 25 U.S.C. §§ 1616(a), 1616(b)(1), 1638e(c)(1), 1645, 1647a; 42 C.F.R. §§ 136.104(c)(1), 136.105, 136.110(b)(4).

obligation exists where the statute "does not unambiguously provide that the United States has undertaken full fiduciary responsibilities." *United States v. Mitchell*, 445 U.S. 535, 542 (1980) ("*Mitchell I*").

Considering a land allotment statute that required the federal government to "hold the land . . . in trust for the sole use and benefit of the Indian" allottee, the Supreme Court in *Mitchell I* concluded that the statute "created only a limited trust relationship . . . that does not impose any duty upon the Government to manage timber resources" on the land. *Id.* at 541, 542 (statutory "trust" language in General Allotment Act of 1887 insufficient to impose specific trust responsibilities). *See also Navajo Nation I*, 537 U.S. at 503 (discussing insufficiency of "bare trust" in *Mitchell I*).

By contrast, in *United States v. Mitchell*, 463 U.S. 206 (1983) ("*Mitchell II*"), the Court found that such a duty did exist where a network of statutes and regulations established "comprehensive responsibilities" and "elaborate control" by the United States over forests and property belonging to Indians. *Id.* at 222, 225 (citation and internal quotation marks omitted) ("All of the necessary elements of a common-law trust are present: a trustee (the United States), a beneficiary (the Indian allottees), and a trust corpus (Indian timber, lands, and funds)."). Unlike the "bare trust" created by the general language in *Mitchell I*'s land allotment statute, the statutes and regulations in *Mitchell II*

"clearly g[a]ve the Federal Government full responsibility to manage Indian resources." *Id.* at 224. [9]

Moreover, as this Court has recognized, to support an order compelling agency action, an agency's legal obligation must be specific, and trust principles do not abrogate this requirement. In *Gros Ventre Tribe v. United States*, 469 F.3d 801 (9th Cir. 2006), this Court addressed a group of Indian tribes that alleged that the government "fail[ed] to prevent unnecessary and undue degradation of public lands." *Id.* at 814. This Court held that "[e]ven assuming that the government has a common law trust obligation that can be tied to its statutorily mandated duties," the tribes had failed to show that "these obligations require the government to take discrete nondiscretionary actions," and therefore the tribes had not identified a basis for compelling agency action. *Id.* at 814-15.

[9] Plaintiff suggests that some more lenient version of this requirement applies because plaintiff seeks injunctive relief, not damages. Pl. Br. 43-44. However, both the Supreme Court and this Court have clearly rejected that view. *See Jicarilla*, 131 S. Ct. at 2325 (applying the requirements for a "specific, applicable, trust-creating statute or regulation" from the *Mitchell* and *Navajo Nation* cases to a non-damages claim); *Gros Ventre Tribe*, 469 F.3d at 812 (rejecting the argument that the *Mitchell I* and *Mitchell II* requirements only apply to damages claims and emphasizing that even for equitable claims, an actionable trust duty requires "an unambiguous provision by Congress that clearly outlines a federal trust responsibility" (quoting *N. Slope Borough v. Andrus*, 642 F.2d 589, 612 (D.C. Cir. 1980)). Indeed, as discussed, *Lincoln v. Vigil* makes quite clear that the kind of programmatic equitable relief sought here cannot be obtained based on general trust principles.

Neither the Snyder Act nor the IHCIA "unambiguously provide[s]" for the standards plaintiff wishes to impose, *Mitchell I*, 445 U.S. at 542; accordingly, these statutes do not—even in light of a general trust relationship—create a judicially enforceable obligation for IHS to take discrete actions. These statutes authorize IHS spending and describe policy goals in general terms, with no relevant duty-imposing provisions. And while these statutes recognize a broad policy of federal responsibility for Indian health, they do not even rise to the level of the federal laws at issue in *Mitchell I*, which expressly required the government to serve as trustee; they certainly do not give "full responsibility" to the United States and detail it "comprehensive[ly]," as in *Mitchell II*'s statutes and regulations. *Mitchell II*, 463 U.S. at 222-25. *See, e.g., Allred v. United States*, 33 Fed. Cl. 349, 355, 357 (1995) (a claim under the Snyder Act and the IHCIA "clearly falls under the *Mitchell I* rather than the *Mitchell II* rationale" because these statutes "only create a general duty" and "neither mandate[s] that the IHS spend its general appropriations in any particular manner, save to improve Indian health"); *Gila River Pima-Maricopa Indian Cmty. v. United States*, 427 F.2d 1194, 1198-99 (Ct. Cl. 1970) (denying that affirmative undertakings to provide health facilities and other services created a trust obligation where there was "no treaty, agreement, order or statute which expressly obligated the United

States to perform these services"); *see also McNabb*, 829 F.2d at 792, 794-95 (explaining that federal responsibility for Indian health is "not … exclusive[]"). *Cf. Lincoln*, 508 U.S. at 194-95 (finding no basis in the Snyder Act, IHCIA, or trust obligations to compel the equitable relief sought); *Yankton Sioux Tribe v. U.S. Dep't of Health & Human Servs.*, 533 F.3d 634, 644 (8th Cir. 2008) (dismissing claim that government breached trust duty in connection with reducing services by closing IHS emergency room and converting it to an urgent care facility).[10]

Although plaintiff relies heavily on this Court's decision in *McNabb v. Bowen*, 829 F.2d 787 (9th Cir. 1987), the Court in that case simply treated trust principles as providing a canon of liberal construction in interpreting a federal regulation that addressed with specificity the federal government's responsibility for Indian health payments. This Court found that the trust relationship prevented IHS from interpreting the regulation to refuse payment

