UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

REDDING RANCHERIA, **a federally-recognized Indian tribe,**	)	
Plaintiff,	)	**Case No. 14-2035 (RMC)**
v.	)	
SYLVIA MATTHEWS BURWELL, **Secretary, United States Department of Health and Human Service, et al.**	)	
Defendants.	)	

REDDING RANCHERIA'S OPPOSITION TO DEFENDANTS' SUMMARY JUDGMENT MOTION AND MEMORANDUM IN SUPPORT OF CROSS-MOTION FOR SUMMARY JUDGMENT

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INTRODUCTION

It is well-established federal policy, as stated in the Indian Health Care Improvement Act of 1976 ("IHCIA"), to encourage Indian participation in ''the planning and management'' of the health services that the federal government is otherwise obligated to provide to Indians under its trust and statutory obligations. 25 U.S.C. § 1601(3). This policy is accomplished largely through the Indian Self-Determination and Educational Assistance Act ("ISDEAA"), which created the framework for tribes to enter compacts with the United States to take on responsibility for the design and operation of tribal health programs. Self-determination means giving an "effective voice" to Indian tribes "in the planning and implementation of programs for the benefit of Indians which are responsive to the true needs of Indian communities." 25 U.S.C. § 450(a)(1). It calls for a "transition from the Federal domination of programs for, and services to, Indians to effective and meaningful participation by the Indian people in the planning, conduct, and administration of those programs and services." 25 U.S.C. § 450a(b).

This action arises out of the Redding Rancheria's effort to protect its self-determination rights to design and operate its health programs consistent with applicable federal law, federal policy, and the Tribe's Compact with the United States.[1] IHS has interfered with the Tribe's efforts to carry out the Compact by denying the Tribe access to Catastrophic Health Emergency Fund ("CHEF") reimbursements unless the Tribe agrees to design and operate its compacted contract health service ("CHS") program in an inefficient manner contrary to the interests of the Tribe and its members. IHS's conduct has cost the Tribe more than a million dollars in healthcare funds, and forced changes to the Tribe's healthcare programs that decrease efficiency

[1] Redding Rancheria is hereafter referred to as "the Tribe." The Secretary of the Department of Health and Human Services is hereafter referred to as "the Secretary." The Director of IHS is hereafter referred to as "the Director." Together, Defendants are referred to as "IHS."

and prevent the Tribe from improving delivery of healthcare services to its community.

At the center of this case is the Tribe's CHS program, which was transferred to the Tribe by Compact. CHS is meant to provide for the purchase of healthcare from non-Tribal facilities when needed. However, the availability of CHS care has historically been very limited due to shortages of federal funding, outdated healthcare delivery systems, lack of professional claims management services, and limited access to provider network pricing arrangements. To combat these systemic inefficiencies, the Tribe developed a member-based self-insurance program (the "TSIP"). The TSIP provides supplemental healthcare funding so that the Tribe's needs for healthcare can be met. The Tribe also coordinates the TSIP with its CHS Program to increase efficiencies in healthcare delivery. The TSIP has access to modern claims processing, network pricing arrangements, and professional claim management services. The Tribe made arrangements to allow its CHS program the benefit of these same efficiencies. The Tribe retained a claims administrator and fiscal intermediary to coordinate member care between the two Tribal health programs. The Tribe adopted procedures to ensure that the programs could maximize healthcare purchased with every dollar spent. For example, the CHS program (but not the TSIP on its own) can purchase certain care at favorable Medicare-like rates ("MLR"). Other care, however, can be secured at "network" rates—lower than what would otherwise be available to CHS when the MLR regulations do not apply—through the TSIP directly.

IHS refused to honor the Tribe's CHS program design improvements, and denied the Tribe access to CHEF benefits for catastrophic claims unless the Tribe agreed to reverse its CHS program design. But the Tribe has the right under the Compact to redesign and administer its CHS program to increase efficiencies. IHS is correspondingly prohibited from denying CHEF eligibility or other federal benefits as a result of the Tribe's exercise of its Compacted rights.

IHS rejected all of the Tribe's attempts to resolve this matter, and it now seeks summary judgment on three main grounds. First, IHS argues that the CHEF statute precludes the Tribe from pursuing remedies under the ISDEAA or Contract Disputes Act ("CDA") because "no part of CHEF or IHS' administration of CHEF is subject to the ISDEAA or the CDA." IHS admits, however, that it is required under the Compact to maintain the Tribe's CHEF eligibility. IHS's failure to fulfill this Compact obligation—to maintain the Tribe's CHEF eligibility—constitutes a breach of the Compact. IHS is also in breach of the Compact by refusing to honor the Tribal CHS program payments as "valid CHS obligations" eligible for CHEF, and for failing to consult with the Tribe on its CHS program design. This is the basis for the Tribe's claims. The Tribe does not, and has not, asserted a right to contract for the administration of CHEF.

Second, IHS argues that it properly rejected the Tribe's Final Offer for a Compact amendment—one that would have resolved this dispute by describing with specificity what is permitted by the Tribe's existing right to design and operate its CHS program. IHS mischaracterized the Tribe's Final Offer as a "request for funds" and a request to delegate an "inherent federal function" to the Tribe. However, this ignores the substance of the Tribe's actual proposal and program design. The Tribe merely sought to confirm its right to adopt improvements and coordinate CHS administration without losing "valid CHS" status.

Third, IHS argues that the Tribe's program design violates the Affordable Care Act ("ACA"). IHS contends—based solely on its own conjecture and disregard of all other federal Indian policy—that the ACA imposed new constraints on the ability of Indian tribes to provide healthcare to their members, and that the ACA changes federal Indian health policy by shifting federal responsibilities onto the backs of Tribal budgets. IHS is wrong, the ACA does not impose such constraints and was not intended to turn Indian health policy on its head. To the contrary,

every change pointed to by IHS was specifically added to strengthen tribal healthcare and the obligations owed by the federal government in that regard. For all of these reasons, as detailed further below, the Court should deny IHS's motion for summary judgment.

The Court should also grant the Tribe's motion for summary judgment. The Tribe designed and operated its health programs in compliance with the Compact and applicable law. IHS created a situation in which the Tribe could not obtain the full benefit of its Compact and was forced to choose between its right to design its own health programs and its right to CHEF eligibility. In doing so, IHS breached its Compact and statutory obligations to the Tribe.

FACTUAL BACKGROUND

I. The Tribe's ISDEAA Compact Guarantees the Tribe's Right to Design its Health Programs and Requires IHS to Maintain the Tribe's CHEF Eligibility.

Redding Rancheria is a federally-recognized Indian tribe. Until 2011, the Tribe relied on federally-operated programs to provide healthcare to its members. The United States provided these health services as required by its trust duties to the Indian tribes and statute—namely the Snyder Act (25 U.S.C. § 13) and the Indian Health Care Improvement Act (25 U.S.C. §§ 1601, et seq.) ("IHCIA"). On August 16, 2011, the Tribe entered a Compact with the Secretary, on behalf of the United States, pursuant to ISDEAA. AR at IHS000323-40. The Secretary transferred the operation of certain health services to the Tribe, and the Tribe became responsible for the design and administration of its direct service and CHS programs to meet the needs of the Tribe and its members—in contrast to the one-size-fits-all approach of federally-operated programs. *Id*. In return, the Tribe received federal funding for the transferred health programs. *Id.*

The United States guaranteed the Tribe's right "to redesign programs, activities, functions and services of the Indian Health Service; to reallocate funds for such programs . . . according to its tribal priorities . . . [and] to enhance the effectiveness of its tribal government

through the reduction of federal management and control." Compact Art. 1, § 2 (IHS000323-24). Indeed, one the principal purposes of the Compact is to give substance to these powers of self-determination and self-governance. *Id*. The Tribe was not required to administer its CHS program in accordance with IHS internal policies; to that end, the Compact states that, unless expressly agreed otherwise, "the Tribe shall not be subject to any circular, policy, manual, guidance, or rule adopted by the Indian Health Service, except for the eligibility provisions of section 105(g) of the [ISDEAA] and regulations promulgated under Section 517 of Title V." Compact Art. II, § 11 (IHS000328). ISDEAA also guarantees the Tribe's right to "redesign or consolidate programs . . . in any manner which the Indian tribe deems to be in the best interest of the health and welfare of the Indian community being served." 25 U.S.C. § 458aaa-5(e). This right is not subject to IHS review or consent. *Id*.

Moreover, nothing in ISDEAA, the IHCIA, or the Compact required the Tribe to give up other federal program benefits, such as CHEF, in exchange for the right to redesign its CHS program. To the contrary, the Compact guaranteed that the Tribe would have access to certain federal programs, the administration of which was not being transferred, for dealing with disasters and emergencies. Compact Art. V, § 4 (IHS000335). Specifically, the United States undertook an affirmative obligation to "maintain the Tribe's eligibility for Catastrophic Health Emergency Fund (CHEF) money on a par with all other Indian Health Service Units and tribal Self-Determination contract operations and for other catastrophic health care funds as may be available from time to time on a par with all other Indian Health Service Units and tribal Self-Determination contract operations." *Id*.

With the Compact, the Tribe and the United States entered a Funding Agreement for the period April 1, 2011 through March 31, 2013. The Funding Agreement provides that the Tribe

will "be eligible for reimbursement for . . . qualifying catastrophic cases on the same basis as other tribes and service units" and that "CHEF allowances will be made available to the Tribe to fund all expenses above the threshold for the problem in accordance with CHEF policy and procedure." AR at IHS000315. None of these provisions, as IHS agrees, contract for the administration of CHEF. They merely ensure that the Tribe's Compacted CHS program will be afforded the same catastrophic loss protection that other programs receive.

II. The Tribe's Health Programs are Designed to Maximize the Availability of Healthcare to its Members.

Two of the Tribe's healthcare programs are relevant here: CHS and the TSIP.

