**UNITED STATES DISTRICT COURT**
**FOR THE DISTRICT OF COLUMBIA**

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| **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 REPLY MEMORANDUM IN SUPPORT OF ITS MOTION FOR SUMMARY JUDGMENT**

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## INTRODUCTION

The material facts and legal principles relevant to Redding Rancheria's Motion for Summary Judgment are beyond dispute and the Court should grant summary judgment in favor of the Tribe.[1]

IHS attempts to avoid liability first by asserting that the Tribe's claims violate the rule against contracting for the administration of the Catastrophic Health Emergency Fund ("CHEF") program, and that the Tribe's CHEF applications were not made in accordance with CHEF policy and procedure. However, the Tribe has never attempted to make the administration of CHEF subject to contract. Moreover, the Tribe has met all requirements for reimbursement under CHEF. At its core, CHEF policy provides for reimbursement of valid Contract Health Service ("CHS") claims above a designated threshold, subject to the availability of funding. 25 U.S.C. § 1621a(d). IHS cannot show that the Tribe failed to comply with these requirements.

IHS also argues that tribal self-insurance is an "alternate resource" to CHS regardless of whether the self-insurance program covers the care at issue or not—and according to IHS, *any* CHS expenditures for patients covered by tribal self-insurance are invalid. Taken to its conclusion, IHS's argument means that any tribe that provides self-insurance, no matter how limited, would lose CHS coverage for its entire membership. This interpretation of CHS and CHEF is contrary to federal law, not to mention nearly three decades of IHS precedent acknowledging that tribal self-insurance is not an alternate resource to CHS or CHEF. Tribes have the right—but are not required—to provide supplemental funding for CHS care to their members through self-insurance or otherwise. But IHS's interpretation of CHS and CHEF laws

[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 the Indian Health Service ("IHS") is hereafter referred to as "the Director." Together, Defendants are collectively referred to as "IHS."

and regulations would actively discourage tribes from using tribal funds to supplementing the healthcare available under federal programs—a result Congress did not intend. Rather than encourage the Tribe's efforts—resulting in millions of dollars voluntarily spent by the Tribe each year on health care through its self-insurance program—IHS interfered with them by denying the Tribe access to CHEF reimbursements unless the Tribe agreed to terminate the TSIP or design and operate its CHS program in an inefficient manner contrary to the interests of the Tribe and its members.

In contrast to IHS's bald assertions, the Tribe's arguments are based on well-established law. The Tribe's Compact under the Indian Self Determination and Educational Assistance Act ("ISDEAA") allows the Tribe freedom to design and administer its CHS program to the extent not inconsistent with applicable CHS regulations (and does not require IHS's permission to do so). The Tribe embraced its responsibilities by designing its CHS program to meet tribal needs and enhancing the efficiency of its healthcare programs. The Tribe's program design is consistent with the Compact, ISDEAA, and all applicable statutes and regulations, as the Tribe established in its opening Memorandum. The Tribe's efforts in this regard are consistent with the important federal policy upon which ISDEAA is based: encouragement of self-determination through "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). Contrary to IHS's assertions, there is no requirement in the Compact, or in any statute or regulation, that makes CHEF eligibility contingent on operating a CHS program the same way that IHS does. Tribal self-insurance that excludes CHS eligible care has never been and is not now an "alternate resource" for purposes of CHS or CHEF. Nor are there any laws or regulations saying that only tribes without self-insurance programs are eligible for CHS or CHEF. IHS's arguments prove

nothing more than its "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 breached its Compact and is statutory obligations under ISDEAA by refusing to recognize the Tribe's CHS program design and authorized expenditures. IHS also breached its Compact and ISDEAA obligations by failing to maintain the Tribe's CHEF eligibility as expressly required under the terms of the Compact, and by improperly rejecting the Tribe's Final Offer of a Compact amendment that would have clarified IHS's obligations and resolved this dispute. IHS's misconduct resulted in more than a million dollars in denied CHEF reimbursements as of the filing of this lawsuit. Sadly, the Tribe's damages have increased substantially since the filing of the suit, because IHS now refuses to even process the Tribe's CHEF applications.

The Court should grant the Tribe's Motion for Summary Judgment.

**ARGUMENT**

IHS makes no principled legal argument in response to the Tribe's Motion for Summary Judgment; instead IHS attempts to justify its conduct with conclusory assertions devoid of any legal or factual basis for its position. First, IHS argues that the funding and administration of CHEF are not subject to contract—but it fails to identify anything in the Tribe's claims that actually implicates this restriction, or to demonstrate how the restriction defeats the Tribe's actual claims. In fact, the Tribe's claims are based on its right under the Compact to authorize CHS care, to maintain CHEF *eligibility*, and on IHS's duties to support the Tribe's administration of the Compact. The Tribe has not asserted, and does not assert, a contractual right to CHEF funding. And IHS admits the facts underlying the Tribe's claim that IHS denied

CHEF eligibility. As such, IHS breached its Compact duty to maintain the Tribe's CHEF eligibility.