[10] In suggesting that the IHCIA gives rise to enforceable trust obligations, plaintiff chiefly relies on language in the Act's findings and "declaration of national Indian health policy," 25 U.S.C. §§ 1601-1602. The language is plainly insufficient in light of the Supreme Court's precedents, and its placement confirms this. *See, e.g.*, *El Paso Natural Gas Co. v. United States*, 750 F.3d 863, 898-99 (D.C. Cir. 2014) (explaining that discussion of "trust responsibility" in findings and purposes section of Indian Agricultural Act, and trust language in findings section of Indian Dump Cleanup Act, did not impose enforceable trust duties). *Cf. Jicarilla*, 131 S. Ct. at 2323 (explaining that, as in *Mitchell I*, "Congress may style its relations with the Indians a 'trust' without assuming all the fiduciary duties of a private trustee").

for an eligible Indian's health services on the ground that an "alternate resource," such as a state or agency, was available to provide payment. *Id.* at 793-94 (explaining that IHS assumes the burden of seeking payment from the "alternate resource"). Here, no provision of federal law akin to the "alternate resource" rule is at issue. Plaintiff does not invoke trust principles to support favorable construction of a specific, existing legal requirement, but seeks to convert the general policy language of the Snyder Act and the IHCIA into judicially enforceable, duty-imposing prescriptions.

In *Blue Legs v. U.S. Bureau of Indian Affairs*, 867 F.2d 1094 (8th Cir. 1989), also relied on by plaintiff, the Eighth Circuit likewise invoked common-law principles in interpreting an express and non-discretionary statutory responsibility. In that case, tribe members brought suit against a tribe and several federal agencies for violations of the Resource Conservation and Recovery Act of 1976 ("RCRA") in connection with the operation of solid-waste disposal sites on the reservation. In holding the federal government (as well as the tribe) liable for cleaning up the dump sites, the Eighth Circuit held that the government was clearly compelled by statute to comply with EPA regulations and to contribute to compliance efforts. The court went on to state that this finding was further "buttressed by the existence of the general trust relationship, between these agencies and the Tribe." *Id.* at 1100. The court

explained that because the RCRA "require[d] that executive agencies refrain from [certain] activities," the defendant agencies had violated the statute and, as a result, the trust relationship; the agencies therefore had a responsibility to fully remedy the wrong—that is, "to insure that the dumps are cleaned up, even if others contributed to the problem." *Id.* at 1101. In short, the court looked to common-law principles in liberally construing the scope of an appropriate remedy for the violation of a discrete statutory responsibility. Plaintiff's reliance on *Blue Legs*, like its reliance on *McNabb*, is misplaced because plaintiff points to no comparable statutorily imposed requirements here.

Finally, plaintiff cites the court of federal claims decision in *Jicarilla Apache Nation v. United States*, 100 Fed. Cl. 726 (2011), which similarly observes that, once Congress establishes trust duties through specific statutory provisions, common-law principles can inform judicial interpretation of the scope of those responsibilities. *Id.* at 738. As we have explained, this proposition does nothing to advance plaintiff's case because the essential underlying provisions are absent.

The Supreme Court has observed that "[o]nce federal law imposes [trust] duties, the common law 'could play a role.'" *Jicarilla*, 131 S. Ct. at 2325 (quoting *United States v. Navajo Nation*, 556 U.S. 287, 301 (2009) ("*Navajo Nation II*")) (explaining that courts "have looked to common-law principles … to

determine the scope of liability that Congress has imposed"). But, as we have noted, the Supreme Court has consistently emphasized the essential components—where plaintiff "cannot identify a specific, applicable, trust-creating statute or regulation that the Government violated, … neither the Government's 'control' over [Indian assets] nor common-law trust principles matter." *Jicarilla*, 131 S. Ct. at 2325 (alterations in original) (citation and internal quotation marks omitted).[11]

[11] Plaintiff also quotes a 1977 South Dakota district court decision, *White v. Califano*, 437 F. Supp. 543, *aff'd*, 581 F.2d 697 (8th Cir. 1978), a case concerning responsibility for the involuntary commitment of a mentally ill member of an Indian tribe. The court held that IHS must "conform their policy to" an existing regulation, which stated that "'[p]riorities for care and treatment, as among individuals who are within the scope of the program, will be determined on the basis of relative medical need,'" and concluded that IHS could not "abandon" a mentally ill tribe member, whose "medical need was extreme." *Id.* at 556 (quoting 42 C.F.R. § 36.12(c)). The court expressly recognized that the IHS "cannot meet all health needs of all Indian people" given its limited budget, and therefore limited its ruling to holding that the agency, "in exercising [its] discretion," must comply with "agency regulations." *Ibid.*

In the present case, no question of compliance with statutory standards or regulatory requirements is at issue. Moreover, since *White* was decided (and, indeed, since this Court's decision in *McNabb*), the Supreme Court has addressed Indian trust obligations in several cases including *Lincoln v. Vigil*, *supra*, and has made clear that the trust relationship does not give rise to enforceable "health-care duties" (Pl. Br. 32) that displace IHS's discretion or otherwise permit the relief plaintiff seeks.

C. Plaintiff Likewise Identifies No Basis for Requiring IHS To Maintain the Clinic Facilities as Trust Property.

The district court also found no separate trust obligation to maintain and preserve the clinic facilities as trust property. ER 9. On appeal, plaintiff questions whether the court failed to accept as true an allegation "that the United States holds the Fort Yuma Service Unit facilities in trust for the Tribe," Pl. Br. 2. To be clear, plaintiff's complaint does not allege that the Fort Yuma *facilities*—which are government-owned—are held in trust. The complaint alleges only that the facilities are located on *land* held in trust (because the land is part of an Indian reservation). *See* ER 18, 26 (FAC ¶¶ 16, 75-76).