A. The CHS Program Provides Healthcare, but Cannot Address All Need.

The Tribe's CHS program is one of the health services transferred from IHS to the Tribe under the Compact. AR at IHS000314. Although the Tribe has significant authority to redesign the program to meet its needs, it has largely adopted IHS regulations regarding patient eligibility and authorization of services. CHS is available as a source of payment for health care services provided to Indians by medical facilities other than those operated by IHS or an Indian tribe. *See* 42 C.F.R. § 136.21(e). CHS is available for services that are medically necessary, but not reasonably accessible or available from an IHS or tribal facility. 42 C.F.R. § 136.23. CHS is not an entitlement program; coverage is subject to the availability of CHS funds. *Id*. CHS is principally funded by the federal government, but tribes operating CHS programs under ISDEAA may use tribal funds to supplement the CHS funds. 25 U.S.C. § 458aaa–5(e) (tribes may redirect funds for compacted programs).

In order to obtain payment from CHS, the provider or patient must generally obtain pre-approval, or, in the case of emergency services, notify the CHS program (typically within 72 hours) of the receipt of CHS-eligible care. 42 C.F.R. § 136.24. For care to be authorized, the

CHS program must determine that any available alternate resources have been exhausted. 25 U.S.C. § 1623; 42 C.F.R. §§ 136.30(j); 136.61. Medicare, Medicaid, private insurance and other benefit programs are potential alternate resources. *Id*. However, IHS is prohibited from seeking reimbursements from tribal self-insurance programs, such as the TSIP, or making them a primary payer unless the Indian tribe specifically authorizes its program to act as an alternate resource. 25 U.S.C. § 1621e(f). The ACA further clarified that tribes and tribal health programs, in addition to IHS, are entitled to "payer of last resort" status. 25 U.S.C. § 1623(b).

To ensure that CHS programs get the most healthcare from their limited budgets, Congress enacted Section 506 of the Medicare Prescription Drug Improvement and Modernization Act of 2003, which, with regulations adopted under the Act, requires Medicare-participating hospitals to "accept no more than" the MLR "as payment in full" for certain "items and services" authorized by a CHS program. 42 C.F.R. § 136.30(a); *see also* 42 C.F.R. § 136.30(j); 42 C.F.R. § 489.29(a). This is a significant benefit to CHS programs because the rates are lower than hospitals' billed rates, and are also lower in many cases than the discounted rates available to private insurance plans. *E.g.*, AR at IHS000114. But not all care is covered by these rules. Absent other arrangements, a CHS program would be required to pay the billed rate—more than the MLR—for care not subject to the MLR regulations.

B. The TSIP Supplements the Tribe's Healthcare Funds.

The Tribe also established a self-funded member-based TSIP to fill several key gaps in the care available under its CHS program. AR at IHS000351-474. Like any organization that chooses to provide supplemental healthcare coverage, the Tribe decided what benefits the TSIP would offer and the terms under which they were offered. The Tribe was under no obligation to provide member-based benefits. Thus, the Tribe specifically designed its TSIP to make sure that Tribal funded benefits were used to supplement rather than supplant any federal benefits that

members would otherwise have access to. AR at IHS00359. The covered benefits and limitations are set forth in detail in the Benefits Schedule. AR at IHS000360. Thus, the TSIP serves as a means for the Tribe to provide supplemental healthcare funding to help mitigate federal shortfalls.

The TSIP also serves as a means to secure access to professional claims processing, large claims management services, and network discounts and for non-MLR care. Claims are processed by the TSIP's Claims Administrator, HealthSmart Benefit Solutions, Inc.,who also serves as a fiscal intermediary to the Tribe's CHS program in order to properly coordinate benefits. AR at Redding 0001806-41. The TSIP provides access to care at discounted rates from providers that participate in the TSIP's provider network—though the network rate is still generally higher than the MLR for a given service. *E.g.,* AR at IHS000114; 359. Thus, the TSIP incudes language limiting its ability to provide supplemental funding for care otherwise entitled to MLR. The TSIP excludes from coverage: "all care or services eligible for coverage by a Contract Health Services program . . . that are eligible for reimbursement under" the CHEF program. AR at IHS000382.

The final determination of what care the TSIP will cover is also "subject to the Coordination of Benefits provision for Indian Health Service and Contract Health Service Programs appearing in Section XII [of the Plan]," as discussed in more detail below. AR at IHS000382. The result is that the TSIP expressly excludes CHS eligible care for specific high cost claims and for claims that meet the CHEF threshold. AR at IHS000382; 421-22.

C. Coordination of Benefits between the CHS Program and the TSIP Enhances the Efficiency of the Tribe's Healthcare Expenditures.

The Tribe's CHS program was specifically designed, consistent with federal law and Indian policy, to ensure that all healthcare benefits available to members through CHS and the

TSIP was coordinated to maximize healthcare for every Tribal and federal dollar spent, and to ensure that the Tribe did not relieve the federal government or federal programs for responsibility for member care. AR at IHS000486. The TSIP provides access to the Blue Cross network for care that is not MLR-eligible and which the CHS program would otherwise pay at higher rates. The Tribe also used supplemental funding—that is, it contributed its own funds to the CHS budget—to increase the volume of care that could be purchased through its CHS Program more efficiently than through a private network.[2]

To this end, the legislative body of the Tribe enacted a Tribal Government Policy on Tribal Self-Insurance Plan Coordination ("Plan Coordination Policy"). TP 9-7000 (AR at IHS000486); *see also* Redding Rancheria Tribal Council Resolution #011-01-24-12 (AR at IHS000476) (adopting TP 9-7000); Redding Rancheria Tribal Operating Procedures OP 4-340 (AR at Redding001845). The Tribe designed the Plan Coordination Policy to ensure that health services provided to the Tribe's members by IHS pursuant to the United States' obligation to provide healthcare to Indians "are not supplanted by medical benefits plans provided by the Redding Rancheria." AR at IHS000486. The Plan Coordination Policy further states that the TSIP "will not be treated as an alternate resource with regard to services or coverage provided by an IHS facility (direct care) or Contract Health Services program." AR at IHS000489.

When a claim is submitted by a member or provider for payment from the TSIP, it undergoes a coordination-of-benefits analysis ("COB" analysis) by the TSIP claims administrator and the CHS program to determine the extent to which each program is responsible for paying the claim. AR at IHS000422; Redding001850-51. However, the Tribe also included in its Plan Coordination Policy the ability for expenses to be fronted on a provisional basis through

[2] United States Government Accountability Office, GAO-12-446, Action Needed to Ensure Equitable Allocation of Resources for the Contract Health Service Program (2012) at 6.

the TSIP pending completion of the COB analysis. AR at IHS000422. This further increased the efficiency of the CHS Program. AR at IHS000032-33. It simplified the process of paying providers and eliminated member collection problems likely to arise if the Tribe forced providers to track down payments from multiple tribal programs. *Id*. To accomplish this, the Tribe made the TSIP's professional claim administration services and fiscal intermediary services available to CHS, and provided for coordination between the claims administrator and the CHS Program. AR at IHS000420-22.

Charges that are eligible for MLR under applicable law and are authorized by the CHS program are paid provisionally through the TSIP program at MLR according to the express terms of the Plan Coordination Policy: "[c]laims paid by the Plan at MLR are paid on behalf of and as a distribution agent for the CHS program." *Id*. If it is "confirmed that IHS or CHS should have been primary under this COB after a provisional payment has been made by the Plan, the Plan shall be entitled to reimbursement for the IHS or CHS program, as applicable." *Id*. This puts CHS in the same position it would have been in if TSIP had excluded all CHS-eligible care and forced the health care provider to proceed through the CHS collection process; reimbursement is limited to no more than the amount that CHS would have paid directly, and to actual payments to providers of CHS-eligible care to Tribal members. AR at IHS000422; Redding001850.

III. The CHEF Program is Operated by IHS Under "Guidelines" that IHS Created—Not the Regulations Required by Federal Law.

The CHEF Program was established to help tribal health programs cover high-cost care—for those programs, it serves a function similar to medical stop-loss or reinsurance that self-insurance programs might use to protect against massive losses caused by a few catastrophic claims. Pub. L. No. 99-500, 100 Stat. 1783 (Oct. 18, 1986); Pub. L. No. 100-713, Title II, § 202 (1988); 25 U.S.C. § 1621a. The CHEF Program is operated by IHS; it was not transferred to the

Tribe under the Compact. 25 U.S.C. § 1621a. Like CHS, the CHEF Program is not an entitlement program and benefits are only available if funds are available. *Id*. The fundamental statutory conditions for payment from CHEF are: (1) that the expenditures are above the annual threshold amount, (2) that the underlying charges are valid CHS obligations, and (3) actual payment is subject to funding availability. 25 U.S.C. § 1621a.

When the CHEF Program was created, Congress instructed IHS to implement regulations for the program. 25 U.S.C. § 1621a(d). The regulations were to provide for:

1. the disasters and catastrophic illnesses for which the cost of the treatment provided under contract would qualify for payment from CHEF;
2. the threshold cost of treatment to be eligible for reimbursement from CHEF;
3. procedures for the reimbursement of such costs;
4. procedures for payment from CHEF when medical circumstances warrant treatment prior to the authorization of such treatment; and
5. procedures to ensure that no payment shall be made from CHEF to any provider if eligible to receive payment for the treatment from any other Federal, State, local, or private source of reimbursement for which the patient is eligible.

IHS has not implemented the regulations called for by 25 U.S.C. § 1621a(d). Instead, IHS has operated the CHEF Program based on internal guidelines and letters on CHEF procedure distributed to tribes each year. AR at IHS000160-200. These "guidelines" were purportedly based on guidance that IHS "developed in August 1987." Def. Mem. SJ at 8-9.

After the Tribe filed this lawsuit, IHS released for the first time proposed regulations for the CHEF Program. Proposed Regulation 42 CFR 136.501 states that, "Alternate Resource means any Federal, State, *Tribal*, local, or private source of reimbursement for which the patient

is eligible." (emphasis added). And Proposed Regulation 42 CFR 136.506 states that:

> No payment shall be made from CHEF to any Service Unit to the extent that the provider of services is *eligible to receive payment for the treatment from any other Federal, State, Tribal, local, or private source of reimbursement for which the patient is eligible*. (Emphasis added.)
>
> The determination of whether a resource constitutes an alternate resource for the purpose of CHEF reimbursement shall be made by the Headquarters of the Indian Health Service, *irrespective of whether the resource was determined to be an alternate resource at the time of PRC payment*. (Emphasis added.)

