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IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF ARIZONA

Cecilia Shortman, an enrolled member of the Hopi Tribe, Plaintiff, vs. Yvette Roubideaux, Acting Director, United States Indian Health Service; Sylvia Burwell, Secretary, United States Department of Health and Human Services; United States of America, Defendants.	CV-14-08087-PCT-DGC **MOTION TO DISMISS**

Defendants Yvette Roubideaux, Acting Director, United States Indian Health Service, Sylvia Burwell, Secretary, United States Department of Health and Human Services[1], and United States of America, move the Court to dismiss the First Amended Complaint (Complaint) (Doc. No. 10) and action pursuant to Fed.R.Civ.P. 12(b)(1) and (6) for lack of subject matter jurisdiction and failure to state a claim on which relief can be granted.

[1] Sylvia Burwell has been substituted for Kathleen Sebelius as Secretary of HHS pursuant to Fed. R. Civ. P. 17.

The parties have conferred and were unable to agree that amendment of the Complaint could resolve the argument whether subject matter jurisdiction is absent and that the Complaint fails to state a claim on which relief can be granted.

MEMORANDUM

It is well settled that the United States, as a sovereign, is immune from suit except as it consents to be sued; the terms of its consent define the parameters of a federal court's jurisdiction to entertain suits brought against it. *See United States v. Orleans*, 96 S.Ct. 1971, 1976 (1976)("the United States can be sued only to the extent that it has waived its immunity"). The United States, its agencies, and its employees acting within their official capacity, are immune from suit unless the United States waives its sovereign immunity. *FDIC v. Meyer*, 114 S.Ct. 996, 1000 (1994); *Hodge v. Dalton*, 107 F.3d 705, 707 (9th Cir. 1997).

A motion pursuant to Fed.R.Civ.P. 12(b)(1) may attack either the sufficiency of the allegations of the complaint or the existence of subject matter jurisdiction in fact, resolving factual disputes if necessary, and the Plaintiff bears the burden of proving that subject matter jurisdiction exists. *Thornhill Publishing Co. v. General Telephone & Electronics Corp*., 594 F. 2d 730, 733 (9th Cir. 1979).

The First Amended Complaint (Compl. Doc. No. 10, ¶ 8) alleges jurisdiction under 28 U.S.C. § 1331 (Federal Question), 28 U.S.C. §§ 1346 and 2671 *et seq*. (Federal Tort Claims Act), 28 U.S.C. §§ 2201, 2202 (Declaratory and Injuctive relief) and 5 U.S.C. §§ 702 and 704 (Administrative Procedure Act).[2]

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[2] The Administrative Procedure Act (APA) is not a grant of subject matter jurisdiction, *Califano v. Sanders*, 97 S.Ct. 980, 983 (1977). Administrative remedies must be exhausted under Section 704. Agency action committed to its discretion is not subject to APA review, Section 701(a)(2). The APA does not waive immunity from a suit for money damages, *Dep't of the Army v. Blue Fox, Inc.*, 119 S.Ct. 687, 692 (1999). As stated in *Luttrell v. United States*, 644 F.2d 1274, 1275 (9th Cir. 1980) "28 U.S.C. §§ 2201 and 2202 create additional remedies in the form of declaratory judgment relief for federal litigants, but do not in and of themselves confer subject-matter jurisdiction on the courts. *Wells v. United States*, 280 F.2d 275 (9th Cir. 1960)."

STATUTORY BACKGROUND

The principal mission of the Indian Health Service (IHS) is the provision of health care to American Indians and Alaska Natives throughout the United States. *See Lincoln v. Vigil*, 508 U.S. 182, 185 (1993). In carrying out that mission, IHS operates under two primary authorizing statutes. The first statute, the Snyder Act, authorizes IHS to expend such moneys as Congress may from time to time appropriate for the conservation of the health of Indians. *See* 25 U.S.C. § 13 (providing that the Bureau of Indian Affairs (BIA) will expend funds as appropriated for, among other things, the conservation of health of Indians); 42 U.S.C. § 2001(a) (transferring the responsibility for Indian health care from BIA to IHS). The second statute, the Indian Health Care Improvement Act (IHCIA), establishes numerous programs to address particular health initiatives, such as alcohol and substance abuse and diabetes. 25 U.S.C. § 1601 *et seq.*

Under these authorities, IHS provides health care services through three separate mechanisms: (1) directly through a nationwide network of federal facilities and clinics; (2) through contracts with Indian tribes and tribal organizations pursuant to the Indian Self Determination and Education Assistance Act (ISDEAA), Pub. L. No. 93-638 (codified at 25 U.S.C. §§ 450–458bbb-1), under which those tribes independently operate health care delivery programs previously provided by IHS; and (3) pursuant to contracts and grants awarded to urban Indian organizations to operate health programs in urban locations. The range of services provided by IHS may vary from location to location, so that a patient is not guaranteed that specific services will be available at all locations.[3] In addition, the Snyder Act and the Transfer Act authorize IHS to pay for medical care provided to IHS beneficiaries by other public or private providers as contract health

[3] *See* Services Available. 42 C.F.R. § 136.11(c) "The Service does not provide the same health services in each area served. The services provided to any particular Indian community will depend upon the facilities and services available from sources other than the Service and the financial and personnel resources made available to the Service."

services (CHS).[4] IHS pays for care under CHS when direct services are unavailable and no alternate resources exist to pay for such care.