Second, IHS argues that the Tribe's CHS program design violates "the ACA's 'payer of last resort' provision and the regulatory 'payor of last resort' rule" because, according to IHS, the TSIP is an alternate resource that should have covered the care underlying the Tribe's CHEF applications. IHS Resp. at 14. However, a tribal self-insurance program that excludes CHS-eligible care from its coverage, like the TSIP does, is not a payer at all—first, second, or last—with respect to CHS-eligible care. IHS cannot deem the Tribe's CHS payments invalid just because the patients may have access to the TSIP for care *other than* CHS-eligible care. An alternate resource, by definition, is a payer that actually covers care that would otherwise be eligible for payment by CHS. The payer of last resort rule, by definition, applies only when two or more payers cover the same care. Tribal self-insurance that excludes CHS-eligible care cannot possibly be treated as a payer source under either such principle. Moreover, the plain language of 25 U.S.C. § 1623(b) puts all Tribal healthcare programs, including the TSIP, on equal footing with regard to payer of last resort status. If there was dual coverage as between multiple payer of last resort programs, the primary payer would be determined through traditional coordination principles. Here, the TSIP expressly provides that the coverage at issue is excluded. And there is no IHS statute or applicable regulation or policy purporting to mandate TSIP coverage.

Third, IHS argues that it properly rejected the Tribe's Final Offer. The Final Offer would have clarified the Tribe's "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. Contrary to IHS's argument, 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. Again, IHS's argument is based on nothing more than repetition of conclusory assertions that fail to address the Tribe's arguments. Moreover, IHS apparently concedes that the Final Offer included severable portions. And even though IHS is obligated by statute to contract the severable portions, IHS refused to do so and now asserts, incorrectly, that the burden is on the Tribe to submit a new Final Offer to enact the severable provisions.

Finally, IHS argues that the Tribe has not provided any evidence on IHS's treatment of other Tribe's CHEF applications. But, as the Court may recall, it was IHS that vigorously opposed any discovery on the issue. Moreover, the only available evidence confirms that IHS handled the Tribe's CHEF applications in a manner inconsistent with its established policy and its treatment of other tribes.

As shown in greater detail below, none of IHS's arguments provide any basis to deny the Tribe's Motion for Summary Judgment.

## I. IHS BREACHED ITS COMPACT DUTIES TO SUPPORT THE TRIBE'S SELF-DETERMINATION CHOICES AND MAINTAIN THE TRIBE'S CHEF ELIGIBILITY.

IHS cannot avoid liability by suggesting that the Compact obligation to maintain the Tribe's CHEF eligibility is somehow "unenforceable." IHS Resp. at 4. IHS conflates obligations that would be inconsistent with the CHEF statute—*e.g.*, contracting with a tribe for entitlement to certain CHEF amounts or regarding administration of CHEF—with IHS's valid Compact obligation to maintain the Tribe's CHEF *eligibility*. IHS does not, and cannot, deny the existence or enforceability of this obligation.

Nor can IHS avoid liability by asserting that it complied with its duty to maintain the Tribe's CHEF eligibility. IHS systematically denied, and continues to deny, the Tribe's CHEF applications. IHS cannot identify any lawful basis for doing so. In fact, IHS's conduct violated not only the Compact but its own CHEF policies.

### A. IHS Cannot Avoid its Compact Duties by Arguing that the Compact is Unenforceable.

IHS argues that the Tribe's contract-based claims are precluded by 25 U.S.C. § 1621a(c), which states that the *administration* and *allocation* of CHEF are not subject to contract. But this restriction does not preclude IHS from undertaking a valid compact obligation to maintain the Tribe's CHEF *eligibility*. There is nothing in § 1621a(c), or any other statute, that precludes such a contractual obligation or makes it unenforceable. IHS is in fact forced to concede that it has a valid obligation to "maintain[] Redding Rancheria's eligibility for reimbursement from CHEF on the same basis as other tribes." IHS Resp. at 4-5.[2] The restrictions of § 1621a(c) would only be implicated if IHS were to "contractually promise payment from the CHEF or to contractually agree to certain administration of the CHEF." IHS Resp. at 4.