The proposed regulations constitute the first proposed regulation or guidance to include "tribal" programs as alternate resources. The proposed regulations, apparently a direct response to this litigation, would preclude CHEF eligibility for any claim that could be covered by a tribal program, and would give IHS unfettered discretion to determine whether payment by a tribally-operated CHS program is eligible for CHEF. As shown below, these proposed regulations purport to legitimize, after the fact, the breaches Compact and statute alleged here.

IV. IHS Improperly Denied the Tribe's CHEF Applications.

The Tribe submitted six CHEF applications covering care provided in 2012 and 2013 that IHS has not approved based on its determination that the underlying charges were not "valid CHS obligations". AR at IHS000078- 97.[3] The patients were participants in the TSIP and eligible for the coverage under the Tribe's CHS Program. AR at IHS000078-79. Accordingly, their benefits were coordinated under the Plan Coordination Policy and the Coordination of Benefits

[3] The Administrative Record contains three of the applications that were submitted to IHS in paper form (the others were submitted through IHS's RPMS system) and are discussed as examples of what the Tribe submitted. AR at Redding 000001-1768. Should the Tribe prevail in the liability phase of this proceeding, the parties agree that all six applications (and any subsequent denials) would need to be considered to determine damages—though the parties do not presently agree on the procedure (the Tribe believes that the Court should determine damages; IHS argues that damages determination should be remanded to the Agency).

provisions in the TSIP. That is, the TSIP made provisional payments for the care until it could be determined what program was the primary payer. For charges determined to be valid CHS obligations, the provisional payments were reimbursed the TSIP. *Id*. The Tribe submitted complete CHEF applications, including documentation of: CHS eligibility (*e.g.*, Redding000007-8; 12-13; 721-723; 1421-24); CHS authorization (*e.g.*, Redding000031; 728; 1427); costs incurred (*e.g.*, Redding000014-30; 724-27; 997-99); availability of alternate resources (*e.g.*, Redding000033; 730; 1430); and, medical records (*e.g.*, Redding001258-1367; 895-977; 1482-95). The CHEF applications were limited to actual amounts paid to third party providers for CHS eligible care.

IHS refused to accept the CHEF applications, but did not issue denial letters—the Tribe only learned of the denials after inquiring about the application status. AR at Redding001863-65. IHS later confirmed that the applications were denied based on its determination that the underlying claims were ineligible for CHEF because the payment for the underlying healthcare was "coordinated through [the Tribe's] coordination of benefits process." Def. Mem. SJ at 13; AR at Redding001861-65. The denials were not based on lack of available funding. *Id*.

Ultimately, IHS's CHEF-eligibility determination was based on its disagreement with how the Tribe was operating its CHS Program and whether the Tribe's coordination of benefits procedures resulted in improper CHS payments. AR at IHS000076. IHS has only identified two reasons for its conclusion. First, IHS stated the TSIP was an alternate resource that should have paid for the care at issue. *Id*. Second, IHS stated that the Tribal Policies and Plan terms allowing provisional payments of CHS claims by the TSIP—and the corresponding payments by CHS for claims that were ultimately authorized—were not valid CHS payments because they were not direct payments to providers for care. *Id*. IHS also initially indicated that the Tribe's CHEF

Applications were rejected because the Tribe used an incorrect font size or did not provide paper checks, but appears to have since backed off of these grounds. AR at Redding001863.

The 1987 "guidelines" that IHS relied on did not provide for an appeal of the denials. From March to June 2013, representatives of the Tribe, including its Chief Executive Officer Tracy Edwards, tried to determine the basis for the rejections of the CHEF Applications and address any actual deficiencies. (Redding001861-65). The Tribe asked CHS for a complete list of all purported defects in its CHEF Applications and all legal grounds in support of IHS's denials, including a request for all legal and factual grounds to support IHS's contention that the payments at issue were not valid CHS obligations. *Id*. The Tribe also sought clarification from IHS as to what the Tribe could do to correct any purported defects, and offered to provide additional information or make any corrections as may be required. *Id*. The Tribe explained that it could, if necessary, reverse any initial payments made through the TSIP, by demanding repayment from the providers, and then reissuing separate payments (with paper checks if necessary) from CHS to the providers. IHS did not provide any legal argument or citation explaining the basis for its contention that the payments at issue were not valid CHS obligations. *Id*. Nor did IHS identify any other actual deficiency in the Tribe's CHEF applications. *Id*.

V. The Tribe Pursued Administrative Remedies to Resolve this Dispute.

After failing to obtain any informal assistance from IHS, the Tribe engaged in several administrative processes to resolve this dispute with IHS.

A. The Tribe Requested Consultation on Administration of the Compact.

On March 26, 2013, the Tribe submitted a formal written request for a government-to-government consultation with IHS in accordance with Executive Order 13175, and as called for under ISDEAA and the Compact, including a request for administrative waiver of any IHS internal agency guidelines or regulations that IHS relied on to deny the Tribe's eligibility for

CHEF, as provided for in Section 6 of Executive Order 13175 ("the Consultation Request"). AR at IHS00010-22. The Tribe explained that it had taken "particular care to design its self-insurance program to specifically coordinate with and build upon the care offered through CHS. Redding looked at what each program could do better and elected to coordinate care in a manner that would encourage each program to do what they do best." AR at IHS000010. The Tribe protested IHS's position of approving CHEF Applications only "if the Tribe employed a broad exclusionary clause with no coordination between its self-insurance and CHS programs, or if the Tribe cut individual vendor checks at the price of paying 'walk in' rates." AR at IHS000011. The Tribe stated that its CHEF eligibility should not be "conditioned on the Tribe agreeing to forego the benefit of professional case management, claim adjudication and fiscal intermediary services that the Tribe has negotiated for the CHSP and paid for by leveraging service provider arrangements through its self-insurance program." AR at IHS000012.

On August 8, 2013, IHS denied the Tribe's Consultation Request. The denial of the Consultation Request (and the underlying CHEF reimbursements) was based entirely on the Tribe's administration of its CHS program. AR at IHS00076-77. IHS stated that it had denied the Tribe's request for reimbursements "because [IHS believed that] the Tribe used contract health services (CHS) funds to reimburse its Tribal self-insurance plan." *Id*. IHS stated that the Tribe's CHS payments were "not valid CHS obligations" on that basis. *Id*.

B. The Tribe Requested a Regulatory Waiver.

On October 15, 2013, after failed effort to secure consultation under Executive Order 13175 and as called for under ISDEAA and the Compact, the Tribe requested a regulatory waiver (or determination of superseded law or regulation) pursuant to 25 C.F.R. §§ 900.140 and 900.148. AR at IHS000506-508. The Tribe pointed out that IHS had not cited to any specific regulatory or statutory grounds for determining that the Tribe's CHS payments were not valid or

otherwise justifying their denial of the Tribe's CHEF applications. *Id*. The Tribe pointed out that the Agency had instead cited to internal policies, guidelines and procedures that did not apply (per 25 U.S.C. § 458aaa-16). *Id*. Accordingly, the Tribe requested a waiver of the specific procedures and regulatory or other legal requirements, if any, that IHS had relied on, and a declaration that such procedures, regulatory requirements or other legal requirements are superseded by the Tribe's assumption of CHS responsibilities under its Title V self-governance compact and funding agreement. *Id*. The Tribe also submitted a request for informal conference in connection with the waiver request. AR at IHS000303-310.

On January 16, 2014, IHS denied the Tribe's request for a regulatory waiver, concluding that the program "that is the subject of the proposal is beyond the scope of programs, functions, services, or activities that are contractible under this Act because the proposal includes activities that cannot lawfully be carried out by the contractor." AR at IHS000503-504. IHS did not acknowledge that the Tribe's request pertained to its compacted CHS program. *See id*.

C. The Tribe Presented Claims Under the CDA.

On October 15, 2013, the Tribe submitted a request for contracting officer's decision under the CDA. AR at IHS00023-75. The Tribe alleged that IHS had breached the Compact by enforcing rules and regulations that did not apply to the Tribe's CHS program, and that would prevent the Tribe from obtaining the benefits it was entitled to under the Compact, including its rights to CHEF eligibility and its right to design and operate its health programs to meet tribal needs. AR at IHS000024-29. Specifically, IHS refused to consider the Tribe's eligibility under CHEF unless the Tribe agreed to administer its CHS program in accordance with internal IHS guidelines that were not negotiated into the Compact and that do not apply to the Tribe or its CHS Program by statute or regulation. AR at IHS000026-27. As a result of IHS's actions, the Tribe and its CHS program lost at least $1,044,545.76 (and still counting) due to improperly

denied CHEF claims. AR at IHS000026. The Tribe also submitted a request for informal conference in connection with the CDA claim. AR at IHS000303-310.

On December 17, 2013, IHS denied all claims and damages in the CDA claim. AR at IHS00006. IHS argued that the CDA claim was improper because "CHEF is outside the scope of the CDA" in that "[n]o part of CHEF or its administration shall be subject to contract or grant under any law." AR at IHS00006 (citing 25 U.S.C. § 1621a(c)). IHS argued that the Tribe's arguments regarding its right to design its programs under the Compact and not be subject to the same restrictions in administering CHS as IHS is an improper challenge to the "CHEF distribution methodology." AR at IHS000008. IHS also determined that the Tribe was seeking reimbursement for invalid CHS expenditures because "the Tribe was seeking reimbursement for payments made to its Tribal self-insurance plan." AR at IHS000007. Additionally, IHS claimed that it had consulted with the Tribe in the early 1980s and this somehow fulfilled IHS's duty to consult with the Tribe regarding administration of a 2011 Compact. AR at IHS000008.

D. The Tribe Proposed a Final Offer.

On October 15, 2013, the Tribe proposed an amendment to the Compact to clarify "its Compact rights to coordinate member care and its exemption from IHS guidance, manuals, and rules . . . that have been applied to prevent that coordination." AR at IHS000108. The proposed amendment would have clarified that the manner in which the Tribe administered CHS benefits and coordinated the benefits with the Tribe's TSIP could be accomplished consistent with applicable CHS rules. Specifically, the Tribe's Final Offer clarified that:

- The Tribe is not subject to Circulars, policies, manuals, guidance, or other rules adopted by IHS except for the eligibility provisions of 25 U.S.C. § 450j(g) and regulations promulgated under 25 U.S.C. § 458aaa-16(a);

- The Tribe's eligibility for reimbursement under CHEF shall be governed solely with reference to 25 U.S.C. § 1621a until and unless applicable regulations are promulgated;
- The Tribe may adopt policy, administrative procedures and plan documents designed to coordinate care between the Compacted Health Program and the Tribal Funded Health Program, including with respect to: exclusionary terms and payment priority; Use of provisional payments and common claim administrator/fiscal intermediary; coordinated CHS payments are valid CHS obligations; and,
- IHS would accept industry-standard payment documentation.