IHS-administered programs are not entitlements, such as Medicare or Medicaid, whose funding is open-ended and limited only, for example, by how much a recipient chooses to contribute in "matching" funds. *See, e.g.*, 42 U.S.C. § 1396b (federal contributions to State Medicaid program are 75% of the amount attributable to compensation or training of skilled professional medical personnel, and staff directly supporting such personnel). Congress appropriates funds for all IHS health care programs, including CHS, through an annual lump-sum appropriation for Indian Health Services. *See, e.g.*, Department of the Interior, Environment, and Related Agencies Appropriations Act, 2009, Pub. L. No. 111-88, Tit. III, 123 Stat. 2945-2948. In 1978, pursuant to the authorities found in the Transfer Act and the Snyder Act, IHS promulgated rules for the establishment of "contract health service delivery areas, and uniform eligibility, notice and related requirements for the provision of contract health services to eligible Indians and other beneficiaries within those areas." 43 Fed. Reg. 34650 (August 4, 1978).[5] IHS currently pays for medical care provided to IHS beneficiaries at other public and private providers in accordance with these CHS regulations found at 42 C.F.R. §§ 136.21-25. Generally, IHS does not pay for self-

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[4] The Consolidated Appropriation Act of 2014 signed by President Obama in January, 2014 adopted a new name, Purchased/Referred Care (PRC), for IHS's CHS program. As set forth in IHS's Congressional Budget Justification where the name change was requested, the new name better describes the purpose of the program and its funding, which is generally for both purchased care, and referred care outside of IHS. The name change does not otherwise change the program, and is not intended to have any effect on the laws that govern or apply to CHS. IHS continues to administer PRC in accordance with all laws applicable to CHS. To avoid confusion and maintain uniformity with existing rules, this memorandum uses the term CHS.

[5] Although the purchase of CHS predates specific authority to purchase care, the Transfer Act was specifically amended in 1973 to authorize IHS "to contract with private or other non-Federal health agencies or organizations for the provision of health services to such people on a fee-for-service basis or on a prepayment or other similar basis." 42 U.S.C. § 2001(b).

referrals: "In nonemergency cases, a sick or disabled Indian, an individual or agency acting on behalf of the Indian, or the medical care provider shall, prior to the provision of medical care and services notify the appropriate ordering official of the need for services and supply information that the ordering official deems necessary to determine the relative medical need for the services and the individual's eligibility." 42 C.F.R. § 136.24.

IHS recognizes, however, that patients sometimes must seek care, including emergency care, before IHS is notified of such care and can pre-authorize it for payment. Therefore, under the regulations, IHS may authorize payment for either emergency or non-emergency care, but IHS assumes liability for the cost of that care subject to a number of other limitations. If any of these limitations are not met, IHS assumes no cost for the care and the patient may be held financially responsible. Generally speaking, the individual seeking coverage under CHS must be eligible for IHS services under 42 C.F.R. § 136.12 and also reside within a contract health service delivery area (CHSDA).[6] A beneficiary is eligible for CHS services if he lives on the reservation or if he lives in the CHSDA for his tribe (which may be broader than the boundaries of a reservation).

IHS will only authorize payment for CHS care if "necessary health services by an Indian Health Service facility are not reasonably accessible or available…" 42 C.F.R. 136.21(a). For non-emergency care, prior notification and approval from IHS is required under 42 C.F.R. § 136.24(b) and, for emergency care,[7] timely notification is required. 42 C.F.R. § 136.24(c).[8] At the discretion of IHS, the requirement for prior notification may

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[6] A CHSDA is "the geographic area within which contract health care services will be made available by the IHS to members of an identified Indian community who reside in the area, subject to the provisions of this subpart." 42 C.F.R. § 136.21(d).

[7] *Emergency* means any medical condition for which immediate medical attention is necessary to prevent the death or serious impairment of the health of an individual. 42 C.F.R. § 136.21(f).

[8] For elderly and disabled patients receiving emergency treatment, IHS is directed

be waived if the patient notifies IHS within 72 hours after the beginning of treatment. 42 C.F.R. § 136.24(b). Additionally, under 25 U.S.C. § 1621s, IHS must respond to the "notification of a claim by a provider of a contract care service with either an individual purchase order or a denial of the claim within 5 working days after the receipt of such notification." Except for patient travel costs IHS may cover under 25 U.S.C. § 1621l, the IHS does not reimburse patients for health care costs under CHS. If IHS does authorize care, a purchase order will be issued by the appropriate ordering official to the provider of services. 42 C.F.R. § 136.24(a).[9] Once IHS authorizes care, the patient "may not be held liable for the payment of any charges or costs associated with the provision of such services." 25 U.S.C. § 1621u. If a referral or notification is not obtained or waived, IHS will not authorize payment for the service and a denial may be issued. 42 C.F.R. § 136.24(a). If IHS does not authorize care, the patient may appeal the decision, but could be held financially responsible for the care by the provider of services.

Finally, CHS is a residual resource. IHS is payer of last resort for services provided through its programs, and IHS only assumes liability after all alternate resources have been considered. 42 C.F.R. § 136.61. Under IHS's "payor of last resort" rule, CHS will not be authorized for services when "[t]he Indian is eligible for alternate resources." 42 C.F.R. § 136.61(b)(1).[10] If a patient is eligible or potentially eligible for alternate

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by statute to allow 30 days for notification as a condition of payment. 25 U.S.C. § 1646.