Thus, the statutory restrictions on contracting CHEF are not implicated here. The Tribe has never sought to have the CHEF Program, or any part of it, transferred to the Tribe under its Compact or any other contract. Nor has the Tribe ever sought any promise of payment or allocation from CHEF. The Tribe merely seeks to remain eligible for CHEF—that is, for IHS to

[2] To the extent IHS argues that the Tribe is attempting to contract CHEF "administration," such arguments are based on hypothetical circumstances not present here. IHS argues that "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" IHS Resp. at 4. The flaw in this argument is that IHS did not follow its own CHEF Policy and procedures when it denied the Tribe's CHEF applications, and would have approved the CHEF applications if it had done so.

process the Tribe's CHEF applications under the statutory criteria and applicable regulations and policy. The Tribe's claims in this case are based on IHS's failure to do so. IHS categorically denied the Tribe's CHEF applications, and expressly conditioned the Tribe's CHEF eligibility on the Tribe operating its CHS program in the manner dictated by IHS. Moreover, since the filing of this suit, IHS continues to deny the Tribe's CHEF eligibility. The Tribe has submitted five more CHEF applications, representing more than $860,000 in healthcare expenses. IHS refuses to take any action on these applications. IHS breached, and is continuing to breach, its Compact obligations to maintain the Tribe's CHEF eligibility.

### B. IHS has Compact Duties to Support the Tribe's Program Design Choices and Maintain the Tribe's CHEF eligibility, and IHS Breached these Duties.

IHS categorically denied the Tribe's CHEF applications based on its objection to the manner in which the Tribe designed and operated its CHS program. In doing so, IHS violated its Compact obligations to support the Tribe's program design choices and maintain the Tribe's CHEF eligibility. 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 relies on two flawed arguments in an attempt to defend its conduct. First, IHS argues that it had no obligation to respect the Tribe's CHS program design choices. Second, IHS argues that it properly applied CHEF policy in denying the CHEF applications. IHS is wrong on both counts.

*1. IHS Violated its Obligation to Support the Tribe's Design of its Compact Programs.*

In addition to its Compact duty to maintain the Tribe's CHEF eligibility, IHS has Compact and statutory duties to support the Tribe's design choices for its Compact programs. IHS has a duty to administer the Compact "[t]o enable the Redding Rancheria Tribe to redesign, programs, activities, functions and services of the Indian Health Service . . . 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) (AR at IHS000323). 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 approval. *Id*. The Tribe can redesign its programs in "any manner" it sees fit. *Id*.

Nevertheless, in an attempt to avoid liability for interfering with the Tribe's design and administration of its CHS program, IHS asserts that the Tribe's changes to its CHS Program did not constitute a "redesign." IHS Resp. at 7. Rather, IHS says the Tribe "exercised its right to coordinate benefits with its Supplemental Program in a manner that IHS does not recognize."[3] *Id*. Thus, instead of recognizing the Tribe's self-determination right to design its programs based on applicable CHS regulations and law, IHS insisted that the Tribe operate its programs in the precise way that IHS recognized, and IHS withheld other benefits to coerce the Tribe into doing as IHS dictated. IHS admit as much but assert that the "consequences of this choice are of Plaintiff's own making." *Id*. at 8.

[3] IHS refers to the limitations on "redesign [of] CHS eligibility rules." IHS Resp. at 7. IHS denies that Tribe undertook any redesign of its CHS program, much less the eligibility rules, and certainly do not identify any fact or argument suggesting that the Tribe changed the basic eligibility rules for its CHS program.

Nothing in ISDEAA or the Compact, however, states that the Tribe's eligibility for federal funding will be curtailed if the Tribe attempts to redesign its CHS program to increase efficiencies or to coordinate care between CHS and self-insurance. Nothing in ISDEAA or the Compact says that some program changes are "redesigns" and others are not, as IHS implies. The Tribe redesigned its CHS Program to enhance the efficiency of the program and to meet the Tribe's governmental priorities for providing healthcare. Moreover, IHS has not explained in the past, and still does not explain, precisely what it is about the Tribe's CHS program design that IHS does not recognize. The Tribe's coordination of benefits provisions and claims administration are consistent with provisions policies that IHS has recognized (AR at Redding001774-91), and even included in its own policy manual (IHM § 2-3.8.I )—which is still IHS's public position on these issues, notwithstanding its flawed argument, discussed in detail below, that such policies are purportedly "superseded" by the Affordable Care Act ("ACA"). The Tribe complied with all applicable statutes and regulations, and IHS breached its Compact and statutory duties by interfering with and undermining the Tribe's performance under the Compact, and its ability to design its CHS program to meet the needs of its members.

