UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

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

REPLY IN SUPPORT OF DEFENDANTS' MOTION FOR SUMMARY JUDGMENT AND OPPOSITION TO PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT

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INTRODUCTION

The IHS decisions at issue in this proceeding are a result of Redding Rancheria's various attempts to use contract theories to address the IHS' denial of Plaintiff's requests for reimbursement from the Catastrophic Health Emergency Fund ("CHEF"). CHEF, however, is a specific type of appropriation which cannot be the subject of a contract or grant under any law. Congress specifically delegated authority for the administration and allocation of CHEF to the headquarters of the IHS. *See* 25 U.S.C. § 1621a(b). When it did so, Congress unequivocally stated 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). Plaintiff argues that it had only sought to "redesign" its CHS program under its compact in a more efficient manner to make use of CHEF funds. CHEF is an emergency appropriation fund, however, and thus cannot be used, as Plaintiff seeks to do, as a payor in the first instance. In order to be eligible for payment from CHEF, Plaintiff's CHEF claims must be submitted in accordance with CHEF policies and procedures—procedures which Redding Rancheria agreed in its Compact that it would follow. The IHS has maintained Redding Rancheria's eligibility for reimbursement from this fund consistent with other CHS programs' eligibility, each of which may only be reimbursed for valid CHS obligations pursuant to the CHEF policies and procedures. Plaintiff is essentially requesting that IHS treat Redding Rancheria's CHS program differently from other CHS programs, creating exceptions to IHS' policies and procedures that would provide Redding Rancheria with greater access to the CHEF appropriations than other CHS programs.

Even if the CHEF statute did not expressly preclude Plaintiff from seeking a contract remedy under the ISDEAA or CDA, IHS met any contractual or statutory obligations to make CHEF available to Plaintiff. In addition, Redding Rancheria's proposal to amend its compact through a "Final Offer" triggers two of the ISDEAA's declination criteria, 25 U.S.C. § 458aaa-6(c)(1)(A)(i), (ii), and the IHS properly rejected Redding Rancheria's proposed "Final Offer" amendment on that statutory basis. Finally, even if Plaintiff's proposed contract remedies were not statutorily barred, their application would result in a contract that directly conflicts with Section 2901(b) of the Patient Protection and Affordable Care Act ("ACA"), 25 U.S.C. § 1623(b). The ACA did not "impose new constraints" on tribes, Pl. MSJ at 3, but it did supersede IHS' prior policy-based exception to the payer of last resort rule for certain tribal self-insurance plans. Accordingly, this Court should grant Defendants' motion for summary judgment and enter judgment for Defendants on Plaintiff's Phase One Claims.

ARGUMENT

I. Plaintiff's First, Second, Third, Fifth, and Sixth Causes of Action Are Expressly Precluded by the CHEF Statute

A. The CHEF statute plainly precludes Plaintiff from seeking a contract remedy under the ISDEAA or CDA.

Plaintiff's First, Second, Third, and Fifth Causes of Action are seeking a contract remedy under the portions of the ISDEAA pertaining specifically to contracts and contract disputes, 25 U.S.C. §§ 450m–1(a) and 458aaa-10(a). However, under the express language of the CHEF statute, no part of CHEF or IHS' administration of CHEF is subject to the ISDEAA or the CDA. 25 U.S.C. § 1621a; Def. MSJ at 22–27

Plaintiff argues that the statutory "prohibition on contracting CHEF relates to issues that the Tribe is not contesting" because Plaintiff is only asserting a "right to CHEF eligibility under

the Compact, and that is the right at issue in this case." Pl. MSJ at 25 (emphasis in original).[1] Plaintiff's claim "that IHS breached its validly-compacted CHEF obligations" is expressly precluded by statute because IHS may not validly compact for any CHEF obligations. *See* Pl. MSJ at 25; Def. MSJ at 22–27. Plaintiff also argues that its proposed "Final Offer" amendment "simply sought to confirm and clarify that IHS's obligations included … maintain[ing] the Tribe's eligibility for CHEF." Pl. MSJ at 41. Plaintiff's proposed amendment sought to do more; its purpose was, in Plaintiff's words, to "clarify the Tribe's right to coordinate member care between the [CHS] Program and the Tribe's [Supplemental Program] and to ensure eligibility for reimbursement under the Catastrophic Health Emergency Fund (CHEF) for eligible care that is coordinated between [these programs]." AR at IHS000110. It also would have prohibited treatment of Plaintiff's Supplemental Program as an "alternate resource" for purposes of CHS eligibility. AR at IHS000111. Indeed, Plaintiff's First Cause of Action asserts that Plaintiff "is entitled to approval of the proposed amendment" as well as "to CHEF reimbursements for all CHS claims properly paid . . . ." Compl. ¶¶ 125–26. Plaintiff's proposed "Final Offer" amendment was simply an attempt to contractually compel the IHS to commit funding that is not subject to the ISDEAA. As Defendants explained in their motion for summary judgment, Plaintiff could not submit a valid "Final Offer" under the ISDEAA in its attempt to ensure payment from the CHEF and therefore its First and Second Causes of Action must fail. Def. MSJ at 22–24.