[9] Generally, the purchase order will be issued in the name of a specific provider, obligating an estimated amount of funding committed to the service. *See* IHS Form 843-1A, Order for Health Services attached as **Exhibit A**. The specific steps involved in a CHS purchase order from the initial request through processing and closeout are diagramed in IHM Manual Exhibit 2-3-K attached as **Exhibit B**.

[10] The current payor of last resort regulation states:

> (a) The Indian Health Service is the payor of last resort of persons defined as eligible for contract health services under these

resources, she must apply for them before CHS funds will be authorized. 42 C.F.R. § 136.61(b). Recently, through the enactment of 25 U.S.C. § 1623(b),[11] Congress established IHS as the payer of last resort for services provided through IHS, superseding all contrary federal laws. Alternate resources primary to CHS under these authorities are

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> regulations, notwithstanding any State or local law or regulation to the contrary.
>
> (b) Accordingly, the Indian Health Service will not be responsible for or authorize payment for contract health services to the extent that:
>
> > (1) The Indian is eligible for alternate resources as defined in paragraph (c), or
> >
> > (2) The Indian would be eligible for alternate resources if he or she were to apply for them, or
> >
> > (3) The Indian would be eligible for alternate resources under State or local law or regulation but for the Indian's eligibility for contract health services, or other health services, from the Indian Health Service, or Indian Health Service funded programs.
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> (c) "Alternate resources" means health care resources other than those of the Indian Health Service. Such resources include health care providers and institutions, and health care programs for the payment of health services including but not limited to programs under title XVIII and XIX of the Social Security Act (i.e. Medicare, Medicaid), State or local health care programs and private insurance.

[11] 25 U.S.C. § 1623(b) establishes IHS as the payer of last resort for care provided to IHS beneficiaries:

> Health programs operated by the Indian Health Service, Indian tribes, tribal organizations, and Urban Indian organizations (as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603)) shall be the payer of last resort for services provided by such Service, tribes, or organizations to individuals eligible for services through such programs, notwithstanding any Federal, State, or local law to the contrary.

health care resources other than CHS, such as health care providers and institutions, as well as health care payers such as Medicare and Medicaid, state or local health care programs, and private insurance, including tribal insurance programs.[12]

Finally, CHS payments are subject to the availability of funding. Appropriations made by Congress[13] are generally unable to fully fund all CHS needs and so IHS prioritizes care based on medical need. 42 § C.F.R. 136.23(e). For example, services that are necessary to prevent the immediate death or serious impairment of the health of the individual are prioritized over preventative and elective health services.[14] Despite establishing medical priorities to cover the most necessary care, IHS is still unable to provide care to all of its beneficiaries. The demand for CHS care consistently exceeds available funding. IHS recently reported to Congress that IHS and tribal CHS programs denied an estimated $760,855,000 for an estimated 146,928 contract care services needed by eligible beneficiaries in FY 2013.[15]

FACTUAL RECORD

Plaintiff is an enrolled member of the Hopi Tribe. Compl. ¶ 1. According to the Complaint, Plaintiff has a rare blood disorder that requires medication to control

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[12] Prior to the enactment of § 1623(b), IHS acknowledged a limited exception to the payer of last resort regulation for self-funded tribal insurance plans. For acknowledgment, a plan claiming the exception is required to submit documentation that describes how and from what resources the plan is funded and a copy of the self-insurance policy, with exclusionary clause clearly indicated. *See* Indian Health Manual (IHM), Part 2. Ch. 3. 2-3.8I.

[13] In recent years, Congress has designated a portion of the appropriation to be available for CHS without fiscal year limitation. *See* Pub. L. No. 111-88 (designating $779,347,000 from the fiscal year (FY) 2010 to remain available for CHS until expended).

[14] Medical priority levels can be found in the IHM, Exhibit 2-3-D, available online at: http://www.ihs.gov/chs/index.cfm?module=chs_requirements_priorities_of_care.

[15] *See* Congress FY 2015 Congressional Justification Purchased/Referred Care Program Description and Accomplishments page 92-95, available online at: http://www.ihs.gov/budgetformulation/congressionaljustifications/.

complications that could be caused by excessive bleeding. Compl. ¶¶ 15-16. Plaintiff has previously received care from IHS, including the IHS Hopi Health Care Center (HHCC). Compl. ¶¶ 19-20.

Plaintiff resided on the Hopi Reservation during the period covered by the Complaint within the boundaries established for eligibility for contract health services. Compl. ¶ 37. Plaintiff was employed during this time period and covered by an insurance plan sponsored by the Hopi Grant School Trust. Compl. ¶¶ 30-31.

Plaintiff sought treatment from IHS and non-IHS providers during the time period in question. Compl. ¶¶ 48, 50; Declaration of Isabella Grover (Grover Dec.) ¶ 4; Declaration of CDR Keith J. Adcock (Adcock Dec.) ¶ 3, attached as **Exhibits C and D**. Plaintiff obtained treatment from IHS several times during 2012, including during the time period between July 1, 2012 and September 30, 2012. Grover Dec. ¶ 3. Plaintiff sought treatment from IHS once in July 2012. Grover Dec. ¶ 3. Although Plaintiff asserts that she attempted to secure appointments with IHS (Compl. ¶ 43), implying that she was unable to obtain them, there is no documentation or evidence indicating that IHS rebuffed such attempts. Rather, Plaintiff cancelled her appointment on June 1, 2012, and did not show for her appointments on June 28, July 19 and July 30. Grover Dec. ¶ 3. In August 2012, Plaintiff was seen by IHS during four separate appointments but missed or canceled scheduled appointments with IHS on August 7th, August 17th, and August 23rd. Grover Dec. ¶ 3. In addition to care sought by Plaintiff from IHS, Plaintiff elected to continue receiving care and treatment from non-IHS providers from July 2012 through September 2012. In July 2012, Plaintiff informed HHCC that she sought treatment from hematologists at Phoenix Children's Hospital. Grover Dec. ¶ 4. As noted in her complaint, Plaintiff elected to have prescriptions written by non-IHS practitioners filled at Walgreens Pharmacy. Compl. ¶¶ 17, 48, 50. On several occasions, medications were sent to HHCC by Walgreens for Plaintiff. Because the medication was expensive and temperature sensitive, IHS refrigerated the drugs and contacted Plaintiff to pick them up.