In any event, the court would not have been required to accept plaintiff's legal conclusion that IHS's Fort Yuma clinic, which is not a tribal asset, is nonetheless held by the United States in trust. Nor would the court have been required to accept plaintiff's contention that Tribe can seek and obtain facility improvements on the basis of an asserted land trust relationship.

As we have discussed, a trust obligation only arises when a specific rights-creating statutory, regulatory, or treaty prescription establishes such an obligation. The establishment of the obligations and benefits of a trust "cannot be premised on control alone." *Navajo Nation II*, 556 U.S. at 301, 302 (rejecting the argument that "the Government's 'comprehensive control' over coal on Indian land gives rise to fiduciary duties" absent "a specific, applicable, trust-

creating statute or regulation"); *Jicarilla*, 131 S. Ct. at 2325 (absent "a specific, applicable, trust-creating statute or regulation … neither the Government's 'control' over [Indian assets] nor common-law trust principles matter") (citation and internal quotation marks omitted).

In *United States v. White Mountain Apache Tribe*, 537 U.S. 465 (2003), the Court found an actionable obligation to maintain land and buildings only because"[t]he statutory language . . . expressly define[d] a fiduciary relationship" and, in addition, the government had plenary control over the trust corpus. *Id.* at 474-75; *see id.* at 469, 474-77 (explaining that the government's duty derived from the statute both expressly stating that the relevant property was held in trust and authorizing the United States to make exclusive use of that property for its own purposes). The relevant statute expressly placed the property and buildings at issue in trust. Pub. L. No. 86-392, 74 Stat. 8 (1960) (declaring that "all right, title, and interest of the United States in and to the lands, *together with the improvements thereon*, … are declared to be held by the United States in trust for the White Mountain Apache Tribe, subject to the right of the Secretary of the Interior to use any part of the land and improvements thereon …") (emphasis added) (quoted in *White Mountain Apache Tribe v. United States*, 46 Fed. Cl. 20, 22 (1999), *rev'd*, 249 F.3d 1364 (Fed. Cir. 2001), *aff'd and remanded*, 537 U.S. 465 (2003)). Plaintiff has cited no such statute here.

II. THE DISTRICT COURT CORRECTLY HELD THAT IHS'S OPERATION OF THE FORT YUMA CLINIC DOES NOT IMPLICATE PLAINTIFF'S CONSTITUTIONAL DUE PROCESS OR EQUAL PROTECTION RIGHTS.

A. The Due Process Clause Does Not Create an Affirmative Constitutional Obligation To Provide a Certain Level of Care.

"[T]he Due Process Clauses generally confer no affirmative right to government aid." *DeShaney v. Winnebago Cnty. Dep't of Soc. Servs.*, 489 U.S. 189, 196 (1989). Indeed, the Supreme Court has expressly rejected the argument that undertaking to provide aid gives rise to a government duty to do so in any particular fashion. *Id.* at 197-98. Instead, a special relationship between the government and an individual only generates a due process right to government care "when 'the State takes a person into its custody and holds him there *against his will*.'" *Campbell v. Wash. Dep't of Soc. & Health Servs.*, 671 F.3d 837, 842-43 (9th Cir. 2011) (quoting *DeShaney*, 489 U.S. at 199-200). In those circumstances, the due process right "arises not from the State's . . . expressions of intent to help [the person], but from the limitation which it has imposed on his freedom to act on his own behalf." *DeShaney*, 489 U.S. at 200. In this case, the district court correctly recognized that no such custodial relationship exists, and therefore the Due Process Clause creates no substantive right to a certain level of government care. ER 12.

Plaintiff's substantive due process claim mistakenly relies on the exception for custodial relationships. Plaintiff asserts that the government must provide medical care "in accordance with minimum constitutional standards," but to identify those standards cites cases addressing detainees and prisoners. Pl. Br. 51-52; *see Gibson v. Cnty. of Washoe, Nev.*, 290 F.3d 1175, 1187-88 (9th Cir. 2002) (applying "the Eighth Amendment's standard of deliberate indifference" to medical screening of arrestee); *Frost v. Agnos*, 152 F.3d 1124, 1128-29 (9th Cir. 1998) (applying an Eighth Amendment standard to disability accommodation for detainee because "pretrial detainees' rights under the Fourteenth Amendment are comparable to prisoners' rights under the Eighth Amendment"). Here, where the government has not limited any individual's freedom to act on his own behalf, constitutional protections comparable to those required for prisoners do not apply. *See, e.g.*, *Allred*, 33 Fed. Cl. at 356 (citing *Richardson v. Belcher*, 404 U.S. 78, 80-81 (1971)). [12]

[12] Plaintiff also claims that IHS is violating a "liberty interest in avoiding the unwanted administration of substances." Pl. Br. 52. This claim bears no relation to the ongoing factual situation plaintiff alleges or to the relief plaintiff requests. Moreover, it relies on similarly inapposite case law describing the rights of prisoners. *See Washington v. Harper*, 494 U.S. 210, 222-23 (1990) (concluding that the government must satisfy certain due process requirements to administer drugs to prisoners against their will); *McKinney v. Anderson*, 924 F.2d 1500, 1507 (9th Cir.) (concluding that exposing prisoners to secondhand smoke violates the Eighth Amendment), *cert. granted, judgment vacated sub nom. Helling v. McKinney*, 502 U.S. 903 (1991), *judgment reinstated*, 959 F.2d 853 (9th Cir. 1992), *aff'd*, 509 U.S. 25 (1993).