[1] Plaintiff also now asserts IHS has breached is duty to construe the Compact and statutes at issue in favor of the Tribe. Pl. MSJ at 23–24. IHS has construed the contract and statutes at issue consistent with their plain and unambiguous meanings.

Any attempt by the parties to contractually promise payment from the CHEF or to contractually agree to certain administration of the CHEF—either by reading such rights into the existing Compact provisions or by attempting to add them to the Compact—is expressly precluded by the CHEF statute. Congress specifically reserved authority for the administration and allocation of the CHEF to the Secretary of the HHS, acting through the headquarters of the IHS. 25 U.S.C. § 1621a(b). When it did so, Congress expressly placed conditions on the use of the fund and limitations on IHS' ability to further delegate responsibility for the administration of the CHEF. 25 U.S.C. § 1621a(c). Specifically, 25 U.S.C. § 1621a(c) provides that "[n]o part of CHEF or its administration shall be subject to contract or grant under any law, including the [ISDEAA], nor shall CHEF funds be allocated, apportioned, or delegated on an Area Office, Service Unit, or other similar basis." 25 U.S.C. § 1621a(c).[2] IHS did not and could not agree to maintain Redding Rancheria's eligibility for CHEF in the manner Redding Rancheria requested. *See* AR at IHS000110-IHS000111. While the parties' Compact mentions CHEF and affirms that Redding Rancheria is eligible for CHEF reimbursement "in accordance with CHEF policy and procedure," AR at IHS000315, if the Compact were to "expressly obligate" IHS to maintain Redding Rancheria's eligibility for CHEF without regard to the applicable CHEF policies and procedures for eligibility, Pl. MSJ at 25, such an obligation would be an unenforceable contract provision expressly precluded by the CHEF statute.

The existing Compact language maintains Redding Rancheria's eligibility for reimbursement from CHEF on the same basis as other tribes—*i.e.*, in accordance with the

[2] Plaintiff lists "fundamental statutory conditions for payment from CHEF," Pl. MSJ at 11, but the statute only directs the Secretary to establish conditions for payment consistent with specific threshold requirements. *See* 25 U.S.C. § 1621a.

requirements of CHEF policy and procedures. AR at IHS000315. IHS could not make any further commitments in the Compact with regard to the CHEF, and Redding Rancheria's proposed "Final Offer" amendment did not ask IHS to treat it like any other CHS program for purposes of CHEF eligibility. Instead, the "Final Offer" amendment proposed that IHS create exceptions to the CHEF policies and procedures for Redding Rancheria's CHS program that would effectively give Redding Rancheria an advantage over other CHS programs in accessing CHEF appropriations.

Whether operated by the IHS or by a tribe under an ISDEAA agreement, all CHS programs must follow the same rules. If IHS allowed exceptions for Redding Rancheria's CHS program, it would not be providing the same opportunity to other CHS programs to seek reimbursement from CHEF. No CHS program is "entitled" to CHEF reimbursements or any other type of guaranteed eligibility for payment from the CHEF, other than an opportunity to meet the same requirements as other CHS programs. The CHEF statute itself indicates that certain requirements must be met before a CHS program is "eligible" for reimbursement from the CHEF, such as reaching a certain threshold amount. 25 U.S.C. § 1621a(d)(2). The parties could not and did not usurp these eligibility requirements through a contract term or otherwise deem Redding Rancheria's CHS program to be unconditionally eligible for reimbursement from the CHEF.