Adcock Dec. ¶ 3. At no time, however, were the medications requested by HHCC, nor did HHCC agree to accept medical or financial responsibility for them. *Id*.

Contrary to Plaintiff's assertion that IHS completed an "application for care and medications" on the same day as being contacted by the White House (Compl. ¶ 12), IHS issued a prescription for medication for the patient on September 24, 2012. Grover Dec. ¶ 5. Due to difficulty in reaching the patient via telephone, Plaintiff was also notified in writing on September 25, 2012 that her prescription was available for pick up from HHCC. Grover Dec. ¶ 5, Attachment 1 to Declaration. IHS received at least three letters from counsel for Plaintiff dated September 20, 2012, September 27, 2012 and January 25, 2013, attached as **Exhibit E**. The September 20, 2012 letter sets forth a request that IHS provide "written confirmation that Hopi Health will cover Cecilia's care and prescription medications" for a future shipment of medication from Walgreens. The September 27, 2012 letter, dated the same day that IHS dispensed medication to Plaintiff, reiterated the request in the earlier letter and informed IHS that "Walgreens needs to ship medications by tomorrow." The January 25, 2013 letter requested reimbursement "to the Trust of actual plan and coinsurance payments as of today totaling $116,352.00, and payment directly to Walgreens for the remaining amount of $58,176.00." Exhibit E.

The January 2013 reimbursement request was not acted upon by IHS. [16] According to IHS, the "the request for payment did not meet the requirements for requesting CHS/PRC coverage as prescribed by regulation." Grover Dec. 2 ¶. The request was unaccompanied by "copies of bills, invoices, or prescriptions, from Plaintiff or Walgreens Pharmacy regarding the medications that Plaintiff obtained from Walgreens Pharmacy from approximately July 1, 2012, to September 27, 2012." *Id*. Plaintiff

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[16] In 2012, HHCC communicated to Plaintiff's attorney that Plaintiff must provide authorization to HHCC to discuss her care him. IHS utilizes form IHS-810 for this purpose, which may be found online at: http://www.ihs.gov/forpatients/patientforms/. Plaintiff provided IHS with a different non-standard representation letter, signed July 2013, months after the January 25, 2013 letter. Grover Dec. Attachment 3.

asserts in the Complaint that she "supplied additional information regarding billing invoices" on August 8, 2013 in response to a request received from HHS with regard to her tort claim, but does not indicate that such information was ever provided to HHCC for consideration of CHS coverage. Compl. ¶ 72. Plaintiff is currently receiving her medication as a direct care service at HHCC and has been since on or about September 24, 2012. Grover Dec. ¶ 4. CHS funds have not been used to pay for Plaintiff's care. Grover Dec. ¶ 5.

ARGUMENT

I. PLAINTIFF'S CLAIMS ARE NOT COGNIZABLE UNDER THE FTCA BECAUSE PLAINTIFF HAS FAILED TO IDENTIFY AN ESTABLISHED CAUSE OF ACTION UNDER THE REQUISITE STATE LAW.

Actions seeking to recover in tort against the United States and its agencies or employees, for personal injury or loss of property based on employee conduct within the scope of employment, are governed by the FTCA. Section 1346(b) of the FTCA grants the United States District Courts jurisdiction under circumstances where the United States, if a private person, would be liable to the claimant in accordance with the law of the place where the act or omission occurred. 28 U.S.C. § 1346(b)(1) (emphasis added). Thus, to assert a cognizable claim under the FTCA, a litigant must identify an established cause of action that is recognized in the jurisdiction where the tort occurred. *See* 28 U.S.C. § 1346(b)(1); *Lomando v. United States*, 667 F.3d 363, 373 (3d Cir. 2011); *Chen v. United States*, 854 F.2d 622, 626 (2d Cir. 1988). "Merely alleging negligence is insufficient to state a claim." *Westbay Steel, Inc. v. United States*, 970 F.2d 648, 650 (9th Cir. 1992); *Art Metal- U.S.A., Inc. v. United States*, 753 F.2d 1151, 1157 (D.D.C. 1985). If a litigant fails to meet the local law requirement, the district court lacks jurisdiction to entertain the claim against the federal government.

An obvious corollary of the state law principle is that "the FTCA was not intended to redress breaches of federal statutory duties." *Johnson v. Sawyer*, 47 F.3d 716, 727-29 (5th Cir. 1995)(en banc)(quoting *Sellfors v. United States*, 697 F.2d 1362, 1365 (11th Cir.