Plaintiff's procedural due process claim also fails, as neither the Due Process Clause nor any other source of law establishes a substantive entitlement to the improvements in services and facilities that plaintiff seeks. Moreover, because plaintiff does not demand a procedural remedy, it is unclear how this claim would support plaintiff's requested relief.

B. Plaintiff Identifies No Basis for Concluding that IHS's Allocation of Funds for Discretionary Programs Violates the Equal Protection Clause.

The district court also properly dismissed plaintiff's equal protection claim. Classifications in social welfare programs do not violate equal protection rights unless they have no reasonable basis. *Dandridge v. Williams*, 397 U.S. 471, 485 (1970). As the district court recognized, the government therefore has broad discretion to allocate funds across such programs. ER 13.

Plaintiff acknowledges that this standard governs the equal protection claim and argues only that IHS lacks any reasonable basis for offering the current set of ambulatory services at Fort Yuma. *See* Pl. Br. 53. However, beyond the conclusory allegation that care at Fort Yuma is "at a level far below that provided to other similarly situated Indians in the United States," ER 29 (FAC ¶ 99), plaintiff identifies no allocation decision—or even any specific difference between services at Fort Yuma and services elsewhere—that might

be unreasonable.[13] In fact, IHS's allocation of its limited funds across its offerings is entirely consistent with its statutory mandate to provide health services to Indians nationwide. (These nationwide offerings include, as described *supra*, a necessary mix of urban and rural resources, direct services and contracted services, and inpatient and outpatient facilities.) To the extent that this allocation of IHS's budget results in less funding for Fort Yuma than either the Tribe or the agency may regard as optimal, it reflects overall budgetary constraints; neither the Constitution nor any statute or common law authorize a judicial remedy.

[13] Plaintiff relies exclusively on the district court decision in *Rincon Band of Mission Indians v. Califano*, 464 F. Supp. 934 (N.D. Cal. 1979), *aff'd on other grounds sub nom. Rincon Band of Mission Indians v. Harris*, 618 F.2d 569 (9th Cir. 1980). That decision was premised on evidence that IHS had failed to consistently apply its resource allocation criteria. *Id.* at 937-38. Plaintiff makes no such allegation here. Moreover, the Ninth Circuit did not accept the district court's equal protection finding in *Rincon* and instead resolved the case on statutory grounds. *Harris*, 618 F.2d at 570.

CONCLUSION

For the foregoing reasons, the decision of the district court should be affirmed.[14]

Respectfully submitted,

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[14] The Department of Justice gratefully acknowledges the assistance of Michael F. Qian, a student at Stanford Law School, in the preparation of this brief.

STATEMENT OF RELATED CASES

We are not aware of any related cases.

CERTIFICATE OF COMPLIANCE

Pursuant to Federal Rule of Appellate Procedure 32(a)(5), (6), (7)(B) and (C) and Ninth Circuit Rule 32, I certify that the attached Brief for Appellees contains 9254 words, and complies with type-volume limitations because it is prepared in Microsoft Word 2000, Garamond, font 14.

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CERTIFICATE OF SERVICE

I hereby certify that on this 15th day of August, 2014, I caused the foregoing brief to be electronically filed with the United States Court of Appeals for the Ninth Circuit, and served to counsel, via the ECF system.

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No. 11-16334

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

QUECHAN TRIBE OF THE FORT YUMA INDIAN RESERVATION,

Plaintiff-Appellant,

v.

UNITED STATES, et al.,

Defendants-Appellees.

On Appeal from the United States District Court
for the District of Arizona,
Case No. 10-2261

ADDENDUM TO APPELLEES' BRIEF

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ADDENDUM CONTENTS

Page

Chapter 7. Judicial Review

5 U.S.C. § 701. Application; definitions

(a) This chapter applies, according to the provisions thereof, except to the extent that--

(1) statutes preclude judicial review; or

(2) agency action is committed to agency discretion by law.

(b) For the purpose of this chapter--

(1) "agency" means each authority of the Government of the United States, whether or not it is within or subject to review by another agency, but does not include--

(A) the Congress;

(B) the courts of the United States;

(C) the governments of the territories or possessions of the United States;

(D) the government of the District of Columbia;

(E) agencies composed of representatives of the parties or of representatives of organizations of the parties to the disputes determined by them;

(F) courts martial and military commissions;

(G) military authority exercised in the field in time of war or in occupied territory; or

(H) functions conferred by sections 1738, 1739, 1743, and 1744 of title 12; subchapter II of chapter 471 of title 49; or sections 1884, 1891-1902, and former section 1641(b)(2), of title 50, appendix; and

(2) "person", "rule", "order", "license", "sanction", "relief", and "agency action" have the meanings given them by section 551 of this title.

5 U.S.C. § 706. Scope of review

To the extent necessary to decision and when presented, the reviewing court shall decide all relevant questions of law, interpret constitutional and statutory provisions, and determine the meaning or applicability of the terms of an agency action. The reviewing court shall--

(1) compel agency action unlawfully withheld or unreasonably delayed; and

(2) hold unlawful and set aside agency action, findings, and conclusions found to be--

(A) arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law;

(B) contrary to constitutional right, power, privilege, or immunity;

(C) in excess of statutory jurisdiction, authority, or limitations, or short of statutory right;

(D) without observance of procedure required by law;

(E) unsupported by substantial evidence in a case subject to sections 556 and 557 of this title or otherwise reviewed on the record of an agency hearing provided by statute; or

(F) unwarranted by the facts to the extent that the facts are subject to trial de novo by the reviewing court.