The IHS followed the plain language of the CHEF statute when it rejected Plaintiff's efforts to secure reimbursement from the CHEF through a proposed amendment to its Compact and through a breach of contract claim. IHS' decisions did not "interfere" with Plaintiff's redesign of its CHS Program, and they did not affect Plaintiff's eligibility to apply for CHEF

reimbursement pursuant to the CHEF procedures that IHS applies to all tribes' requests for CHEF reimbursement. The IHS decisions at issue in there proceeding were rejections of Plaintiff's various attempts to ensure payment from the CHEF for CHS Program costs that were coordinated in a manner that IHS does not recognize. The statutory bar in 25 U.S.C. § 1621a(c) precludes Plaintiff's First, Second, Third, Fifth, and Sixth Causes of Action, which seek a contract remedy under portions of the ISDEAA specifically pertaining to contracts and contract disputes. Accordingly, this Court should enter judgment for Defendants on Plaintiff's Phase One Claims.

B. The Declaratory Judgment Act does not provide a stand-alone cause of action.

Plaintiff brought this action under the ISDEAA and the Declaratory Judgment Act, and Plaintiff's Second and Sixth Causes of Action seek declaratory relief. *See* Compl. ¶ 4 (citing 25 U.S.C. §§ 450m–1(a), 458aaa-10(a); 28 U.S.C. § 1331; 28 U.S.C. § 2201). Plaintiff concedes that these claims cannot form independent bases for relief pursuant to the Declaratory Judgment Act. Pl. MSJ at 45 n.17. As a result, Plaintiff's Sixth Cause of Action and Plaintiff's claim in its Second Cause of Action seeking declaratory relief are without merit and should be rejected.

II. Even if Plaintiff's Claims Were Not Expressly Precluded, IHS Properly Rejected Plaintiff's Administrative Efforts to Resolve the Compact Disputes.

A. IHS Met Any Contractual or Statutory Obligations to Make CHEF Available to Plaintiff.

Even if Plaintiff's breach of Compact and breach of ISDEAA claims were not expressly precluded by the CHEF statute, IHS met any contractual obligations to make CHEF available to Redding Rancheria in accordance with CHEF policy. Plaintiff asserts that IHS "conditioned" this CHEF eligibility on operating Redding Rancheria's CHS program in a certain manner, and

that this "interference" violated Plaintiff's "right to design and operate its CHS program" as well as "IHS's obligation to maintain the Tribe's CHEF eligibility." Pl. MSJ at 22–25.

First, Plaintiff is authorized to redesign programs, activities, functions, and services of the IHS "if the redesign or consolidation does not have the effect of denying eligibility for services to population groups otherwise eligible to be served under applicable Federal law." 25 U.S.C § 458aaa-5(e);[3] *see also* AR at IHS000323-IHS000324. Plaintiff has not proposed a "redesign" of its CHS program within the meaning of 25 U.S.C. § 458aaa-5,[4] but to the extent Redding Rancheria seeks to redesign its CHS program, it cannot redesign the CHS eligibility rules. Contractors like Plaintiff must adhere to IHS eligibility rules pursuant to 25 U.S.C. §§ 450j(g) and 458aaa-16(e). Moreover, Plaintiff must still follow CHEF procedures—including only requesting reimbursement for valid CHS obligations—in order to obtain emergency funding from CHEF. Plaintiff could hypothetically choose to redesign its CHS program to cover preventative care only, but as a result there would be no CHS claims for which it could seek CHEF reimbursement. Here, Plaintiff exercised its right to coordinate benefits with its Supplemental Program in a manner that IHS does not recognize, and IHS has not "interfered" with Plaintiff's ability to do so. However, Plaintiff's chosen manner of coordinating benefits

[3] Plaintiff asserts that "it has largely adopted IHS regulations regarding patient eligibility and authorization of services." Pl. MSJ at 6. To the extent Plaintiff has redesigned its CHS program to alter eligibility, such a redesign would violate 25 U.S.C § 458aaa-5(e).

[4] Plaintiff proposed to amend its Compact pursuant to the "Final Offer" amendment process under 25 U.S.C. § 458aaa-6 to memorialize a method for coordinating benefits with its Supplemental Program in a manner that IHS does not recognize. Such a proposal is not a "redesign" or "consolidation" of a program within the meaning of 25 U.S.C. § 458aaa-5, nor did the Tribe assert any such intention in its proposed "Final Offer" amendment. AR at IHS000107-IHS000108. Moreover, while tribes may rebudget resources within a contract notwithstanding any other law, 25 U.S.C. 450j-1(o), redesign authority under 25 U.S.C. § 458aaa-5 does not authorize the same flexibility.

prevents reimbursement from the CHEF emergency backstop. The consequences of this choice are of Plaintiff's own making, and IHS is not obligated to make an exception for Plaintiff in order to ensure Plaintiff's access to the emergency funding of the CHEF.