1983)). Indeed, "the FTCA does not apply 'where the claimed negligence arises out of the failure of the United States to carry out a [federal] statutory duty in the conduct of its own affairs.'" *Sea Air Shuttle Corp. v. United States*, 112 F.3d 532, 536 (1st Cir. 1997) (quoting *Johnson*, 47 F.3d at 728); *see Love v. United States*, 60 F.3d 642, 644 (9th Cir. 1997). "The FTCA's law of the place requirement is not satisfied by direct violations . . . of federal statutes or regulations standing alone. . . . The alleged violations must also constitute violations of duties analogous to those imposed under local law." *Chen*, 854 F.2d at 626 (internal quotations marks and citations omitted); *Art Metal*, 753 F.2d at 1157 (noting the "well-established principle that the violation of a federal statute or regulation by government officials does not of itself create a cause of action under the FTCA" and citing cases); *Delta Sav. Bank v. United States*, 265 F.3d 1017, 1024 (9th Cir. 2001) ("Plaintiffs suggest, without support, that an FTCA claim can be brought for violations of federal statutes that provide private federal causes of action, even if there is no analogous state law. This is not so." (emphasis in original)); *Sea Air*, 112 F.3d at 536 ("[V]iolation of a federal statute by governmental actors does not create liability unless state law would impose liability on a 'private individual under like circumstances.'" (quotation and citations omitted)).

In her Complaint, Plaintiff has failed to identify a local law under which the United States can be held liable for the alleged acts of negligence. Plaintiff vaguely asserts a duty owed to her by Defendants to pay for or provide medical care and Medicine that was medically necessary and to make eligibility decisions in a timely manner, but she fails to reference a local law that imposes such a duty. Compl. ¶¶ 128-129. Throughout her Complaint Plaintiff cites to the Indian Health Care Improvement Act, a federal statute, and IHS regulations, as the law that imposes a duty which Defendants breached. In fact, Plaintiff solely relies upon those "foregoing statutory regulatory and federal agency policy requirements . . ." to undergird her allegations of negligence. *Id.* ¶ 153 (emphasis added). These sources of a federal statute and corresponding regulations

are insufficient to maintain a cause of action under the FTCA.

II. PLAINTIFF HAS NOT STATED AN ACTIONABLE CLAIM BECAUSE SHE HAS NOT IDENTIFIED ANY TORT LIABILITY ON THE PART OF AN APPROPRIATE ANALOGOUS PRIVATE PERSON.

Plaintiff asserts various acts of negligence against Defendant United States under the FTCA. However, the United States is only subject to liability "under circumstances where the United States, if a private person, would be liable to the claimant in accordance with the law of the place where the act or omission occurred." 28 U.S.C. § 1346(b). The United States is only subject to liability "in the same manner and to the same extent as a private individual in like circumstances." 28 U.S.C. § 2674. The United States Supreme Court has "interpreted these words to mean what they say, namely, that the United States waives sovereign immunity 'under circumstances' where local law would make a '*private person*' liable in tort." *United States v. Olson*, 546 U.S. 43, 44 (2005)(emphasis in original).[17] The plain meaning of Section 1346(b) is that the United States cannot be held liable when there is no comparable cause of action against a private citizen. As to claims falling within this jurisdictional grant, the FTCA makes the United States liable in the same manner and to the same extent as a private individual under like circumstances. 28 U.S.C. § 2674.

Plaintiff's negligence claims against the United States fail because such claims would not be viable against a similarly situated private person under Arizona law. For the first time, in her amended Complaint, Plaintiff claims that IHS owed a common law duty under Arizona law to provide medical care to her, rather than pay for medical care she received elsewhere. Compl. ¶ 128. On its face, this claim fails. Arizona law

[17] Relevant to this case, local law means state law, not tribal law and therefore Plaintiff's claims based on duties owed under Hopi law must fail. *See Brock v. U.S.*, 601 F.2d 976, 978 ("Congress had in mind the law of the state where the negligence occurred"); *Seyler v. United States*, 832 F.2d 120 (9th Cir.1987) (applying state law to a tort that occurred on tribal land); *see also Bryant ex rel. Bryant v. U.S.*, 147 F.Supp.2d 953, (D.AZ. 2000).

recognizes a duty to provide medical care in circumstances that are not present here, requiring hospitals "to accept and render emergency care to all patients who present themselves in need of such care." *Thompson v. Sun City Community Hosp., Inc.*, 141 Ariz. 597, 602 (1984). Even if Plaintiff did request that IHS provide care, as alleged in the Complaint, she has acknowledged in the Complaint that she continued to receive medication from sources that were external to IHS. Compl. ¶ 48. Indeed, she had her medication mailed to HHCC on several occasions and picked it up there herself, in non-emergent circumstances. Adcock Dec. ¶ 3. Thus, Plaintiff's claim that IHS breached a common law duty to provide care is not cognizable under Arizona law.[18] Moreover, Plaintiff has not pled that IHS was negligent in the care that it did provide when Plaintiff accessed care from HHCC. Rather, her claims are squarely grounded on the proposition that HHCC did not respond to her requests to assume financial responsibility for the costs of medication she obtained from external sources.

With respect to such costs, Plaintiff generally avers that government officials at the IHS were negligent in their failure to act upon her alleged request for CHS. CHS care is governed exclusively by federal law and regulations, and there is no private analog. Contrary to Plaintiff's contention, CHS is not like insurance. Complaint ¶ 101. CHS does not offer anything remotely comparable to a defined benefit plan and, unlike many other government health programs, does not even meet the minimum essential coverage provisions in federal law.[19] CHS is a procurement function under which IHS pays for care that it cannot provide directly, subject to a number of restrictions set forth through regulations promulgated by IHS. CHS does not reimburse patients for expenses they incur when they self-refer. Unless an emergency exists, patients are not free to self-

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[18] Plaintiff asserts that she received "emergency" blood transfusions, but there is no allegation that IHS failed to provide such care to her directly. Complaint ¶ 10.