In making the foregoing determinations, the court shall review the whole record or those parts of it cited by a party, and due account shall be taken of the rule of prejudicial error.

Chapter 1. Bureau of Indian Affairs

25 U.S.C. § 13. Expenditure of appropriations by Bureau

The Bureau of Indian Affairs, under the supervision of the Secretary of the Interior, shall direct, supervise, and expend such moneys as Congress may from time to time appropriate, for the benefit, care, and assistance of the Indians throughout the United States for the following purposes:

> General support and civilization, including education.
>
> For relief of distress and conservation of health.
>
> For industrial assistance and advancement and general administration of Indian property.
>
> For extension, improvement, operation, and maintenance of existing Indian irrigation systems and for development of water supplies.
>
> For the enlargement, extension, improvement, and repair of the buildings and grounds of existing plants and projects.
>
> For the employment of inspectors, supervisors, superintendents, clerks, field matrons, farmers, physicians, Indian police, Indian judges, and other employees.
>
> For the suppression of traffic in intoxicating liquor and deleterious drugs.
>
> For the purchase of horse-drawn and motor-propelled passenger-carrying vehicles for official use.
>
> And for general and incidental expenses in connection with the administration of Indian affairs.

Notwithstanding any other provision of this section or any other law, postsecondary schools administered by the Secretary of the Interior for Indians, and which meet the definition of an "institution of higher education" under section 101 of the Higher Education Act of 1965 (20 U.S.C. 1001), shall be eligible to participate in and receive appropriated funds under any program authorized by the Higher Education Act of 1965 (20 U.S.C. 1001 *et seq.*, 42 U.S.C. 2751 *et seq.*) or any other applicable program for

the benefit of institutions of higher education, community colleges, or postsecondary educational institutions.

Chapter 18. Indian Health Care

25 U.S.C. § 1601. Congressional findings

The Congress finds the following:

(1) Federal health services to maintain and improve the health of the Indians are consonant with and required by the Federal Government's historical and unique legal relationship with, and resulting responsibility to, the American Indian people.

(2) A major national goal of the United States is to provide the resources, processes, and structure that will enable Indian tribes and tribal members to obtain the quantity and quality of health care services and opportunities that will eradicate the health disparities between Indians and the general population of the United States.

(3) A major national goal of the United States is to provide the quantity and quality of health services which will permit the health status of Indians to be raised to the highest possible level and to encourage the maximum participation of Indians in the planning and management of those services.

(4) Federal health services to Indians have resulted in a reduction in the prevalence and incidence of preventable illnesses among, and unnecessary and premature deaths of, Indians.

(5) Despite such services, the unmet health needs of the American Indian people are severe and the health status of the Indians is far below that of the general population of the United States.

25 U.S.C. § 1602. Declaration of national Indian health policy

Congress declares that it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians--

(1) to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy;

(2) to raise the health status of Indians and urban Indians to at least the levels set forth in the goals contained within the Healthy People 2010 initiative or successor objectives;

(3) to ensure maximum Indian participation in the direction of health care services so as to render the persons administering such services and the services themselves more responsive to the needs and desires of Indian communities;

(4) to increase the proportion of all degrees in the health professions and allied and associated health professions awarded to Indians so that the proportion of Indian health professionals in each Service area is raised to at least the level of that of the general population;

(5) to require that all actions under this chapter shall be carried out with active and meaningful consultation with Indian tribes and tribal organizations, and conference with urban Indian organizations, to implement this chapter and the national policy of Indian self-determination;

(6) to ensure that the United States and Indian tribes work in a government-to-government relationship to ensure quality health care for all tribal members; and

(7) to provide funding for programs and facilities operated by Indian tribes and tribal organizations in amounts that are not less than the amounts provided to programs and facilities operated directly by the Service.

25 U.S.C. § 1621. Indian Health Care Improvement Fund

(a) Use of funds

The Secretary, acting through the Service, is authorized to expend funds, directly or under the authority of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 *et seq.*), which are appropriated under the authority of this section, for the purposes of--

(1) eliminating the deficiencies in health status and health resources of all Indian tribes;

(2) eliminating backlogs in the provision of health care services to Indians;

(3) meeting the health needs of Indians in an efficient and equitable manner, including the use of telehealth and telemedicine when appropriate;

(4) eliminating inequities in funding for both direct care and contract health service programs; and

(5) augmenting the ability of the Service to meet the following health service responsibilities with respect to those Indian tribes with the highest levels of health status deficiencies and resource deficiencies:

(A) Clinical care, including inpatient care, outpatient care (including audiology, clinical eye, and vision care), primary care, secondary and tertiary care, and long-term care.

(B) Preventive health, including mammography and other cancer screening.

(C) Dental care.

(D) Mental health, including community mental health services, inpatient mental health services, dormitory mental health services, therapeutic and residential treatment centers, and training of traditional health care practitioners.

(E) Emergency medical services.

(F) Treatment and control of, and rehabilitative care related to, alcoholism and drug abuse (including fetal alcohol syndrome) among Indians.

(G) Injury prevention programs, including data collection and evaluation, demonstration projects, training, and capacity building.

(H) Home health care.

(I) Community health representatives.

(J) Maintenance and improvement.

(b) No offset or limitation

Any funds appropriated under the authority of this section shall not be used to offset or limit any other appropriations made to the Service under this chapter or section 13 of this title, or any other provision of law.