Moreover, Plaintiff's Compact does not contain any language requiring IHS to approve Plaintiff's CHEF reimbursement requests. AR at IHS000007-IHS00009 (citing Sections 6 and 16 of Plaintiff's funding agreement, *see* AR at IHS000315, IHS000318). Tribes—including Redding Rancheria—are equally eligible to meet the conditions for reimbursement from the CHEF, but the allocation of emergency funding appropriations like the CHEF is committed to agency discretion and the IHS is not required to approve payment for any tribe that does not follow the CHEF procedures. Payment from CHEF is never a "guaranteed" benefit, Pl. MSJ at 23, as it is an appropriated emergency fund and not an entitlement program. *See* Pl. MSJ at 11 (noting CHEF is not an entitlement program); 25 U.S.C. § 1621a.

Indeed, although its denial of Redding Rancheria's CHEF reimbursement requests was not subject to appeal under the CDA, IHS rejected Redding Rancheria's breach of contract claim because it determined that it had met its contractual obligations to the tribe. AR at IHS000006-IHS000007. IHS noted that Redding Rancheria's funding agreement provides that CHEF funds would be made available "in accordance with the CHEF policy," which the agency had applied in its CHEF denial decisions. AR at IHS000007. As such, the agency had met any contractual obligations to make CHEF available in accordance with CHEF policy and procedure. AR at IHS000007-IHS00009 (citing Sections 6 and 16 of Plaintiff's funding agreement, *see* AR at IHS000315, IHS000318).

IHS also noted that it had consulted with tribal organizations when developing its reimbursement procedures, and that Redding Rancheria's compact provision exempting Redding Rancheria from "any circular, policy, manual, guidance, or rule adopted by the [IHS]" "unless expressly agreed to by the Tribe" did not waive the applicability of IHS' funding methodologies for determining the funding a tribe may be eligible to receive. AR at IHS000008. Plaintiff argues that these procedures are not applicable to Redding Rancheria because they were adopted by the IHS without Redding Rancheria's express consent. Pl. MSJ at 24 (citing AR at IHS000328). But Redding Rancheria expressly agreed that it was eligible for CHEF reimbursement in accordance with the CHEF policies and procedures. AR at IHS000315, IHS000318. Redding Rancheria thus agreed to CHEF eligibility provisions in order to be eligible for CHEF reimbursement, and until IHS' proposed regulations go into effect, these policies and procedures govern payment from CHEF.[5]

If IHS has a Compact duty to "maintain the Tribe's eligibility for [CHEF] money on par with all other [IHS] Units and tribal Self-Determination contract operations," IHS has fulfilled this duty. IHS would not reimburse another tribe under the same circumstances as those at issue

[5] Plaintiff argues that these policies were last updated in 1991, "do[] not even address tribal self-insurance programs," and "have little relevance to the modern CHEF program." Pl. MSJ at 35. IHS updated the Contract Health Services chapter of the IHM as recently as 2008, *see* Indian Health Manual, Parts and Chapters, *available at* https://www.ihs.gov/ihm/index.cfm?module=dsp_ihm_pc_main (listing the dates on which IHM chapters were last updated), and provided an explicit policy-based exception for certain tribal self-insurance programs. This chapter of the IHM has not been updated since this limited policy-based exception was invalidated by the ACA. In addition to the IHM policy, IHS annually issues CHEF procedures. *See, e.g.*, AR at IHS000182.

here, and Redding Rancheria has provided no evidence to the contrary.[6] If IHS made a special exception for Redding Rancheria here, then other tribes that might not have alternate resources like Plaintiff's Supplemental Plan could be deprived of this limited emergency funding.

Plaintiff alleges briefly in its Third Cause of Action that the IHS refused to consult in good faith with Redding Rancheria as required by the Compact and the ISDEAA and alleges damages "in the amount of all CHEF denials based on IHS' refusal to treat CHS payments from the Tribe as contract health service payments eligible for reimbursement under CHEF." Compl. ¶¶ 139–40. Plaintiff now argues that this breach stems from IHS' "refus[al] to work with the Tribe to resolve issues concerning Tribal self-determination" and the agency's purported undermining of Redding Rancheria's self-determination choices. Pl. MSJ at 23 (citing AR at IHS000329; 42 C.F.R. § 137.6); *id*. at 37, 40.