[19] 26 U.S.C. 5000A(f).

refer at all when seeking CHS care. Rather, IHS selects the appropriate provider based on costs and quality factors.[20] Under CHS regulations, the burden for taking steps to obtain CHS care fall on the patient. The individual requesting CHS must obtain prior authorization for care by supplying "information that the ordering official deems necessary to determine the relative medical need for services…" 42 C.F.R. § 136.24(b). Although Plaintiff asserts that she "applied" for CHS in advance, she does not contend that she provided notification in accordance with § 136.24(b). What Plaintiff appears to be asserting is that she notified IHS in advance of her intent to continue obtaining medication from Walgreens and then shortly thereafter began obtaining such medication. Plaintiff does not allege with any specificity when this "notification" occurred.

IHS records indicate that Plaintiff did not show for her appointments with Julie Polzin, Nurse Practitioner, on June 28, July 19, July 30, August 7, August 17, and August 23, 2012. Grover Dec. ¶ 3. IHS records also indicate that Plaintiff began having her medication from Walgreens, obtained through self-referral, mailed to HHCC at the beginning of July 2013. Adcock Dec. ¶ 3. When a patient misses appointments and instead chooses to obtain care from non-IHS sources through self-referral, IHS's ability assess the need for such care, and approve or deny payment for it in advance is lost. Whether the care is necessary or not, IHS will not consider CHS in such circumstances.

Assuming Plaintiff notified IHS and sought prior authorization in accordance with 42 C.F.R. 136.24(b), however, IHS still had no duty under CHS rules to approve care or issue a purchase order within a specified time period. When IHS pays for contract health care, it is by way of a contractual arrangement with the non-IHS provider of care that IHS selects. Typically, this contractual arrangement is accomplished, after notification is provided, through the issuance of a purchase order or referral to a specific provider. *See*

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[20] See Indian Health Manual (IHM) 2-3.21, available online at http://www.ihs.gov/IHM/index.cfm?module=dsp_ihm_pc_p2c3#2-3.21D

infra at 6. When IHS refuses to contract for care under CHS, IHS provides beneficiaries with a comprehensive multi-level reconsideration and appeal process that permits beneficiaries to appeal directly to the Director, Indian Health Service. *See* 42 C.F.R. § 136.25(c). This process does not anticipate, however, that a patient will self-refer before a decision can be made and then claim to be harmed by the absence of that process. Indeed, the entire unique regulatory process for CHS approvals, denials and appeals would be thwarted if a claimant can pursue a remedy in tort for non-payment of self-referred health care services that would not otherwise be covered. What remains is a fundamental problem: simply put, there is no private analog comparable to the process by which IHS makes funding decisions for IHS CHS.

In *Clark v. United States*, perhaps the closest analogous case involving the FTCA, plaintiffs sought damages for the government's alleged negligence in the delay of processing an application for disability retirement benefits. 321 Fed. Appx. 672, 673 (9th Cir. 2009)(unpublished). The district court dismissed the plaintiffs' FTCA claims against the United States for lack of subject matter jurisdiction because, among other reasons, their claims would be preempted by ERISA. *Id.* at 673. The Ninth Circuit affirmed, stating "to the extent the [plaintiffs have] identified a cognizable tort under applicable local law, it would be preempted by [ERISA] against a private employer." *Id.* (citation omitted); *see e.g., Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 48 (1987)("The common law causes of action raised in [plaintiff's] complaint, each based on alleged improper processing of a claim for benefits under an employee benefit plan, undoubtedly meet the criteria for pre-emption under § 514(a).").

Plaintiff relies on the Indian Health Care Improvement Act and the CHS regulations in support of her negligence allegations; however, she fails to recognize the irony that, in doing so, her claims would not be cognizable against a similarly situated private person. Accordingly, Plaintiff's claims against the United States under the FTCA fail, and they must be dismissed for lack of subject matter jurisdiction.

III. PLAINTIFF'S CLAIMS ARE NOT COGNIZABLE UNDER THE FTCA BECAUSE THEY ARE BARRED UNDER THE "DUE CARE" EXCEPTION.

Section 2680(a) of the FTCA exempts the United States from liability for "[a]ny claim based upon an act or omission of an employee of the Government, exercising due care, in the execution of a statute or regulation, whether or not such statute or regulation be valid . . . ." This "due care" exception "prevents the United States from being held liable for actions of its officers undertaken while reasonably executing the mandates of a statute." *Welch v. United States*, 409 F.3d 646, 651 (4th Cir. 2005). A two-part test is applied to determine if this exception applies: (1) whether the statute or regulation prescribes a specific course of action for an officer to follow; and (2) if a mandatory course of action is required, sovereign immunity is not waived if "the officer exercised due care in following the dictates of the statute or regulation." *Welch*, 409 F.3d at 652; *see also Crumpton v. Stone*, 59 F.3d 1400, 1403 (D.C. Cir. 1995).