(c) Allocation; use

(1) In general

Funds appropriated under the authority of this section shall be allocated to Service units, Indian tribes, or tribal organizations. The funds allocated to each Indian tribe, tribal organization, or Service unit under this paragraph shall be used by the Indian tribe, tribal organization, or Service unit under this paragraph to improve the health status and reduce the resource deficiency of each Indian tribe served by such Service unit, Indian tribe, or tribal organization.

(2) Apportionment of allocated funds

The apportionment of funds allocated to a Service unit, Indian tribe, or tribal organization under paragraph (1) among the health service responsibilities described in subsection (a)(5) shall be determined by the Service in consultation with, and with the active participation of, the affected Indian tribes and tribal organizations.

(d) Provisions relating to health status and resource deficiencies

For the purposes of this section, the following definitions apply:

(1) Definition

The term "health status and resource deficiency" means the extent to which--

(A) the health status objectives set forth in sections 1602(1) and 1602(2) of this title are not being achieved; and

(B) the Indian tribe or tribal organization does not have available to it the health resources it needs, taking into account the actual cost of providing health care services given local geographic, climatic, rural, or other circumstances.

(2) Available resources

The health resources available to an Indian tribe or tribal organization include health resources provided by the Service as well as health resources used by the Indian tribe or tribal organization, including services and financing systems provided by any Federal programs, private insurance, and programs of State or local governments.

(3) Process for review of determinations

The Secretary shall establish procedures which allow any Indian tribe or tribal organization to petition the Secretary for a review of any determination of the extent of the health status and resource deficiency of such Indian tribe or tribal organization.

(e) Eligibility for funds

Tribal health programs shall be eligible for funds appropriated under the authority of this section on an equal basis with programs that are administered directly by the Service.

(f) Report

By no later than the date that is 3 years after March 23, 2010, the Secretary shall submit to Congress the current health status and resource deficiency report of the Service for each Service unit, including newly recognized or acknowledged Indian tribes. Such report shall set out--

(1) the methodology then in use by the Service for determining tribal health status and resource deficiencies, as well as the most recent application of that methodology;

(2) the extent of the health status and resource deficiency of each Indian tribe served by the Service or a tribal health program;

(3) the amount of funds necessary to eliminate the health status and resource deficiencies of all Indian tribes served by the Service or a tribal health program; and

(4) an estimate of--

(A) the amount of health service funds appropriated under the authority of this chapter, or any other Act, including the amount of any funds transferred to the Service for the preceding fiscal year which is allocated to each Service unit, Indian tribe, or tribal organization;

(B) the number of Indians eligible for health services in each Service unit or Indian tribe or tribal organization; and

(C) the number of Indians using the Service resources made available to each Service unit, Indian tribe or tribal organization, and, to the extent available, information on the waiting lists and number of Indians turned away for services due to lack of resources.

(g) Inclusion in base budget

Funds appropriated under this section for any fiscal year shall be included in the base budget of the Service for the purpose of determining appropriations under this section in subsequent fiscal years.

(h) Clarification

Nothing in this section is intended to diminish the primary responsibility of the Service to eliminate existing backlogs in unmet health care needs, nor are the provisions of this section intended to discourage the Service from undertaking additional efforts to achieve equity among Indian tribes and tribal organizations.

(i) Funding designation

Any funds appropriated under the authority of this section shall be designated as the "Indian Health Care Improvement Fund".

25 U.S.C. § 1631. Consultation; closure of facilities; reports

(a) Consultation; standards for accreditation

Prior to the expenditure of, or the making of any firm commitment to expend, any funds appropriated for the planning, design, construction, or renovation of facilities pursuant to section 13 of this title, popularly known as the Snyder Act, the Secretary, acting through the Service, shall--

(1) consult with any Indian tribe that would be significantly affected by such expenditure for the purpose of determining and, whenever practicable, honoring tribal preferences concerning size, location, type, and other characteristics of any facility on which such expenditure is to be made, and

(2) ensure, whenever practicable, that such facility meets the standards of the Joint Commission on Accreditation of Health Care Organizations by not later than 1 year after the date on which the construction or renovation of such facility is completed.

(b) Closure; report on proposed closure

(1) Notwithstanding any provision of law other than this subsection, no Service hospital or outpatient health care facility of the Service, or any portion of such a hospital or facility, may be closed if the Secretary has not submitted to the Congress at least 1 year prior to the date such hospital or facility (or portion thereof) is proposed to be closed an evaluation of the impact of such proposed closure which specifies, in addition to other considerations--

(A) the accessibility of alternative health care resources for the population served by such hospital or facility;

(B) the cost effectiveness of such closure;

(C) the quality of health care to be provided to the population served by such hospital or facility after such closure;

(D) the availability of contract health care funds to maintain existing levels of service;

(E) the views of the Indian tribes served by such hospital or facility concerning such closure;

(F) the level of utilization of such hospital or facility by all eligible Indians; and

(G) the distance between such hospital or facility and the nearest operating Service hospital.

(2) Paragraph (1) shall not apply to any temporary closure of a facility or of any portion of a facility if such closure is necessary for medical, environmental, or safety reasons.

(c) Health care facility priority system

(1) In general

(A) Priority system

The Secretary, acting through the Service, shall maintain a health care facility priority system, which--

(i) shall be developed in consultation with Indian tribes and tribal organizations;

(ii) shall give Indian tribes' needs the highest priority;

(iii)

(I) may include the lists required in paragraph (2)(B)(ii); and

(II) shall include the methodology required in paragraph (2)(B)(v); and

(III) may include such health care facilities, and such renovation or expansion needs of any health care facility, as the Service may identify; and

(iv) shall provide an opportunity for the nomination of planning, design, and construction projects by the Service, Indian tribes, and tribal organizations for consideration under the priority system at least once every 3 years, or more frequently as the Secretary determines to be appropriate.