Even if the remedies and consultation procedures provided to tribes under the CDA and ISDEAA contract provisions were available to Plaintiff in its CHEF dispute, IHS provided Redding Rancheria with ample opportunity for consultation.[7] Redding Rancheria requested waiver of the CHEF procedures and consultation pursuant to Executive Order 13175, and IHS met with Redding Rancheria to discuss its concerns before upholding the agency's rejection of Redding Rancheria's reimbursement requests on August 8, 2013. AR at IHS000528, IHS000531; AR at IHS000076-IHS000077. In addition, IHS' February 5, 2014, denial of Redding Rancheria's request for an informal conference pursuant to 42 C.F.R. § 137.421 noted

[6] Plaintiff argues that IHS has "approved" exclusionary clauses "similar to the Tribe's", Pl. MSJ at 36 n.14, but there is no indication that those exclusionary clauses were conditional in nature or that the tribes with those clauses received reimbursement from the CHEF.

[7] The IHS California Area Office has also provided Redding Rancheria with informal technical assistance.

several IHS offices were available to provide technical assistance to Redding Rancheria. AR at IHS000299. IHS' March 11, 2014, denial of Redding Rancheria's similar request for an informal conference and request for consultation under Executive Order 13175 noted IHS' willingness to engage in consultation with Redding Rancheria and described two ways for Redding Rancheria to schedule such consultation—through personalized consultation at a Tribal Delegation Meeting or through the IHS California Area Office 2014 Annual Tribal Consultation meeting on March 13, 2014. AR at IHS000301.[8] Even if Plaintiff's breach of contract claims were not expressly precluded by the CHEF statute, IHS met any contractual obligations to make CHEF available to Redding Rancheria in accordance with CHEF policy and procedure. Accordingly, this Court should enter judgment for Defendants on Plaintiff's Third and Fifth Causes of Action.

B. Plaintiff's "Final Offer" Amendment Triggered Two of the ISDEAA's Declination Criteria and Was Properly Rejected.

Even if the CHEF statute did not expressly preclude Plaintiff from seeking a contract remedy under the ISDEAA or CDA, Redding Rancheria's proposal to amend the parties' Compact through a "Final Offer" triggers two of the ISDEAA's declination criteria, 25 U.S.C. § 458aaa-6(c)(1)(A)(i), (ii). IHS properly rejected Redding Rancheria's proposed "Final Offer" amendment on those statutory grounds—either of which is a sufficient basis for rejection—and there was no severable portion of the proposed amendment which could have been approved. *See* Def. MSJ at 29–33.

[8] IHS denied these requests for informal conference because the CHEF is not subject to the ISDEAA and the ISDEAA's informal conference appeal procedures are therefore not available to resolve CHEF disputes. AR at IHS000299, IHS000301.

First, IHS determined that Plaintiff's proposed "Final Offer" amendment met the ISDEAA's first declination criteria, 25 U.S.C. § 458aaa-6(c)(1)(A)(i), which provides for rejection when "the amount of funds proposed in the final offer exceeds the applicable funding level to which the Indian tribe is entitled under this part," and properly rejected it on that basis. AR at IHS000101-IHS000103. As noted above, although Plaintiff has characterized its proposed "Final Offer" amendment as simply a clarification of existing Compact obligations, Pl. MSJ at 41–42, its amendment was an attempt to contractually compel the IHS to commit funding that is not subject to the ISDEAA. The CHEF is not a part of the Secretarial amount, nor does it qualify as CSC or any other type of funding to which a tribe is entitled. 25 U.S.C. § 450j-1(a)(1). Furthermore, unlike the Secretarial amount or CSCs, the CHEF is specifically prohibited from being the subject of an ISDEAA agreement. As a result, Plaintiff had no right to contract for the CHEF funds that it sought to secure through its proposed "Final Offer" amendment to IHS. Plaintiff requested funds which "exceed[ed] the applicable funding level to which [Plaintiff] is entitled," 25 U.S.C. § 458aaa-6(c)(1)(A)(i), and IHS properly rejected the proposed amendment as a result.