AR at IHS000110-111. The Tribe submitted a request for informal conference in connection with the Final Offer, and was willing to sever those portions of the proposed amendment that were subject to a proper challenge in accordance with ISDEAA. AR at IHS000303-310.

On December 4, 2013, IHS rejected the Tribe's Final Offer and identified four reasons for doing so. AR at IHS000098.[4] First, although the Tribe did not request any additional funding (as opposed to eligibility for funds), IHS chose to interpret the Final Offer as a "request for funds" and rejected the offer as "a request for funds that exceeds the applicable funding level to which the Tribe is entitled." AR at IHS000102. IHS argued that the Final Offer would make the Tribe's expenditures eligible for CHEF reimbursement when they had not (in IHS's view) previously been eligible. AR at IHS000103. Its basis for this contention was that the Tribe's CHS expenditures were not valid CHS obligations because under the IHS payer of last resort rule, the TSIP was an alternate resource. *Id*. IHS argued that the payments at issue were not valid CHS obligations even though "IHS has long recognized an exception for tribal self-insurance to its CHS payer of last resort rule (42 C.F.R. 136.61), [as] that rule has been superseded in

[4] IHS does not rely on all four of these reasons for its motion for summary judgment.

statute." *Id*. IHS claimed that 25 U.S.C. § 1623(b), enacted as part of the ACA, "establishes that health programs operated under IHS authority are the payers of last resort for care provided to IHS beneficiaries" and that "Congress created no exception for tribal self- insurance." *Id*. Relying on its internal policies and § 1623(b), IHS claimed that the "Tribe is not entitled to exclude care under its tribal self-insurance program and shift all payment burdens directly to the federal budget until exhausted, as it seeks to accomplish through its language proposal. *Id*.

Second, IHS characterized the Final Offer as an attempt to contract an "inherent federal function" that cannot be contracted, and cited this as an additional basis for rejecting the Final Offer. AR at IHS000103. IHS claimed that "the Tribe's proposal encroaches upon functions reserved to IHS" because it would "compel IHS to administer CHEF in accordance with the terms of the Tribe's contract and ensure reimbursement for medical claims." *Id*.

Third, IHS rejected the Final Offer because "IHS is not required to approve payment from CHEF for any Service Unit that does not follow CHEF procedures." AR at IHS000103-04. IHS argued that 25 U.S.C. § 458aaa-16(e) "does not waive the applicability of funding methodologies either for funds included in the Tribe's 106(a)(1) amount or other discretionary funds the Tribes may be eligible to receive." AR at IHS000103.

Fourth, and finally, IHS rejected the Final Offer as containing terms not mandated by ISDEAA: nothing "requires the inclusion of language offered by the Tribe, whether such language relates to the reimbursement of medical claims from the CHEF or to coordination between CHS and a non-IHS program, like the Tribe's self-insurance plan." AR at IHS000105.

IHS did not honor the Tribe's request to sever those portions of the proposed amendment that could be severed. *Id.*

On December 2, 2014, the Tribe commenced this action to seek relief for IHS's breach of

Compact and the ISDEAA.

STANDARD OF DECISION

I. IHS's Actions are Subject to De Novo Review

Following briefing and argument by the parties, this Court correctly found that this case is subject to de novo review. Status Conf. Tr. 22:8-18, Sept. 11, 2015. In its Summary Judgment motion, IHS is improperly attempting to re-litigate this issue. In doing so, IHS relies on the very same arguments that this Court already properly rejected. But IHS had no authority then, and has none now, to rebut the well-established rule that *de novo* review is critically important in ISDEAA cases in large part because of IHS's "obvious conflict of interest" in dealing with the "transfer [of] federal programs and funds to tribes." *Shoshone-Bannock Tribes v. Shalala*, 988 F. Supp. 1306, 1316-1317 (D. Or. 1997). IHS even acknowledges that it agreed to *de novo* review for other ISDEAA claims, but says it only did so "because it had determined that the Plaintiff had brought claims under the CDA, which requires de novo review." Def. Mem. SJ at fn.11. Of course, the Tribe brings CDA claims in this case. IHS does not explain why it believes that *de novo* review is appropriate in other CDA cases, but not here.[5]

Additionally, IHS has the burden of demonstrating by clear and convincing evidence the validity of its grounds for rejecting the Final Offer. 25 U.S.C. § 458aaa-6(d).

II. The Court Should Interpret Relevant Federal Statutes in Favor of the Tribe

Federal statutes must be liberally interpreted in favor of tribes. *Cty. of Yakima v. Yakama Indian Nation*, 502 U.S. 251, 269 (1992). "[S]tatutes are to be construed liberally in favor of the Indians with ambiguous provisions interpreted to their benefit." *Montana v. Blackfeet Tribe*, 471

[5] The Tribe incorporates by reference its arguments in support of *de novo* review as set forth in its August 28, 2015 Opposition to Defendants' Memorandum in Support of their Argument to Bar Discovery (Dkt. No. 23).

U.S. 759, 766 (1985).

ARGUMENT

The Tribe has the right and obligation under its Compact and federal law to design its CHS program in the manner it determines to be most beneficial to the Tribe and its members. The Tribe did just that. It coordinated the advantages of its two main health programs, the TSIP and CHS, to obtain the maximum value for every healthcare dollar spent. These are precisely the benefits that self-determination is meant to achieve, but they were never fully realized because of IHS's interference with the Tribe's performance under the Compact. In doing so, IHS breached its statutory and Compact duties to support the Tribe's self-determination choices in the design and administration of its CHS program, and to consult with the Tribe on these matters. IHS also has breached its Compact obligation to maintain the Tribe's eligibility for the CHEF program. Instead of recognizing and supporting the Tribe's legitimate self-determination choices, IHS used them as a basis for denying the Tribe's CHEF eligibility. In response to this breach of Compact and federal law, the Tribe pursued administrative remedies. IHS improperly denied the administrative claims, and the Tribe is entitled to summary judgment.

IHS defends its conduct, and asserts that it is entitled to summary judgment, with three principal arguments—all of which are based on flawed assumptions about the Tribe's programs and disregard for IHS's Compact and statutory duties. First, IHS argues that the Tribe's claims are not subject to the ISDEAA or the CDA. Def. Mem. SJ at 22. As shown in greater detail below, IHS's argument that CHEF administration is not subject to compact or contract is misplaced because the Tribe has never attempted to contract for the administration of CHEF. Just because CHEF administration is not subject to compact does not mean IHS has a license to breach other obligations of the Compact. The statutory provision that IHS relied on says that

CHEF funds cannot be distributed by grant and that the program cannot be transferred to tribes under ISDEAA. Nothing in the Tribe's proposed Compact amendment would violate this prohibition. Moreover, IHS itself concedes that it previously included CHEF-related obligations in the Compact without violating this rule. IHS breached these obligations and used its CHEF determinations as a mechanism for interfering with the Tribe's ability to design and administer its CHS program under the Compact.

Second, IHS contends that the Tribe is improperly requesting funds to which it is not entitled to and is improperly asking IHS to delegate the operation of CHEF to the Tribe. Def. Mem. SJ at 30. But IHS mischaracterizes what the Tribe is seeking. The Tribe is only requesting the eligibility—not funding—for CHEF guaranteed in the Compact.

Finally, IHS argues that the Tribe's operation of its health programs violates the ACA's payer of last resort provision. Def. Mem. SJ at 33. This argument is contrary to the statutory language, congressional intent, and IHS policy.

I. The Tribe Made Lawful Self-Determination Choices in the Design of its CHS Program and IHS Breached its Duties Under the Compact by Interfering with those Choices.

It is undisputed that IHS denied the Tribe's CHEF eligibility based on the assertion that the applications included payments that were not valid CHS obligations.[6] No claim administered under the Tribe's health programs would qualify for CHEF according to IHS. It is equally undisputed that this denial significantly disrupted the Tribe's operation of its health programs—it resulted in more than a million dollars of additional healthcare costs to the Tribe. IHS put the

[6] To the extent that IHS characterizes its conduct as denying individual claims rather than denying the Tribe's general CHEF eligibility that is, in the circumstances of this dispute, a distinction without a difference. As shown in greater detail in the following sections, IHS *systematically* denied the CHEF Applications based on objections to fundamental elements of the Tribe's CHS program design. The Tribe had no chance of obtaining CHEF reimbursements unless it gave in to IHS's improper demands to change the Tribe's program.

Tribe in the position of being forced to choose between a benefit guaranteed under the Compact—CHEF eligibility—and the right to make self-determination choices—also guaranteed by the Compact. Nevertheless, IHS contends that the Tribe has no actionable claim because IHS breached no legal duty owed to the Tribe. Def. Mem. SJ at 16 (citing 25 U.S.C. § 1621a(c)).

In fact, IHS breached at least five Compact, statutory, and regulatory duties, and the Tribe can pursue Compact remedies. IHS cannot justify its conduct by relying on any other statute or regulation, as explained in detail in Part II. IHS breached the following duties:

- First, IHS has an obligation to administer the Compact "[t]o enable the Redding Rancheria Tribe to redesign, programs, activities, functions and services of the Indian Health Service; to reallocate funds for such health programs . . . according to its tribal priorities . . . [and] to enhance the effectiveness of its tribal government through the reduction of federal management and control." Art. 1, Sec. 2 (b) (IHS000323). IHS has corresponding duties under the Funding Agreement. AR at IHS000315. Here, the Tribe redesigned its CHS program to enhance the effectiveness of its tribal government; IHS interfered and thereby breached the Compact and Funding Agreement obligations.
- Second, IHS has the duty under 42 C.F.R. § 137.6 to support "the self-determination choices of each Tribe . . .[and] to work with all Tribes on a government-to-government basis to address issues concerning Tribal self-determination." These consultation duties are also incorporated into the Compact. AR at IHS000329. IHS took actions to undermine the Tribe's self-determination choices, and refused to work with the Tribe to resolve "issues concerning Tribal self-determination," thereby breaching this duty. *Id*.
- Third, IHS has a duty to construe the Compact and statutes at issue in favor of the Tribe under 25 U.S.C. § 458aaa-11(a) (requiring the Secretary to interpret all laws and

regulations to facilitate "the implementation of compacts" and "the achievement of tribal health goals and objectives."). Here, IHS construed the Compact in the narrowest possible terms to prevent to the Tribe from achieving its "health goals and objectives."