(B) Needs of facilities under ISDEAA agreements

The Secretary shall ensure that the planning, design, construction, renovation, and expansion needs of Service and non-Service facilities operated under contracts or compacts in accordance with the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 *et seq.*)

are fully and equitably integrated into the health care facility priority system.

(C) Criteria for evaluating needs

For purposes of this subsection, the Secretary, in evaluating the needs of facilities operated under a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 *et seq.*), shall use the criteria used by the Secretary in evaluating the needs of facilities operated directly by the Service.

(D) Priority of certain projects protected

The priority of any project established under the construction priority system in effect on March 23, 2010, shall not be affected by any change in the construction priority system taking place after that date if the project--

(i) was identified in the fiscal year 2008 Service budget justification as--

(I) 1 of the 10 top-priority inpatient projects;

(II) 1 of the 10 top-priority outpatient projects;

(III) 1 of the 10 top-priority staff quarters developments; or

(IV) 1 of the 10 top-priority Youth Regional Treatment Centers;

(ii) had completed both Phase I and Phase II of the construction priority system in effect on March 23, 2010; or

(iii) is not included in clause (i) or (ii) and is selected, as determined by the Secretary--

(I) on the initiative of the Secretary; or

(II) pursuant to a request of an Indian tribe or tribal organization.

(2) Report; contents

(A) Initial comprehensive report

(i) Definitions

In this subparagraph:

(I) Facilities Appropriation Advisory Board

The term "Facilities Appropriation Advisory Board" means the advisory board, comprised of 12 members representing Indian tribes and 2 members representing the Service, established at the discretion of the Director--

(aa) to provide advice and recommendations for policies and procedures of the programs funded pursuant to facilities appropriations; and

(bb) to address other facilities issues.

(II) Facilities Needs Assessment Workgroup

The term "Facilities Needs Assessment Workgroup" means the workgroup established at the discretion of the Director--

(aa) to review the health care facilities construction priority system; and

(bb) to make recommendations to the Facilities Appropriation Advisory Board for revising the priority system.

(ii) Initial report

(I) In general

Not later than 1 year after March 23, 2010, the Secretary shall submit to the Committee on Indian Affairs of the Senate and the Committee on Natural Resources of the

House of Representatives a report that describes the comprehensive, national, ranked list of all health care facilities needs for the Service, Indian tribes, and tribal organizations (including inpatient health care facilities, outpatient health care facilities, specialized health care facilities (such as for long-term care and alcohol and drug abuse treatment), wellness centers, and staff quarters, and the renovation and expansion needs, if any, of such facilities) developed by the Service, Indian tribes, and tribal organizations for the Facilities Needs Assessment Workgroup and the Facilities Appropriation Advisory Board.

(II) Inclusions

The initial report shall include--

(aa) the methodology and criteria used by the Service in determining the needs and establishing the ranking of the facilities needs; and

(bb) such other information as the Secretary determines to be appropriate.

(iii) Updates of report

Beginning in calendar year 2011, the Secretary shall--

(I) update the report under clause (ii) not less frequently that once every 5 years; and

(II) include the updated report in the appropriate annual report under subparagraph (B) for submission to Congress under section 1671 of this title.

(B) Annual reports

The Secretary shall submit to the President, for inclusion in the report required to be transmitted to Congress under section 1671 of this title, a report which sets forth the following:

(i) A description of the health care facility priority system of the Service established under paragraph (1).

(ii) Health care facilities lists, which may include--

(I) the 10 top-priority inpatient health care facilities;

(II) the 10 top-priority outpatient health care facilities;

(III) the 10 top-priority specialized health care facilities (such as long-term care and alcohol and drug abuse treatment); and

(IV) the 10 top-priority staff quarters developments associated with health care facilities.

(iii) The justification for such order of priority.

(iv) The projected cost of such projects.

(v) The methodology adopted by the Service in establishing priorities under its health care facility priority system.

(3) Requirements for preparation of reports

In preparing the report required under paragraph (2), the Secretary shall--

(A) consult with and obtain information on all health care facilities needs from Indian tribes and tribal organizations; and

(B) review the total unmet needs of all Indian tribes and tribal organizations for health care facilities (including staff quarters), including needs for renovation and expansion of existing facilities.

(d) Review of methodology used for health facilities construction priority system

(1) In general

Not later than 1 year after the establishment of the priority system under subsection (c)(1)(A), the Comptroller General of the United States shall prepare and finalize a report reviewing the methodologies applied, and the processes

followed, by the Service in making each assessment of needs for the list under subsection (c)(2)(A)(ii) and developing the priority system under subsection (c)(1), including a review of--

(A) the recommendations of the Facilities Appropriation Advisory Board and the Facilities Needs Assessment Workgroup (as those terms are defined in subsection (c)(2)(A)(i)); and

(B) the relevant criteria used in ranking or prioritizing facilities other than hospitals or clinics.

(2) Submission to Congress

The Comptroller General of the United States shall submit the report under paragraph (1) to--

(A) the Committees on Indian Affairs and Appropriations of the Senate;

(B) the Committees on Natural Resources and Appropriations of the House of Representatives; and

(C) the Secretary.

(e) Funding condition

All funds appropriated under section 13 of this title, for the planning, design, construction, or renovation of health facilities for the benefit of 1 or more Indian Tribes shall be subject to the provisions of section 102 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450f) or sections 504 and 505 of that Act (25 U.S.C. 458aaa-3, 458aaa-4).