*2. IHS Did Not Follow its Own CHEF Policy.*

IHS argues that its denial of the Tribe's CHEF eligibility was justified because IHS "applied [CHEF policy] in its CHEF denial decisions." IHS Resp. at 8 (citing AR at IHS00007).[4] As a threshold matter, IHS has not shown that the purported "CHEF policy" applies to the

[4] IHS violated its own CHEF Policy in other respects. Nothing in the guidelines precludes the Tribe from implementing an exclusionary clause. 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.

Tribe.[5] But the Court need not even reach that issue to reject this argument, because IHS did not follow its "CHEF policy." 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). The guidelines do not address the coordination between tribal CHS programs and tribal self-insurance. IHS has not identified a CHEF policy it believes to have been violated. Instead, IHS made up additional rules as it went along in an attempt to justify its denial of the Tribe's CHEF applications.

When IHS argues that IHS applied CHEF policy, it is referring to IHS's denial of the Tribe's Contract Disputes Act ("CDA") claim (IHS Resp. at 8), in which IHS stated that:

> [T]he Agency determined that the Tribe was *seeking reimbursement for payments made to its Tribal self-insurance plan*. Accordingly, the Agency determined that the expenditures for which the Tribe sought reimbursement were not valid authorized CHS expenditures.

AR at IHS00007 (emphasis added).

IHS's claim that "the Tribe was seeking reimbursement for payments made to its Tribal self-insurance plan" is an apparent reference to the Tribe's implementation of a claim administration process for its CHS program in which its TSIP and its claims administrator acted as intermediaries in the processing and payment of claims. AR at IHS000422. As the Tribe explained in greater detail in its opening Memorandum, the Tribe's claim administration process

[5] IHS has 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). The Tribe may agree to be bound IHS policies or other guidance, but IHS has not shown that the Tribe did so here. While the Funding Agreement refers to "CHEF policy" it does not specifically identify the policies at issue and the language is therefore too vague to bind the Tribe to anything but the statutory requirements for CHEF and regulations validly enacted under those statutes—and IHS does not rely on any such authority here.

merely ensured that all CHS claims were ultimately paid as CHS obligations, and that all non-CHS claims were paid by the Tribe itself through funds budgeted for its self-insurance program. Moreover, no reimbursements were sought for claims that were not valid CHS obligations. IHS made assertions to the contrary without meeting with the Tribe or making any effort to secure actual detail as to whether and how the Tribe's claims administration process ensured valid CHS payments. Instead, IHS simply assumed that the Tribe was seeking reimbursement for non-CHS expenditures and repeated this mantra without inquiry. Nothing in IHS's Response addresses the substantive arguments set forth by the Tribe to show the lawfulness of its claims administration and provisional payment provisions. Nevertheless, IHS now relies *solely* on the argument that the provisional payment process renders the Tribe's CHS payments invalid to support the assertion that IHS applied "applied [CHEF policy] in its CHEF denial decisions." IHS Resp. at 8 (citing AR at IHS00007). But CHEF policy does not mention self-insurance, nor does it prohibit the Tribe's CHEF applications or make them ineligible for reimbursement. IHS did not, and cannot, rely on CHEF policy to deny the Tribe's CHEF applications.

For all of these reasons, and as shown in the Tribe's opening Memorandum, IHS violated its Compact obligations by failing to maintain the Tribe's CHEF eligibility and interfering with the Tribe's design and operation of its CHS Program.[6]

[6] IHS asserts that "Plaintiff concedes that [its Second and Sixth Causes of Action] cannot form independent bases for relief pursuant to the Declaratory Judgment Act." IHS Resp. at 6, purportedly citing Pl. MSJ at 45 n.17. IHS's assertion makes no sense—and certainly is not a fair representation of any statement in the Tribe's opening Memorandum. IHS does not refute the substance of the argument in the Complaint and the Tribe's opening Memorandum, that the Tribe's claims for declaratory relief are based on violations of ISDEAA and the Compact and the Tribe can seek declaratory relief with respect to IHS's violations pursuant to 28 U.S.C. § 1331 (federal question jurisdiction), 28 U.S.C. § 2201 (Declaratory Judgment Act), and 25 U.S.C. § 450m–1(a) (the district courts may order appropriate relief for violation of ISDEAA).