- Fourth, IHS had a duty under the Compact to not make the Tribe "subject to any circular, policy, manual, guidance, or rule adopted by the Indian Health Service, except for the eligibility provisions of section 105(g) of the [ISDEAA] and regulations promulgated under Section 517 of Title V." Art. II, § 11 (IHS000328). IHS breached this duty by requiring the Tribe to follow IHS's internal guidelines (and IHS's peculiar and indefensible interpretation of such guidelines) for designing and administering its CHS program, in order to enjoy the CHEF eligibility guaranteed under the Compact.
- Fifth, IHS has a Compact duty to "maintain the Tribe's eligibility for Catastrophic Health Emergency Fund (CHEF) money on a par with all other Indian Health Service Units and tribal Self-Determination contract operations." Art. V., Sec. 4 (IHS000335). IHS denied the Tribe's CHEF eligibility in breach of this duty.

Based on the foregoing, the Tribe has asserted a breach of Compact claim against IHS for "interfere[ing] with" and "fail[ing] to cooperate" with the Tribe's performance under the Compact, namely the Tribe's design and operation of its CHS program. *Malone v. United States*, 849 F.2d 1441, 1445 (Fed. Cir.) *modified*, 857 F.2d 787 (Fed. Cir. 1988); *see also Peter Kiewit Sons' Co. v. United States*, 151 F.Supp. 726, 731 (Ct. Cl. 1957) (in every government contract there is an implied obligation on part of the government not to willfully or negligently interfere with contractor's performance). The fact that IHS used CHEF denials as a mechanism for doing so does not shield it from liability. The government cannot withhold benefits in order to pressure a contractor to do something not required by the contract—"[w]hether styled as an unjustifiable

breach of the contract's express terms or as a breach of the duty of good faith and fair dealing," such conduct is improper and gives rise to a contract claim against the government. *Rumsfeld v. Freedom NY, Inc.*, 329 F.3d 1320, 1331 (Fed. Cir. 2003) *adhered to on denial of reh'g en banc*, 346 F.3d 1359 (Fed. Cir. 2003).

IHS argues that its actions are not breaches of any legal duty because "[n]o part of CHEF or its administration shall be subject to contract or grant under any law, including the Indian Self-Determination and Education Assistance Act." Def. Mem. SJ at 16 (citing 25 U.S.C. § 1621a(c)). This argument is meritless. IHS admits, as it must, that it does have Compact duties relating to CHEF. Indeed, CHEF *eligibility* is a matter of Compact under ISDEAA and IHS is expressly obligated to "maintain the Tribe's eligibility" for CHEF. AR at IHS000334. IHS concedes that it does—consistent with 25 U.S.C. § 1621a(c)—have "contractual obligations to make CHEF available." Def. Mem. SJ at fn.13; 16 (asserting that "the agency had met its contractual obligations to make CHEF available in accordance with CHEF policy"); *see also* 25 U.S.C. § 1621a(d)(3)(B) (allowing IHS to authorize non-IHS facilities and providers to be eligible for CHEF). IHS baldly asserts that it complied with these obligations, and declares that is the end of the story. Def. Mem. SJ at fn.13; 16. But the Tribe's claim is that IHS breached its validly-compacted CHEF obligations. IHS conditioned the Tribe's CHEF eligibility on operating its CHS program in a certain manner. This violated the Tribe's right to design and operate its CHS program, and it violated IHS's obligation to maintain the Tribe's CHEF eligibility.

Moreover, the Tribe's claims in this case do not implicate the restrictions of § 1621a(c). The prohibition on contracting CHEF relates to issues that the Tribe is not contesting. The Tribe has never sought to have the CHEF Program, or any part of it, transferred to the Tribe under ISDEAA. The Tribe does, however, have an explicit and uncontested right to CHEF *eligibility*

under the Compact, and that is the right at issue in this case.

For all of these reasons, the Tribe has asserted a breach of compact claim and IHS cannot dismiss the Tribe's claims as "various attempts to use contract theories to address the IHS' denial of Plaintiff's requests for reimbursement from the CHEF." Def. Mem. SJ at 22. The Tribe's "contract theories" are the basis for claims upon which the Tribe is entitled to relief. IHS may believe it can manipulate the CHEF program with impunity to micromanage the Tribe's performance of the Compact, but IHS crossed the line by using CHEF as a mechanism to frustrate and interfere with the Tribe's performance under the Compact.

II. The Tribe Designed and Operated its CHS Program in Compliance with the Compact, ISDEAA, and all Applicable Laws and Regulations.

When the Tribe undertook responsibility for its healthcare programs under the Compact, it implemented changes to the transferred programs to serve the Tribe's "tribal priorities" of maximizing the value and efficiency of its healthcare programs and "enhance[ing] the effectiveness of its tribal government" programs. Compact Art. 1, § 2 (IHS000323-24). Redding implemented two principal design changes to its CHS program to achieve these ends.

The first change was to coordinate the benefits provided by the CHS Program with those that the TSIP provides. The two programs work closely together to maximize the efficiency of the CHS program. In some circumstances, CHS can purchase care more efficiently, and in other cases the TSIP can do so. The goal of the coordination of benefits provisions is to ensure that, in any given situation, the most efficient payer purchases the care. By coordinating member care, all health care claims could be adjudicated at the best rate (MLR or TSIP network), and all claims could have access to professional claims management, efficient claim processing, and prompt electronic payments. IHS-operated CHS programs typically do not pursue such efficiencies. The second change was the process for paying claims. The Tribe's CHS program

payments are processed by the TSIP and its claims administrator. While other CHS programs are chronic late payers, the Tribe's program pays claims on time.[7] By having the TSIP pay claims on a provisional basis pending the COB analysis, the providers were guaranteed prompt payment, and members could avoid collection matters caused when providers must pursue multiple payment sources in response to the use of broad exclusionary clauses. *See* AR at IHS000032-33. Moreover, these features of the Tribe's health programs comply with all applicable laws. Contrary to IHS's assertions, these design features do not render the Tribe's CHS expenditures "invalid" and ineligible for CHEF. AR at IHS000076. IHS cannot justify its denial of the Tribe's CHEF eligibility by reference to 25 U.S.C. §§ 1621a, 1623, or its internal CHEF "guidelines."[8]

A. The TSIP "Exclusionary Clause" was Enacted Consistent with Federal Law and is an Essential Element in the Tribe's Coordination of Health Programs.

The TSIP includes a provision known as an "exclusionary clause," which, as the name suggests, excludes from coverage care that is eligible for coverage by a CHS program or for reimbursement under CHEF. AR at IHS000382. In other words, the TSIP will not use Tribal funds to pay for services that are eligible for payment by federal programs.[9] The exclusionary clause is a critical element in the Tribe's coordination of benefits arrangement; it is the

[7] United States Government Accountability Office, GAO-14-57, Indian Health Service: Opportunities May Exist to Improve the Contract Health Services Program (2013) at 12 (more than half of CHS claims are not paid within 3 months of the service).

[8] IHS's assertions that the Tribe's CHEF Applications were incomplete are just that—assertions. Redding Rancheria submitted all the required information. The Treibe asked IHS to clarify the purported deficiencies in the applications. IHS has never explained what was purportedly missing from applications. IHS has also asserted that there were formatting defects in the CHEF Applications (*e.g.*, incorrect font size), and that CHEF reimbursements were available only for payments documented with "paper checks" to each provider. Redding 0001863-64. IHS appears to have withdrawn these assertions and there is no basis in law or regulation for finding that such purported defects are valid reasons for rejecting the applications.

[9] The Tribe does have a mechanism for supplementing CHS funds by permitting the TSIP to pay for care that would otherwise be CHS-eligible, but not seek reimbursement from CHS.

mechanism that allows the Tribe to match healthcare claims with the program that can pay them most efficiently. If CHS care could not be excluded, and tribal funds were treated as an alternate resource, Tribal healthcare benefits would simply replace benefits that members were otherwise entitled from the federal programs. The Tribe's exclusionary clause is squarely permitted by federal statutes, and serves to carry out the policy underlying the statutes. 25 U.S.C. §§ 1621e; 1623(b). IHS's arguments to the contrary fail because they rely on IHS polices that do not apply to the Tribe and are contrary to federal law in any event.

1) ***The Tribe Implemented an Exclusionary Clause as Permitted by Federal Law.***

The concept of an "exclusionary clause" is based on the statutory determination that tribal-insurance programs are not to be treated as "alternate resources" with respect to CHS programs "[a]bsent specific written authorization by the governing body of an Indian tribe for the period of such authorization." 25 U.S.C. § 1621e(f); *see also* Indian Health Manual 2-3.8.I ("The IHS is prohibited from seeking recovery when the health services provided to an eligible patient are covered by a self-insured health plan funded by a Tribe or Tribal organization under Section 206(f) of the IHCIA, P.L. 94-437, 25 U.S.C. §1621e(f)."). In other words, federal law says that tribal insurance programs are alternate resources with respect to CHS programs *only to the extent specifically authorized by the tribe*. 25 U.S.C. § 1621e(f).

This is consistent with the goals and policies of CHS and Indian health generally. CHS was designed to pay for health services secondary to any private insurance or other health benefits that might be available to a tribal member. 42 C.F.R. § 136.61. This served to conserve CHS's limited resources and maximize the healthcare services available to tribal members. This dynamic changed when tribes began implementing their own insurance programs, with healthcare paid directly from the general assets of the tribe rather than through an insurer. The interest of maximizing the use of tribal health funds was not served by requiring the tribe itself to

pay before CHS funds were available, or by giving CHS a right to collect from tribe's own program. 25 U.S.C. § 1621e. Congress addressed this by clarifying that, by default, CHS is not a secondary payer to tribal self-insurance. Congress gave tribes significant discretion in defining those circumstances under which tribal self-insurance will pay primary to CHS—only as specifically allowed by "written authorization." *Id*.