(f) Development of innovative approaches

The Secretary shall consult and cooperate with Indian tribes and tribal organizations, and confer with urban Indian organizations, in developing innovative approaches to address all or part of the total unmet need for construction of health facilities, that may include--

(1) the establishment of an area distribution fund in which a portion of health facility construction funding could be devoted to all Service areas;

(2) approaches provided for in other provisions of this subchapter; and

(3) other approaches, as the Secretary determines to be appropriate.

(h) Funds appropriated subject to section 450f of this title

All funds appropriated under section 13 of this title, for the planning, design, construction, or renovation of health facilities for the benefit of an Indian tribe or tribes shall be subject to the provisions of section 102 of the Indian Self-Determination Act (25 U.S.C. 450f).

(g) Priority of certain projects protected

The priority of any project established under the construction priority system in effect on March 23, 2010, shall not be affected by any change in the construction priority system taking place after that date if the project--

(1) was identified in the fiscal year 2008 Service budget justification as--

(A) 1 of the 10 top-priority inpatient projects;

(B) 1 of the 10 top-priority outpatient projects;

(C) 1 of the 10 top-priority staff quarters developments; or

(D) 1 of the 10 top-priority Youth Regional Treatment Centers;

(2) had completed both Phase I and Phase II of the construction priority system in effect on March 23, 2010; or

(3) is not included in clause (i) or (ii) and is selected, as determined by the Secretary--

(A) on the initiative of the Secretary; or

(B) pursuant to a request of an Indian tribe or tribal organization.

25 U.S.C. § 1661. Establishment of the Indian Health Service as an agency of the Public Health Service

(a) Establishment

(1) In general

In order to more effectively and efficiently carry out the responsibilities, authorities, and functions of the United States to provide health care services to Indians and Indian tribes, as are or may be on and after November 23, 1988, provided by Federal statute or treaties, there is established within the Public Health Service of the Department the Indian Health Service.

(2) Director

The Service shall be administered by a Director, who shall be appointed by the President, by and with the advice and consent of the Senate. The Director shall report to the Secretary. Effective with respect to an individual appointed by the President, by and with the advice and consent of the Senate, after January 1, 2008, the term of service of the Director shall be 4 years. A Director may serve more than 1 term.

(3) Incumbent

The individual serving in the position of Director of the Service on the day before March 23, 2010, shall serve as Director.

(4) Advocacy and consultation

The position of Director is established to, in a manner consistent with the government-to-government relationship between the United States and Indian Tribes--

(A) facilitate advocacy for the development of appropriate Indian health policy; and

(B) promote consultation on matters relating to Indian health.

(b) Agency

The Service shall be an agency within the Public Health Service of the Department, and shall not be an office, component, or unit of any other agency of the Department.

(c) Duties

The Director shall--

(1) perform all functions that were, on the day before March 23, 2010, carried out by or under the direction of the individual serving as Director of the Service on that day;

(2) perform all functions of the Secretary relating to the maintenance and operation of hospital and health facilities for Indians and the planning for, and provision and utilization of, health services for Indians, including by ensuring that all agency directors, managers, and chief executive officers have appropriate and adequate training, experience, skill levels, knowledge, abilities, and education (including continuing training requirements) to competently fulfill the duties of the positions and the mission of the Service;

(3) administer all health programs under which health care is provided to Indians based upon their status as Indians which are administered by the Secretary, including programs under--

(A) this chapter;

(B) section 13 of this title;

(C) the Act of August 5, 1954 (42 U.S.C. 2001 *et seq.*);

(D) the Act of August 16, 1957 (42 U.S.C. 2005 *et seq.*); and

(E) the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 *et seq.*);

(4) administer all scholarship and loan functions carried out under subchapter I of this chapter;

(5) directly advise the Secretary concerning the development of all policy-and budget-related matters affecting Indian health;

(6) collaborate with the Assistant Secretary for Health concerning appropriate matters of Indian health that affect the agencies of the Public Health Service;

(7) advise each Assistant Secretary of the Department concerning matters of Indian health with respect to which that Assistant Secretary has authority and responsibility;

(8) advise the heads of other agencies and programs of the Department concerning matters of Indian health with respect to which those heads have authority and responsibility;

(9) coordinate the activities of the Department concerning matters of Indian health; and

(10) perform such other functions as the Secretary may designate.

(d) Authority

(1) In general

The Secretary, acting through the Director, shall have the authority--

(A) except to the extent provided for in paragraph (2), to appoint and compensate employees for the Service in accordance with Title 5;

(B) to enter into contracts for the procurement of goods and services to carry out the functions of the Service; and

(C) to manage, expend, and obligate all funds appropriated for the Service.

(2) Personnel actions

Notwithstanding any other provision of law, the provisions of section 472 of this title, shall apply to all personnel actions taken with respect to new positions created within the Service as a result of its establishment under subsection (a).

Chapter 85. District Courts; Jurisdiction

28 U.S.C. § 1361. Action to compel an officer of the United States to perform his duty

The district courts shall have original jurisdiction of any action in the nature of mandamus to compel an officer or employee of the United States or any agency thereof to perform a duty owed to the plaintiff.

CERTIFICATE OF SERVICE

I hereby certify that on this 15th day of August, 2014, I caused the foregoing addendum to be electronically filed with the United States Court of Appeals for the Ninth Circuit, and served to counsel, via the ECF system.

/s/ Samantha L. Chaifetz
SAMANTHA L. CHAIFETZ
Counsel for Appellees