Plaintiff asserts that IHS has violated trust duties, and duties under federal statutes and regulations. Plaintiff's contentions with respect to each alleged violation are without merit. IHS did not violate any federal responsibility, whether founded on trust, statute or regulation. With respect to Plaintiff's assertions regarding trust, this case does not involve federal fiduciary obligations in managing Indian property or trust assets. *See United States v. Mitchell*, 463 U.S. 206 (1983). The United States has special responsibilities to the American Indian population, including the provision of health care, but such obligations are creatures of statute. The government's responsibility to Indians does not create a specific financial obligation where one does not otherwise exist by virtue of statute, except in circumstances not present here, where the Federal government assumes control or supervision over tribal monies or property, *i.e.*, a tangible trust corpus. *See, e.g., United States v. Cherokee Nation of Oklahoma*, 480 U.S. 700, 707 (1987)(government's "fiduciary obligations" "do not create property rights where none would otherwise exist but rather presuppose that the United States has interfered with

existing tribal property interest"); *see also Reuben Quick Bear v. Leupp*, 210 U.S. 50, 80 (1908)(distinguishing between appropriations for the benefit of Indians, which are gratuitous, and specific treaty obligations under which funds have been set aside for the benefit of Indians). Nothing in the language of any of these cases prescribes a specific course of action that must be followed by IHS, nor do they support an enforceable trust responsibility for health care services. IHS provides no guarantee that beneficiaries will receive services when requested. Indeed, IHS's regulations reflect that IHS direct services depend on financial and personnel resources available to the service and that services will vary from area to area.[21]

As set forth below, IHS did not breach any statutory or regulatory duties. Plaintiff quotes the first three paragraphs of the introductory section of the IHCIA, 25 U.S.C. § 1601, which articulates the Congressional findings underlying the legislation. Compl. ¶ 87. Plaintiff also emphasizes a policy set forth in 25 U.S.C. 1602(1) "to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy. *Id.* Plaintiff asserts that IHS failed to meet these statutory requirements with respect to Plaintiff's request for coverage. *Id.* ¶ 92. The Supreme Court has cautioned against judicial reliance on statements of legislative findings and objectives:

> [N]o legislation pursues its purposes at all costs. Deciding what competing values will or will not be sacrificed to the achievement of a particular objective is the very essence of legislative choice – and it frustrates rather than effectuates legislative intent simplistically to assume that *whatever* furthers the statute's primary objective must be the law.

Rodriguez v. United States, 480 U.S. 522, 525-26 (1987)(per curiam)(italics original); *see*

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[21] *See also Denny v. U.S.*, 171 F.2d 365, 366 (5th Cir. 1948) ("Any negligent breach of duty on the part of the Army medical authorities which may have existed, in failing to extend promptly *the gratuitous medical services* requested, clearly could not have resulted in any actionable damage.")(emphasis added).

also Westside Mothers v. Olszewski, 454 F.3d 532, 543 (6th Cir. 2006)(broad, nonspecific statutory language "ill-suited to judicial remedies" and call for "policy decisions for which a court has little expertise and even less authority").

In this case, there a vast difference between findings and a declaration of policy toward the health care of Indians, and the entitlement that Plaintiff claims to reimbursement for her personal health care expenses. The Congressional Findings and the Declaration of National Indian Health Policy in IHCIA neither impose a specific duty on IHS, nor establish that IHS must accept financial responsibility for Plaintiff's care. To the contrary, in the very same IHCIA statement of findings, in a subparagraph Plaintiff chose not to quote in the Complaint, Congress declared that although "[f]ederal 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," 25 U.S.C. § 1601(4), Indian health needs remain unmet. 25 U.S.C. § 1601(5).

Rather than arising from an enforceable trust obligation or the findings and declaration found in the IHCIA, the regulations governing the provision of contract health care to IHS beneficiaries were originally promulgated under the authority of the Snyder Act and the Transfer Act.[22] Neither of these statutes prescribes a specific course of action that must be followed. Rather, they serve as basis for IHS, at its discretion, to allocate funds appropriated by Congress. *See Vigil*, 508 U.S. at 192 ("The allocation of funds from a lump-sum appropriation is another administrative decision traditionally regarded as committed to agency discretion."); *see also Salazar v. Ramah Navajo Chapter*, ___U.S. ___, 132 S. Ct. 2181, 2190 (2012)(quoting *Vigil* with approval and confirming that the ability to direct CSC funds within an appropriation is "committed to agency discretion by law"). In *Vigil*, the Court recognized that appropriations for Indian

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[22] *See* Provision of Contract Health Services, Notice of Proposed Rulemaking, 42 F.R. 46792 (Oct. 22, 1976).

health care under the Snyder Act (and the Indian Health Care Improvement Act, 25 U.S.C. § 1601 *et seq*.), are not trust assets to which fiduciary obligations attach, and that "whatever the contours of [the trust] relationship", it does not serve as the basis for courts to impose legal obligations on the IHS in allocating resources. *Id*. at 194. Far from dictating a mandatory course of action, *Vigil* acknowledges that the allocation of funding under IHS's appropriation is committed to agency discretion as a matter of law and thus exempt under section 2680(a).