Nothing in § 1621e, or any other statute, limits the ability of tribe to implement an exclusionary clause that applies only to certain care or in certain circumstances. Contrary to IHS's assertions, exclusionary clauses need not be all or nothing. Indeed, the constraints imposed by § 1621e(f) are on IHS, not on tribes. IHS must identify "specific written authorization" to demand that *any* tribal insurance plan act as a primary payor. 25 U.S.C. § 1621e(f).

2) *The ACA Strengthened the Tribes' Rights to Implement Exclusionary Clauses and other Measures to Protect Tribal Health Resources.*

IHS argues that the so-called statutory payer of last resort rule (25 U.S.C. § 1623(b)) makes the Tribe's exclusionary clause invalid. IHS's conclusion is the exact opposite of what the text calls for. The statute states that "[h]ealth programs operated by the Indian Health Service, Indian tribes, [and other Indian organizations] . . . 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." 25 U.S.C. § 1623(b). The text of § 1623 is inclusive—it protects *all* tribal resources allocated for health programs, including tribal self-insurance programs.

IHS asserts that the TSIP is not "a 'health program' within the meaning of the ACA's 'payer of last resort' provision." Def. Mem. SJ at 35. But there is no basis in the statute for concluding that the term "[h]ealth programs operated by . . . Indian tribes" excludes *any* health program operated an Indian tribe. IHS cites to other statutes where Congress did specifically

limit application of the statute in question to programs administered by IHS or by tribes pursuant to a compact. But when Congress did so it used the terms "Indian health program" or "tribal health program"—and created specific definitions for those terms that do not include tribal self-insurance programs. 25 U.S.C. § 1603(25). Congress used different, broader language in § 1623. In fact, earlier versions of the "payer of last resort" statute did include the more restrictive terms but Congress made a deliberate choice to use the more inclusive language.[10] *Compare* § 1623(b) *with* S.R. 110-197 at 62 (proposed payer of last resort provision applying to "Indian Health Programs and health care programs operated by Urban Indian Organizations"). IHS does not address in its brief the plain language of the statute or the deliberate decision underlying that language. IHS does not explain—because it cannot—why the Court should ignore the plain statutory language in favor of IHS's assertions that the statute does not mean what it says. Moreover, to the extent of an ambiguity, the statute must be read in favor of the Tribe. *Cty. of Yakima v. Yakama Indian Nation*, 502 U.S. 251, 269 (1992).

Instead, IHS discussed at length its own "payer of last resort" rules and regulations, which pre-date § 1623. Those regulations are simply not relevant to the question of what § 1621e or § 1623 mean with respect to tribal self-insurance programs. The regulations do not address the question of whether, or under what circumstances, a tribal self-insurance program could be treated as an alternate source or have payer of last resort status. Even if the regulations did address the issue, IHS does not, and cannot, identify any basis in law for the contention that an agency regulation trumps a statute that plainly states the opposite of what IHS thinks the regulation means. *See United States v. Maes*, 546 F.3d 1066, 1068 (9th Cir. 2008) (citing

[10] Moreover, if Congress had intended the law to exclude any tribal program, it would have added "tribal law" to the provision "notwithstanding any Federal, State, or local law to the contrary." 25 U.S.C. § 1623(b).

Chevron U.S.A. Inc. v. Nat'l Res. Def. Coun., Inc., 467 U.S. 837, 842–43 (1984)) ("a regulation does not trump an otherwise applicable statute . . .").

It is also significant that in the more than five years since § 1623 was enacted, IHS has not taken the position it advocates here in any context outside this litigation. IHS cites no public announcement, rule, or policy to support the position—not even in the new (albeit improper) proposed CHEF regulations. In fact, current IHS guidance is directly contrary to IHS's position in this litigation. IHS FAQ, available at https://www.ihs.gov/chs/index.cfm?module=chs_faq ("Tribal self-insurance can be billed as an [alternate resource], unless the insurance plan contains an exclusionary clause designating it as residual to IHS."). A recent report by the Government Accountability Office relied on 25 U.S.C. §§ 1621e and 1623 when it stated that "certain tribally funded health insurance plans are not considered alternate resources and the CHS program must pay for care before billing the tribally funded insurance plan." United States Government Accountability Office, GAO-14-57, Indian Health Service: Opportunities May Exist to Improve the Contract Health Services Program (2013) at n.17 (IHS/HHS noted disagreements with portions of GAO's report (28), but not the quoted statement).[11]

Until this dispute arose, IHS did not treat § 1623 as an upheaval of federal Indian law and policy. The Court should reject IHS's invitation to do so now. Making tribes or tribal programs a primary payer would relieve the federal government of its responsibility by shifting the burden of large claims onto the very group that the program is intended to benefit. There is nothing in the text or legislative history to suggest that Congress intended to do this with § 1623(b).

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[11] *See also*, United States Government Accountability Office, GAO-12-446, Action Needed to Ensure Equitable Allocation of Resources for the Contract Health Service Program (2012) at n.19 ("[C]ertain tribally funded insurance plans are not considered alternate resources and the CHS program must pay for care before billing the tribally funded insurance plan. *See* 25 U.S.C. § 1621e(f).")

3) *IHS Rules and Policies on Exclusionary Clauses are Contrary to Federal Law.*

As a corollary to its argument that § 1623 is an upheaval of the law on exclusionary clauses, IHS argues that all of its past "program guidance establishing a limited policy based exception [to the payer of last resort rule] for tribal self-insurance" is invalid. Def. Mem. SJ at 38. IHS also argues that even if the program guidance were valid, the Tribe's exclusionary clause would be improper under IHS "program guidance." IHS is correct in admitting error, but it still does not get the law right. The Tribe's exclusionary clause complies with all applicable law and regulation, and IHS's policies do not. The "guidance" in question is the Indian Health Manual Part 2. Ch. 3. This "guidance" has *never* been controlling authority for the Tribe's Compact programs, including CHS, because the Compact states that, unless expressly agreed otherwise, "the Tribe shall not be subject to any circular, policy, manual, guidance, or rule adopted by the Indian Health Service, except for the eligibility provisions of section 105(g) of the [ISDEAA] and regulations promulgated under Section 517 of Title V." Art. II, § 11 (IHS000328). The Tribe has the right and responsibility to administer its CHS Program, and the Tribe—not IHS—decides whether another payer is an alternate resource. Compact Art. 1, § 2 (IHS000323-24).

Moreover, IHS's policies are contrary to the terms of 25 U.S.C. § 1621e. IHS asserts that a tribal self-insurance plan is an alternate resource unless the tribe says otherwise—that is, unless the Tribe affirmatively implemented an exclusionary clause. IHM § 2-3.8.I. Furthermore, IHS-operated CHS programs (as opposed to tribally-operated CHS programs) will not recognize exclusionary clauses except after an IHS review process. *Id*. IHS requires verification that a health plan meets these requirements through the submission of documentation describing "how and from what resources the plan is funded" and "[a] copy of the self-insurance policy, with [the] exclusionary clause clearly indicated." *Id*. (IHM, § 2-3.8(I)(2)). IHS attempts to use 25 U.S.C. § 1621e as a basis for regulating the terms of tribal insurance plans, the operation of tribal CHS

programs, and the interaction of the programs. In fact tribal consent for IHS to treat a self-insurance plan as an alternate resource is required by law—and IHS's policies regarding exclusionary clauses are not consistent with 25 U.S.C. § 1621e(f).[12] The statute says that a tribal self-insurance plan is not primary to CHS unless specifically authorized by the tribe, but the IHS policy says exactly the opposite. The Tribe's exclusionary clause complies with all applicable law and regulation, and IHS cannot identify any authority to the contrary.

B. Provisional Payments by TSIP Make Claim Administration More Efficient.

Another measure that enhances the efficiency of the Tribe's health programs is the centralized payment and processing of claims. The Tribe allows its TSIP and its claims administrator to act as intermediaries in the processing and payment of claims. AR at IHS000422. Claims are initially processed by the TSIP Claims Administrator. Payments are made from TSIP funds—including provisional payments for claims that are potentially CHS-eligible. *Id*. If CHS coverage is confirmed, CHS reimburses TSIP for the payment that TSIP made to the provider on CHS's behalf. *Id*. CHS pays no fee for these administrative services (though CHS programs often pay fees for claim administration and processing). This coordination process enhances the efficiency of processing and paying healthcare expenses. It also serves several Tribal governmental priorities. Tribal members do not have to contend with collections actions that providers could commence if CHS claims were not paid on time. It simplifies supplemental funding for its CHS Program for categories of care that the Tribe elects to exempt from its exclusionary clause—TSIP can simply pay for care directly on behalf of CHS.

[12] IHS attempts to avoid the consequences of a decision based on the text of 25 U.S.C. § 1621e—as opposed to the gloss on the statute in IHS's policies—by pointing out that the statute "pertains specifically to IHS' right to bill for direct care services, which is not implicated here." Def. Mem. SJ at n.20. IHS's implication is that § 1621e does not apply. But even if that were true, it would not help IHS. There would be no basis for IHS to assert that a tribal self-insurance plan was primary to IHS under any circumstance if not for the language of § 1621e.

The system also preserves a good relationship with providers, because they get paid more quickly and do not have to sort through different payment systems. Moreover, the idea of provisional payments is not new or unique. Self-insurance programs, including the Federal Employees Health Benefit Program, routinely make provisional payments for charges that are ultimately the responsibility of a third party, for example, in the context of reimbursement and subrogation rights. *See* 5 C.F.R. § 890.106 (process for subrogation and reimbursements).