In addition, IHS determined that Plaintiff's proposed "Final Offer" amendment met the ISDEAA's second declination criteria, 25 U.S.C. § 458aaa-6(c)(1)(A)(ii), which provides for rejection when "the program, function, service, or activity (or portion thereof) that is the subject of the final offer is an inherent Federal function that cannot legally be delegated to an Indian tribe," and properly rejected it on that basis. AR at IHS000103. The ISDEAA defines "inherent Federal functions" as "those Federal functions which cannot legally be delegated to Indian tribes." 25 U.S.C. § 458aaa(a)(4). The administration and allocation of CHEF cannot legally be

delegated to Indian tribes because these duties are expressly reserved to IHS headquarters by the CHEF statute, which provides that no part of CHEF may be subject to a contract or grant under any law, including the ISDEAA, "nor shall CHEF funds be allocated, apportioned, or delegated on an Area Office, Service Unit, or other similar basis." 25 U.S.C. § 1621a(c) (emphasis added). These statutory provisions prohibit the IHS from delegating its responsibility to administer the CHEF, including the responsibility to assess CHEF claims and determine whether they should be paid from the CHEF. They also prohibit IHS from conferring any contractual rights to the CHEF. IHS properly rejected Plaintiff's proposed "Final Offer" as an attempt to contract for this inherent Federal function.

Finally, when IHS rejected Plaintiff's "Final Offer" amendment, it did not offer Plaintiff the option of entering into any severable portions of that amendment because no portion of Plaintiff's "Final Offer" can be considered severable. Plaintiff argues that three provisions of the "Final Offer" amendment were severable and Redding Rancheria should have had the option to enter into these severable portions. Pl. MSJ at 43–44; 25 U.S.C. § 458aaa-6(c)(1)(D). However, IHS determined that each portion of the proposed language in Plaintiff's "Final Offer" amendment is part and parcel of the same objective— Plaintiff is attempting to secure payment from the CHEF through a proposed amendment to its ISDEAA Compact. Since this objective is prohibited by statute, IHS could not offer Plaintiff the option of entering into any portion of the proposed amendment. Moreover, nothing prevents Plaintiff from proposing these Compact

amendments in a new "Final Offer" amendment if they truly are separate from its attempt to secure payment from CHEF.[9]

Even if Plaintiff's proposed "Final Offer" amendment were not expressly precluded by the CHEF statute, this proposed amendment triggered two of the ISDEAA's declination criteria and was properly rejected under 25 U.S.C. § 458aaa-6(c)(1)(A). Accordingly, this Court should enter judgment for Defendants on Plaintiff's First, Second, and Sixth Causes of Action.

III. Even if Plaintiff's Claims Were Not Otherwise Statutorily Barred, Plaintiff's Proposals Violate the ACA

Even if the Court were to determine that Plaintiff's Phase One Claims are not statutorily barred, those claims still fail as a matter of law. Characterizing it as an amendment to their CHS Program under the ISDEAA and simply a "confirmation" of existing Compact rights, *see* Compl. ¶ 81, Pl. MSJ at 41–42, Plaintiff seeks to add a provision to the parties' Compact that violates the "payer of last resort" provision in section 2901(b) of the ACA and cannot become a legally enforceable part of the parties' Compact, as Defendants explain in their motion for summary judgment. Def. MSJ at 33–40. Similarly, Plaintiff's breach of contract and breach of ISDEAA claims in its Third and Fifth Causes of Action seek approval of Plaintiff's coordination of benefits process—which cannot be permitted because the process would shift payment burdens to the limited federal CHEF appropriations from Plaintiff's Supplemental Program in violation of the ACA's "payer of last resort" provision and the regulatory "payor of last resort" rule. *Id.* Accordingly, this Court should enter judgment for Defendants on Plaintiff's Phase One Claims.

[9] However, two of the three provisions reference "the Tribal Funded Health Program" which is not an IHS program, was never administered by IHS, and is not a program, service, function or activity subject to inclusion in a contract with IHS. *See* 25 U.S.C. 458aaa-4(b).

When Congress enacted section 2901(b) of the ACA, it enacted a "payer of last resort" provision that applies to all services provided by health programs operated by the IHS or through an ISDEAA compact, including services provided to CHS beneficiaries. Plaintiff asserts that this payer of last resort provision "protects all tribal resources allocated for health programs, including tribal self-insurance programs." Pl. MSJ at 29. However, the "payer of last resort" provision expressly provides:

> Health programs operated by the Indian Health Service, Indian tribes, tribal organizations, and Urban Indian organizations (as those terms are defined in section 1603 of this title) shall be the payer of last resort for services provided by [IHS], 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) (emphasis added). In turn, 25 U.S.C. § 1603 defines an "Indian health program" as: "(A) any health program administered directly by the [IHS]; (B) any tribal health program; and (C) any Indian tribe or tribal organization to which the Secretary provides funding pursuant to [25 U.S.C. § 47, commonly known as the 'Buy Indian Act']." Section 1603 further defines a "tribal health program" as "an Indian tribe or tribal organization that operates any health program, service, function, activity, or facility funded, in whole or part, by the [IHS] through, or provided for in, a contract or compact with the [IHS] under the [ISDEAA]."[10] In addition, the terms "Indian tribe," "tribal organization," and "urban Indian organization" in 25

[10] Plaintiff suggests that because Congress did not use these exact terms, it must have meant something different by "health program." Pl. MSJ at 30. That argument ignores the legislative history of this statutory provision. Section 2901(b) of the ACA was introduced in Amendment No. 2786 to H.R. 3590, which substituted the ACA for a different act. Section 2901(b) was not enacted as part of the Indian Health Care Improvement Act ("IHICIA"), which did not contain definitions for "Indian Health Program" or "Tribal Health Program" in 2009. The IHCIA reauthorization bill, S.1790, was subsequently added to the ACA pursuant to subsequent Amendment No. 3276. *See* 155 Cong. Rec. S13490-02.

U.S.C. § 1603—used throughout the Indian Health Care Improvement Act—specifically reference and relate to special programs and benefits provided by the United States to Indians and urban Indians, respectively, and not to health plans operated outside of such authorities. Accordingly, the ACA's "payer of last resort" provision expressly applies to tribes, but only to the extent they qualify as tribal health programs providing services to IHS beneficiaries under 25 U.S.C. § 1603. Tribal self-insurance programs and Plaintiff's Supplemental Program would not qualify as a tribal health program under Section 1603 and therefore would not qualify as a tribal health program for purposes of the ACA's "payer of last resort" provision.

Federal law, before and after the ACA, has treated tribal self-insurance programs as alternate resources. The only exception to this was a limited policy-based exception for exclusionary clauses, which has been invalidated by the ACA.[11] The ACA's "payer of last resort" provision does not constitute an "upheaval of federal Indian law and policy", Pl. MSJ at 31, but simply erased a limited policy-based exception to a longstanding rule.[12] *See* Def. MSJ at

[11] Even if IHS' program guidance establishing a limited policy based exception for tribal self-insurance did not directly conflict with the express language of section 2901(b) of the ACA, this program guidance would still be inapplicable to Plaintiff's Supplemental Program because Plaintiff's "exclusionary" clause does not prohibit payment if the individual is eligible for CHS. Plaintiff's proposed amendment to the Compact would not alter the conditional nature of the Supplemental Program's exclusionary clause. *See* AR at IHS000110-IHS000111. The failure to prohibit payment for CHS eligible patients disqualifies Plaintiff's Supplemental Program from the IHS' policy-based exception in the IHM for certain tribally-funded self-insured health plans, AR at IHS000149, even if such an exception still existed after Congress instituted the ACA's "payer of last resort" provision. IHS is assuming, for purposes of this motion, that Plaintiff's Supplemental Program otherwise meets the definition of a tribal self-insurance plan. IHS did not reach a determination as to whether or how much of Plaintiff's Supplemental Program is a tribally-funded self-insured health plan, as this determination was not required for the agency decisions that are at issue here.

[12] IHS recently finalized a rule governing payment for CHS care obtained from non-hospital providers and suppliers. *See* 81 Fed. Reg. 14,977. That rule expressly incorporates 25 U.S.C. § 1623(b) in its coordination of benefits provision, and it provides that tribal CHS programs are

37–38. In contrast, Plaintiff's interpretation of the ACA's "payer of last resort" provision would create a true "upheaval" by effectively reordering payment between tribal self-insurance and Medicare/Medicaid, both of which have pre-existing coordination of benefits laws. *See* 42 U.S.C. §§ 1395y(b) (Medicare), 1396a(a)(25) (Medicaid).

Without this policy-based exception, Plaintiff's CHS Program is a "health program" within the meaning of the ACA's "payer of last resort" provision, but Plaintiff's Supplemental Program is not. 25 U.S.C. §§ 1603, 1623(b). The ACA's "payer of last resort" provision and IHS' payor of last resort regulation thus could not make Plaintiff's Supplemental Program a payer of last resort, because Plaintiff's CHS Program—which is operated through an ISDEAA compact—cannot be primary to Plaintiff's Supplemental Program for services provided to CHS beneficiaries.