Of course, IHS will assume responsibility for the cost of health care provided by a non-IHS provider, and allocate funding for such care, but only in accordance with regulations governing CHS. IHS does not pay for care under other circumstances. Even if IHS's conduct under the "due care" exception is assessed from the perspective of whether it followed the regulations and statutes governing CHS, IHS did not violate any responsibility under those rules. Though she could have coordinated her care with IHS, HHCC's records reflect that from June through September 2012, Plaintiff missed and cancelled several appointments with her HHCC primary care provider, Nurse Practitioner Julie Polzin. Grover Dec. ¶ 3. IHS beneficiaries are not required to obtain care from IHS. Many patients, like Plaintiff, have insurance and can choose to seek care from non-IHS providers, for which IHS assumes no financial responsibility.[23] In this case, Plaintiff elected to obtain her medications at Walgreens without obtaining prior authorization as required by 42 C.F.R. § 136.24(a). Even assuming Plaintiff properly notified IHS,

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[23] Plaintiff asserts that the Tribal School Plan was not an alternate resource to CHS. Compl. ¶ 33. It does not matter whether the Tribal School Plan is an alternate resource to CHS or not for the purposes of this motion because IHS never assumed any residual liability for the costs of Plaintiff's care under CHS. The basis for Plaintiff's assertion would matter if Plaintiff's care had been authorized for payment under CHS, subject to consideration by alternate resources. The September 20, 2012 letter from Plaintiff's Counsel states that the plan excluded "IHS/CHS eligible care" as of July 1, 2012. The Complaint does not explain why the Tribal School Plan did not cover costs not authorized by CHS. Compl. ¶ 32. Curiously, Plaintiff's apparent acceptance that her insurance can deny coverage for her medical care does not appear to be in her best interests.

payment would not be guaranteed.

Although the Complaint demonstrates that Plaintiff wanted IHS to cover the cost of her medications through CHS, the Complaint also demonstrates that she was aware that IHS had not made her any such assurances, and in fact even acknowledges that obtaining authorized CHS services is subject to approval by a committee at HHCC. Compl. ¶ 27. It is hard to reconcile Plaintiff's acknowledgment and understanding of the CHS approval process with her pattern of self-referral decisions and missed appointments, which limited her opportunity to obtain care from IHS and approval for CHS. *See* Grover Dec. ¶ 3-4. Although counsel for Plaintiff submitted a two-page letter in January 2013 requesting reimbursement for expenses allegedly incurred, it was submitted months after the care was provided and was not identified by IHS as actionable under CHS rules. *See* Grover Dec. ¶ 2. Moreover, IHS has no record of Plaintiff authorizing IHS to discuss her care with her attorney prior to July 2013. Assuming that IHS should have considered the January 2013 request, however, it failed to offer any evidence of prior approval or notification in accordance with CHS rules and failed to include any supporting information "necessary to determine the relative medical need for the services…" 42 C.F.R. § 136.24(b). At this point, nearly two years later, there still is no clear basis for IHS to consider CHS coverage. Leaving aside the lack of proper notification and/or prior approval, every other CHS requirement would still need to be assessed and met, including consideration of medical priorities, alternate resources, direct service resources and the availability of funds. IHS has never assessed any of these requirements in relation to Plaintiff's non-IHS care. Moreover, since September 2012, IHS been providing care directly through HHCC rather than though CHS, and when care is available directly, CHS is not authorized. 42 C.F.R. § 136.23(a).

In Plaintiff's case, direct care services were available and accessible to Plaintiff. Plaintiff's opportunity to obtain care from IHS was impacted by missed appointments and self-referrals. Even if Plaintiff believed IHS was delaying a coverage decision under

CHS rules for care that was unavailable directly, IHS has no evidence that proper retroactive approval, as required by the rules, was sought or obtained for the non-IHS care that Plaintiff obtained, and no invoices or claims for payment were received by HHCC for payment. Ultimately, Plaintiff is not entitled to specific direct health care services, nor is she entitled to coverage through CHS for care that IHS cannot provide directly. It is well documented that there remain unmet health care needs amongst the IHS beneficiary population. Indeed, the present case exists because IHS has not assumed financial responsibility for the cost of Plaintiff's care, and it has no obligation under Federal law to do so. Plaintiff failed to seek relief through the regulatory process governing CHS, and she should not be able to bypass that procedure by relabeling her request for payment as a tort claim.

IV. THE COMPLAINT DOES NOT PRESENT A SUBTANTIAL FEDERAL QUESTION.

Federal question jurisdiction exists only where there is a federal cause of action or a substantial question of federal law. *Merrell Dow Pharmaceuticals Inc. v. Thompson*, 106 S.Ct. 3229, 3232, (1986); *Peabody Coal Co. v. Navajo Nation*, 373 F.3d 945, 949 (9th Cir. 2004). There can be no substantial federal question where, as here, the claim is foreclosed by controlling precedent. *Hagans v. Lavine*, 94 S.Ct. 1372, 1378-79 (1974); *Cook Inlet Region, Inc. v. Rude*, 690 F.3d 1127, 1131 (9th Cir. 2012). *See also, Gunn v. Minton*, 133 S.Ct. 1059, 1064-66, (2013)(federal question jurisdiction precluded by precedent); *Caterpillar Inc. v. Williams*, 107 S. Ct. 2425, 2429 (1987)(federal question jurisdiction exists only when presented on the face of the complaint). As explained above, the statutory framework and trust doctrines do not provide a federal cause of action for damages (all Counts) and the allegations of the Complaint do not present a substantial question of federal law.

CONCLUSION

The allegations of the Complaint fall outside any waiver of sovereign immunity or grant of subject matter jurisdiction, and fail to state a claim on which relief can be granted. The Complaint and action should be dismissed.

Respectfully submitted this 5th day of September, 2014.

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CERTIFICATE OF SERVICE

I hereby certify that on September 5, 2014, I filed the foregoing with the Clerk's Office using the ECF system, which electronically transmitted a Notice of Filing to the following registered CM/ECF users:

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