Nevertheless, IHS contends that the provisional payment process makes the Tribe's CHS expenditures invalid because the CHS payments do not go directly to the provider. Def. Mem. SJ at 13. However, this puts form over substance. There is no statute or regulation applying to the Tribe that prevents its CHS program from processing claims and administering payments in this way. All reimbursements at issue were for charges actually paid to a third party provider. In fact, the Tribe's system is not much different from the "fiscal intermediary" ("FI") system that IHS-operated CHS programs use to process and pay claims. For example, Blue Cross and Blue Shield of New Mexico (BCBSNM) is the FI for the federal CHS program and numerous tribal programs. *See* http://www.bcbsnm.com/ihsfi/about_fi.html. The FI pays CHS claims with funds from the CHS programs.[13] IHS does not contend that this makes any CHS payment invalid. There is no difference in principal—and little difference in practice—between making CHS payments through Blue Cross, as IHS does, and making payments through the TSIP claims administrator, as the Tribe's CHS program does. In both cases, CHS uses a third party to pay providers for eligible care provided to eligible patients at the appropriate rate.

[13] Some IHS-operated CHS programs issue provisional purchase orders pending determination of whether alternate resources are available, "[i]n these cases, if the FI paid the claim before alternate resources were confirmed, the FI would seek to recover from the provider any overpayments for services covered by these alternate resources." United States Government Accountability Office, GAO-14-57, Indian Health Service: Opportunities May Exist to Improve the Contract Health Services Program (2013), at 24.

C. IHS Cannot Rely on its Guidelines to Deny the Tribe's CHEF Eligibility.

In addition to IHS's legally incorrect interpretations of §§ 1621e and 1623 discussed above, IHS has asserted that its CHEF determinations are supported by "CHEF policy." However, IHS cannot rely on its "CHEF policy"—which is actually just a set of thirty year old internal guidelines that do not have the force of law or regulation—as a basis for its actions. The so-called policy is so old that it does not even address tribal self-insurance programs and just barely acknowledges tribally-operated CHS programs. Moreover, IHS cannot use the policy to justify actions that are unlawful. Agency discretion would have no bounds if the application of any law or contract could be suspended by implementing internal guidelines.

IHS's "CHEF policy" is actually the "Administrative Guidelines" for CHEF that IHS first issued in 1987 and last updated in 1991 (AR at IHS000160-181) and procedure memoranda that IHS distributes yearly (AR at IHS000182-200). These guidelines do not have the force of statute or regulation, especially when IHS applies them in a manner that is contrary to statute. Moreover, the guidelines have little relevance to the modern CHEF program. The universe of health programs operated by and for Indian tribes has expanded significantly in the last 30 years. Tribally-operated CHS programs are the norm, not the exception, and the programs are operated under Compacts like the Tribe's that guarantee significant discretion in how the programs are operated. Tribal self-insurance programs are common now, but were rare (if any existed at all) when the guidelines were issued. The guidelines do not address such programs. AR at IHS000160-181. IHS did not address these developments by issuing regulations, as it was required to do under law. Instead, IHS made rules up as it went along.

And even if the guidelines had any relevance to this matter—and they do not—IHS did not follow them. Nothing in the guidelines precludes the Tribe from implementing an

exclusionary clause.[14] The guidelines simply state that requests for reimbursement comply with applicable regulations (AR at IHS000176) and "valid CHS obligations" (AR at IHS000191). The Tribe's CHEF applications meet these requirements. Nothing in the guidelines precludes the Tribe's COB policy or provisional payment arrangement.

III. IHS Improperly Rejected the Tribe's Administrative Efforts to Resolve the Compact Disputes.

The Tribe attempted to pursue administrative remedies for IHS's violation of the Compact and ISDEAA. Because IHS breached the Compact, the Tribe commenced an administrative claim for breach of compact under the CDA—a required first step for proceeding with a contract claim against the government. At the same time, the Tribe pursued other administrative remedies. It proposed an amendment to the Compact that would clarify the Tribe's rights to design its own CHS program and IHS's obligations to maintain the Tribe's CHEF eligibility. The Tribe also made requests for consultation and regulatory waiver—IHS is required to consult with the Tribe regarding Compact administration, and if the dispute could not be resolved by agreement, IHS could simply waive application of the regulations.

IHS improperly rejected all of the Tribe's efforts to resolve the dispute through the administrative process. IHS invoked a number of statutory criteria purportedly supporting its denials, but had to re-characterize the Tribe's claims beyond recognition in order to do so. In

[14] Even if the Court were to agree that IHS could deny CHEF applications based on the assertion that an improper exclusionary clause made the underlying CHS payments invalid, that would not end this matter. IHS's obligation under the Compact is to "maintain the Tribe's eligibility for [CHEF] money on a par with all other Indian Health Service Units and tribal Self-Determination contract operations." IHS has in fact approved of exclusionary clauses similar to the Tribe's. *E.g.*, AR at Redding001774-91. This would suggest that IHS is breaching its obligation to maintain the Tribe's CHEF eligibility "on par" with other tribes and service units. Thus, if the Court were to conclude that IHS could deny CHEF Applications based on the Tribe's exclusionary clause, the Tribe should be permitted to address this additional issue by conducting discovery. Fed. R. Civ. P. 56(d), (e).

each case, IHS started with, and did not question, the assumption that it was correct on the underlying substantive issues discussed above—that the Tribe was operating its CHS program improperly and that IHS was not constrained by Compact or statute from denying the Tribe's CHEF eligibility as a result. But IHS is wrong on those fundamental points and its reliance on them to deny the Tribe's administrative remedies means that the denials are also improper. As discussed below, IHS did not, and cannot, identify any legitimate basis for its actions.

A. IHS Improperly Rejected the Tribe's Requests for Consultation and Waiver.

The Tribe first attempted to resolve this dispute by submitting formal requests for consultation and regulatory waiver to IHS. In its consultation request, the Tribe explained in detail why it had designed its health programs as it did, and why its designs complied with the Compact and federal law. AR at IHS000010-22. IHS refused to even *consider* the Tribe's detailed explanation. AR at IHS000076. IHS summarily denied the request for further consultation, relying entirely on the uninformed assumption that "the Tribe used contract health services (CHS) funds to reimburse its Tribal self-insurance plan." *Id*. Although IHS had an obligation to confer in good faith with the Tribe regarding the Compact, ISDEAA, and the IHCIA, IHS refused to engage on a critical matter of Compact administration. In doing so, IHS precluded the Tribe from obtaining the benefits of the Compact and prolonged this dispute.

IHS also improperly rejected the Tribe's request for a regulatory waiver (or determination of superseded law or regulation). The Tribe had pointed out that IHS has not cited to any specific regulatory or statutory grounds for denial of the Tribe's CHEF applications, nor to support IHS's contention that the Tribe's coordination of member care between its CHS and Self-Insurance programs was improper. AR at IHS000506-07. IHS appeared to be relying on internal policies, guidelines and procedures that do not apply to the Tribe. *Id*. (citing 25 U.S.C. § 458aaa-16). Accordingly, the Tribe saw an opportunity to resolve the dispute by requesting that IHS waive

application of the procedures and rules. *Id*. Without engaging in meaningful discussion of the Tribe's proposal, IHS declined the Tribe's request for a regulatory waiver claiming that "the proposal includes activities that cannot lawfully be carried out by the contractor." AR at IHS000503-04. Despite the Tribe's willingness to engage with IHS in discussion of how the Tribe's program designs complied with law, achieved the goals of federal Indian health policy, and increased healthcare availability to Tribal members, IHS refused to waiver from the misguided assumption that it formed when it initially rejected the CHEF Applications—the Tribe's CHS program is wrong because it does not look like an IHS program. *Id*.

B. IHS Improperly Rejected the Tribe's Contract Disputes Act Claim.

IHS's refusal to honor its consultation duties forced the Tribe to initiate the administrative process for a breach of Compact claim. The Tribe submitted its claim to IHS under the CDA. 41 U.S.C. §§ 7101-09. The CDA applies to "any express or implied contract . . . made by an executive agency for . . . the procurement of services," including claims for breach of compact under ISDEAA. 41 U.S.C. § 7102(a). The CDA establishes an administrative procedure that must be following before a lawsuit can be filed. First, the contractor must submit its claim in writing to the contracting officer for a decision within six years of accrual of the claim. For claims in excess of $100,000, the contractor must certify the accuracy of the claim. 41 U.S.C. § 7103. The Tribe properly presented its breach of compact claims to IHS in a timely request for contracting officer's decision under the CDA and IHS concedes that "the Tribe has met the procedural requirements for filing a claim under the CDA." AR at IHS000006. [15]

Although the Tribe noted, as it was required to do, that its financial injuries traced back to the denied CHEF Applications in the amount of $1,044,545.76, the Tribe went to great lengths to

[15] Redding Rancheria submitted its CDA claim within six years of the alleged breach of compact and filed this lawsuit within one year of IHS's denial. (IHS000028); Complaint.

make clear to IHS that the contractual dispute arose from IHS's attempts to enforce Compact rights through its CDA claim so as to deny the Tribe's CHEF eligibility—the Tribe was not asserting a contractual right to any specific CHEF payment, rather the Tribe alleged that, under the Compact and ISDEAA, it "is not bound by the IHS internal guidelines in the administration of its tribal CHS program, including the administration of CHEF -qualifying treatment" and by requiring the Tribe "to comply with the IHS internal guidelines as a condition to receiving CHEF reimbursement, and by failing to address these concerns through meaningful consultation, IHS is in breach of the Compact." AR at IHS000028. Moreover, the "internal IHS guidance and rules" that IHS was attempting to enforce "were not negotiated into the Compact and are not required by statute or regulation." AR at IHS000026. The Tribe further alleged that IHS had breached its duty to consult with the Tribe with regard to Compact administration. AR at IHS000025.

Despite the Tribe's numerous allegations of breach of Compact, IHS denied the claims based primarily on the argument that a CDA claim was an improper means of remedying IHS's misconduct because "CHEF is outside the scope of the CDA" in that "[n]o part of CHEF or its administration shall be subject to contract or grant under any law, including the Indian Self-Determination and Education Assistance Act. 25 U.S.C. § 1621a(c)[.]" AR at IHS00006. But, as shown above, the Tribe has not alleged, and does not allege, any contractual right to specific CHEF benefits. The Tribe sought to enforce its right to design its CHS program and to preserve its CHEF eligibility—Compact obligations that IHS acknowledges. *E.g.*, Def. Mem. SJ at fn.12.