Plaintiff relies on 25 U.S.C. § 1621e for the proposition that Congress determined tribal self-insurance programs are alternate resources with respect to CHS programs only to the extent specifically authorized by a tribe. Pl. MSJ at 28–29. This statutory provision was cited as evidence of what IHS believed to be the then-prevailing Congressional intent when IHS adopted its narrow policy-based exception for certain tribally-funded self-insured health plans from the payor of last resort regulation requirements in the IHM. *See* AR at IHS000149 (citing Section 206(f) of the IHCIA, 25 U.S.C. § 1621e(f)). However, 25 U.S.C. § 1621e only relates to IHS'

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the payers of last resort for such care. 42 C.F.R. § 136.203(b)(1); *see also* 42 C.F.R. § 136.30(g)(1) (using nearly identical language for the coordination of benefits for hospital services). The new rule expressly applies to "Health programs operated by an Indian Tribe or Tribal organization pursuant to a contract or compact with the IHS under the Indian Self–Determination and Education Assistance Act (25 U.S.C. 450 *et seq.*), provided that the Indian Tribe or Tribal organization has agreed in such contract or compact to be bound by this Subpart pursuant to 25 U.S.C. 450l and 458aaa–16(e), as applicable." 42 C.F.R. § 136.201(c).

right to bill for direct care services, which is not in any way implicated here. In 25 U.S.C. § 1621e(f), Congress expressly prohibited IHS from billing a tribally funded self-insurance plan for direct care services provided at IHS facilities or clinics. By its express language, this prohibition only applies to United States' right of recovery under 25 U.S.C. § 1621e(a); it is not implicated in the present case because Plaintiff's claims do not involve direct care services provided at IHS facilities or clinics, nor is Plaintiff being billed by the United States. Plaintiff's CHS program is a payer—a residual one—for care provided to CHS beneficiaries, not a biller for services directly provided.

In the final rule adopting the IHS' payor of last resort regulation, IHS explained that 25 U.S.C. § 1621e was not intended to address and "has nothing to do with contract health care":

> [S]ome States have recognized that State laws requiring local relief programs to be funded through local real estate taxes place a particular burden on those counties which contain large areas of Federal trust land, in this case Indian reservations. Thus, they have taken steps to relieve those counties through increased State contributions or other methodologies which have the effect of spreading the burden statewide.
>
> It was suggested by one commentor that section 204 of the recent Indian Health Care Amendments of 1988[, 25 U.S.C. § 1621e,] is evidence that Congress did not intend to preempt the states in this area. Section 204 gives IHS the right to pursue collections from third parties to reimburse IHS facilities for services provided to certain individuals. In the past most private insurance contracts contained a clause which excluded payment of services for which the subscriber has no legal obligation to pay (i.e., subscriber was not financially liable). . . . Section 204 was enacted to remedy the situation with regard to exclusionary clauses thus allowing IHS to bill for services provided in IHS facilities. The provision was not intended to address and has nothing to do with contract health care.

55 Fed. Reg. 4606-01 (Feb. 9, 1990).[13] Indeed, if 25 U.S.C. § 1621e applied to CHS programs instead of only to IHS' right to bill for direct care services, the provision would eviscerate the ACA's "payer of last resort" provision and IHS' payor of last resort regulation.

Plaintiff's proposed amendment to the parties' Compact seeks to shift payment burdens to the limited federal CHEF appropriations from an alternate resource by prohibiting treatment of Plaintiff's Supplemental Program as an alternate resource for purposes of CHS eligibility. AR at IHS000110-IHS000111; *see also* AR at IHS000382, IHS000489. Similarly, Plaintiff's breach of contract and breach of ISDEAA claims seek approval of Plaintiff's coordination of benefits process. As such, even if Plaintiff's proposed contract remedies were not statutorily barred, their application would result in a coordination of benefits provision that violates the ACA's "payer of last resort" provision. Accordingly, this Court should grant Defendants' motion for summary judgment and enter judgment for Defendants on Plaintiff's Phase One Claims.

CONCLUSION

Based on the foregoing and Defendants' Motion for Summary Judgment, Defendants respectfully request that the Court grant Defendants' motion for summary judgment and enter judgment for Defendants on Plaintiff's Phase One Claims.

[13] To the extent a GAO report cited Section 1621e for the proposition that CHS programs must pay for care before billing a tribal health program, Pl. MSJ at 31 (citing GAO-14-57 at n.17), this is an inaccurate reading of the statute. CHS programs do not bill and could not pay for care before billing a tribal health program.

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Respectfully submitted,

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