IHS also denied the CDA claim based on allegations that the Tribe was improperly seeking reimbursement for invalid CHS expenditures and, by seeking such reimbursement, was challenging the "CHEF distribution methodology." AR at IHS000007-8. In fact, the Tribe's CHS program operated consistent with applicable law, and the program expenditures were valid, as

shown in Part II above. The Tribe asked for no exception or change to the CHEF distribution methodology, just that IHS honor its Compact obligation to apply that methodology fairly, and that the Tribe's CHS expenditures be given the same opportunity for reimbursement as those of other tribes and IHS-operated CHS programs. In response, IHS claimed that consultation had already occurred—in the early 1980s. AR at IHS000008. Given that IHS is relying on consultation that allegedly occurred decades before this dispute arose, IHS effectively admits that it did not engage in consultation with the Tribe on the issues raised in the CDA claim.

The Tribe established that IHS breached the Compact and caused financial damage. The Tribe has perfected its claim through the administrative process and this Court can grant relief.

C. IHS Improperly Rejected the Tribe's Final Offer.

The ISDEAA creates a process for tribes and the United States to resolve disputes about what terms should be included in a compact. Tribes have a statutory right to make a "final offer" to the Secretary that will be deemed approved if it is not timely and properly rejected.[16] For rejection to be proper, it must be based on findings, supported by controlling legal authority, that: the final offer seeks a funding level above what is due; seeks transfer of an inherent federal function; the tribe cannot carry out the program without endangering public health; or, the tribe is ineligible to participate in self-governance. 25 U.S.C. § 458aaa-6(c). When IHS challenged the Tribe's operation of its health programs for purportedly not following the Compact and statute, the Tribe believed that the dispute was based largely on IHS's misapprehension of the parties' duties under the Compact. AR at IHS000108. Thus, even though the Compact is clear on the

[16] Contrary to IHS's suggestion (Def. Mem. SJ at 31), the final offer process applies whenever "the Secretary and a participating Indian tribe are unable to agree, in whole or in part, on the terms of a compact," including with respect to amendments. 25 U.S.C. § 458aaa-6(b). The Secretary's agreement can be implied by law, so this process does not contradict the requirement that compact amendments be based on "mutual agreement." 25 U.S.C. § 458aaa-3(b).

parties' obligations in respect to the Tribe's right to design and operate its programs and IHS's obligation to maintain the Tribe's CHEF eligibility, the Tribe hoped that the dispute over those obligations could be resolved by clarifying the terms of the Compact. *Id*.

1) *The Tribe's Final Offer Clarified Existing Compact Obligations.*

The Tribe made a Final Offer for an amendment to the Compact to clarify "its Compact rights to coordinate member care and its exemption from IHS guidance, manuals, and rules . . . that have been applied to prevent that coordination." AR at IHS000108. The proposed amendment did not seek to change the obligations or rights of the Tribe or the United States. Rather, the Tribe simply sought to confirm and clarify that IHS's obligations included permitting the Tribe's design and operation of its CHS program to meet tribal government priorities and maintain the Tribe's eligibility for CHEF—in terms that the agency would understand and comply with. Accordingly, the proposed amendment set forth in the Final Offer confirmed several key principles, among others. AR at IHS000110-111. First, the Tribe is not subject "to Circulars, policies, manuals, guidance, or other rules adopted by the Indian Health Service ("IHS") except for the eligibility provisions of" 25 U.S.C. § 450j(g) and regulations promulgated under 25·U.S.C. § 458aaa-16(a). *Id*. Second, until regulations are promulgated in accordance with 25 U.S.C. § 1621a, the Tribe's eligibility for CHEF reimbursement shall be governed solely by the statutory criteria. *Id*. Third, "[t]he Tribe may adopt policy, administrative procedures and plan documents designed to coordinate care between the Compacted Health Program and the Tribal Funded Health Program," including with respect to: exclusionary terms and payment priority; use of provisional payments and claims administrator or fiscal intermediary; and the validity of coordinated CHS payments as CHS obligations. *Id*.

IHS rejected the Final Offer on December 4, 2013. AR at IHS000098. Each of the reasons given by IHS for rejecting of the Final Offer operated on the assumption that the Tribe's

CHS program was making invalid CHS expenditures and that IHS's denial of CHEF eligibility on that basis was therefore proper. As shown in part II, above, IHS is wrong on those points.

First, IHS characterized the Final Offer as a specific funding request with an implied requirement that IHS change its funding methodologies. In IHS's words—not the Tribe's—the Final Offer sought "funds that exceed[] the applicable funding level to which the Tribe is entitled." AR at IHS000102-03. IHS claimed that in order to dispense the requested funds, it would have to approve payment from CHEF for a "Service Unit that does not follow CHEF procedures," which it could not do because 25 U.S.C. § 458aaa-16(e) does not allow IHS to "waive the applicability of funding methodologies" for any funding the Tribe may be eligible to receive. *Id*. IHS's position is based on the assumption that if IHS stopped denying the Tribe's CHEF eligibility, that would result in more CHEF reimbursements, hence the Final Offer is a "funding request." *Id*. According to IHS's characterization, it would have to change its funding methodologies to approve the Tribe's purportedly improper CHEF requests. *Id*. IHS's position, though, is based wholly on the premise that the Tribe's CHS expenditures were invalid, and that permitting CHEF eligibility would result in reimbursements to which the Tribe was not entitled. Of course, if the premise is wrong, the conclusion is wrong. As shown in Part II above, the Tribe was not asking for funds that it was not eligible to apply for and, if available, to receive.

Second, IHS mischaracterized the Final Offer as purportedly addressing terms and functions that cannot, or are not required to be, included in a compact. AR at IHS000104 ("terms not mandated by ISDEAA"); 103 ("inherent federal function"). IHS claimed that the proposed amendment "would compel IHS to administer CHEF in accordance with the terms of the Tribe's contract and ensure reimbursement for medical claims from the CHEF without regard to the process established by IHS for determining eligibility for such funds." AR at IHS000103.

However, this is just a variation on IHS's argument, already shown to be meritless in Part II above, that the Tribe is attempting to make CHEF subject to contract in violation of 25 U.S.C. § 1621a(c). IHS completely ignored its own Compact duties to maintain the Tribe's CHEF eligibility and support the Tribe's redesign of its health programs. IHS based its decision on the incorrect premise that the Tribe's CHS expenditures were invalid and that the Tribe was attempting to force IHS to implement rules that were different from what was called for under statute. Every argument based on this incorrect assumption is also incorrect.

IHS cannot prevail by mischaracterizing the Tribe's Final Offer to fit statutory declination conditions because such mischaracterizations are not consistent with the substance of what the Tribe sought in its Final Offer. IHS provided no controlling authority for its application of the ISDEAA declination provisions, and in fact violated ISDEAA and the Compact by going to great lengths to construe the ISDEAA provisions against the Tribe. For all of these reasons, IHS failed to identify any legitimate reason for denying the Tribe's Final Offer.

2) ***The Tribe's Final Offer Included Severable Provisions that IHS Should have Accepted, Even if it Rejected Other Provisions.***

When the Secretary rejects a tribe's final offer, ISDEAA requires the Secretary to provide the tribe with the option of entering into the severable portions of a compact or funding agreement that the Secretary did not reject, subject to alterations necessary to conform the agreement to the severed provisions. 25 U.S.C. § 458aaa-6(c)(D). Many portions of the proposed amendment were not disputed in IHS's rejection and should have been accepted by IHS and severed from the disputed portions, thus limiting the scope of this litigation. IHS's reasons for rejecting the Final Offer do not apply to the following provisions, at the very least:

- The Final Offer sought agreement that "[t]he Compacted Health Program and the Tribal Funded Health Program may use a common fiscal intermediary or third party Claims

administrator to coordinate claim responsibility between the two programs." AR at IHS000111. Nothing in IHS's reasons for rejecting the Final Offer would precludes IHS from agreeing to this provision. While IHS objected to other aspects of the Tribe's CHS Program design, IHS did not contend that use of a common claims administrator for multiple programs, in and of itself, resulted in purportedly invalid CHS payments.

- The Final Offer sought agreement that "[t]he Tribe may pay CHS eligible claims through the Tribal Funded Health Program, in lieu of excluding such care; as a means to provide supplemental funding to the Compacted Health Program." AR at IHS000111. Nothing in the reasons stated for rejecting the Final Offer would have precluded IHS from agreeing to this provision. There is not dispute that tribes can supplement the CHS program with tribal funds. The Tribe simply wanted to confirm that it could do so by having its insurance program pay CHS charges directly—rather than transferring funds to CHS. IHS objected to other portions of the Tribe's program design, but did not appear to object to this element.
- The Final Offer sought confirmation that IHS·would "accept industry standard documentation to demonstrate CHS obligated payments for purposes of CHEF reimbursement, including electronic payment records rather than individual paper checks to each separate provider." AR at IHS000111. IHS could have agreed to this provision without prejudicing its objection to other aspects of the offer.

Each of these provisions, even if not combined with the other CHS program features that the Tribe developed, would make the Tribe's delivery of healthcare more efficient, and it would have been valuable to the Tribe to have clarification at an early stage that it could continue the practices. IHS's refusal to agree to these severable portions of the Final Offer is a violation of its

obligations under ISDEAA. It also demonstrates that IHS never gave serious consideration to the details of Tribe's proposal or its concerns regarding Compact administration. Instead, IHS reflexively and improperly denied each and every one of the Tribe's proposals.

CONCLUSION

IHS breached contractual and statutory duties owed to the Tribe. These breaches have harmed the Tribe and threaten to cause additional harm in the future, thereby entitling the Tribe to injunctive and declaratory[17] relief, as well as money damages. Based on the arguments above, the Tribe respectfully submits that this Court should find that IHS is liable to the Tribe for breach of Compact and the ISDEAA, and enter judgment as set forth in the Proposed Order filed with this Memorandum. While the Court has indicated that it will determine money damages in a future proceeding, the Court can and should grant the injunctive and declaratory relief immediately. The Court should grant such relief to prevent IHS from avoiding this Court's decision by issuing a regulation that is not consistent with federal law and the Compact.

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[17] Contrary to IHS's assertions, Redding Rancheria does not contend that Declaratory Judgment Act provides a stand-alone cause of action. Each claim for declaratory relief arises from IHS's violation of the Compact, ISDEAA, or other federal law and regulation.