## II. IHS CANNOT AVOID LIABILITY BY RELYING ON INDEFENSIBLE CONSTRUCTIONS OF THE PAYER OF LAST RESORT STATUTES.

IHS contends that the Tribe's coordination of benefits ("COB") policies violate "the ACA's 'payer of last resort' provision [25 U.S.C. §1623(b)]" and "the regulatory 'payor of last resort' rule"—that is, IHS's interpretation of 25 U.S.C. § 1621e. IHS Resp. at 14. Both of these statutes protect tribal health resources and permit the efficiency-enhancing COB provisions that the Tribe adopted. Under 25 U.S.C. §1623(b), tribal health programs, including tribal self-insurance programs, are payers of last resort, and, under § 1621e, IHS has a right of recovery against an Indian tribe only to the extent that the tribe specifically authorizes.

The Tribe's COB policies are squarely permitted by these statutes, and serve to carry out the policy underlying the statutes. 25 U.S.C. §§ 1621e; 1623(b). The Tribe coordinates 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. To achieve this end, TSIP 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, or for which a federal program can pay at a more favorable rate. *Id.* As the Tribe can exclude care from coverage by the TSIP, or even terminate the TSIP entirely, there is simply no basis for IHS to object to the Tribe's agreement to cover non-CHS eligible care, or care that can be more efficiently provided through a private network. IHS's attempt to avoid the plain-language application of these statutes is an attack not just on the mechanism that allows the Tribe to match healthcare claims with the program that can pay them most efficiently, but also

on the right of the Tribe to make the fundamental program design choices guaranteed by the Compact and ISDEAA.

### A. Under the Plain Language of 25 U.S.C. § 1623(b), IHS Cannot Force the Tribe to Make the TSIP Primary to the CHS Program.

Under § 1623(b), "[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." This language is inclusive[7]—it protects all tribal resources allocated for health programs, including tribal self-insurance programs. IHS's arguments regarding § 1623(b) are far removed from what the statute actually says. IHS disregards the plain language of the statute and attempts to re-write it to suit its own purposes. IHS contends that "[h]ealth programs operated by . . . Indian tribes" excludes tribal self-insurance programs. IHS Resp. at 15. IHS does not, and cannot, make any principled argument to support its position—but criticizes the Tribe for asking the Court to apply the statute as written. IHS Resp. at n.10.

IHS claims that "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." IHS Resp. at 16 (emphasis added). This argument fails because the statutory definitions of the terms "Indian health program" and "tribal health program" include the Tribe itself. 25 U.S.C. § 1603(12)(C) (Indian Health Program means "any Indian tribe or tribal organization to which the Secretary provides funding ") and § 1603(25)

[7] The term "health program" is intentionally broad, and would by common usage include self-insurance. For example, the Federal Employee Health Benefit Program, which is an employment based program that offers insured and self-insured benefit options, is referred to as a "health program." *See*, https://www.opm.gov/healthcare-insurance/healthcare.

(tribal health program "means an Indian tribe or tribal organization that operates any health program, service, function, activity, or facility funded, in whole or part, by the Service through, or provided for" under a compact). Moreover, 25 U.S.C. § 1603(14) states that "The term 'Indian tribe' means any Indian tribe, band, nation, or other organized group or community . . . *which is recognized as eligible for* the special programs and services provided by the United States to Indians because of their status as Indians." (Emphasis added.) There is no dispute that the Tribe is "recognized as eligible for the special programs and services provided by the United States to Indians." *Id*. Nor is there any dispute that the TSIP is a health program funded by the Tribe providing benefits to CHS-eligible members. AR at IHS000357, 392.

Accordingly, the Tribe is an Indian tribe under §§ 1603 and 1623(b), and all of its health programs are covered by the payer of last resort rule—including the TSIP. Under IHS's contorted reading of § 1623(b), the Tribe's CHS program would be an "Indian tribe," but the Tribe itself would not be an "Indian tribe." IHS's argument makes no sense and is contrary to all rules of statutory interpretation—with failure to respect the plain meaning chief among them.

Even if IHS's argument was not contrary to the plain language of § 1623(b), it would still fail. First, the payer of last resort rule applies only where there are two potential payers for the same care and it is necessary to determine which payer has primary responsibility. But a payer is not an alternate resource—and the payer of last resort rule is therefore not implicated—if the payer does not cover the care at issue. In this case the Tribe voluntarily provides TSIP benefits for some member care, but specifically excludes CHS-eligible care from such coverage. IHS cannot use § 1623(b) to force the Tribe to pay benefits that it did not provide in the first instance.

Second, while § 1623(b) preempts federal, state, and local programs and law to the contrary, it does not purport to preempt tribal programs or law to the contrary. Thus, even if IHS

were otherwise correct in its interpretation of § 1623(b)—and it clearly is not—it would still have no basis for arguing that the Tribe cannot enact government laws and policies that allow or require the TSIP to exclude CHS-eligible care from its coverage.

Finally, IHS cannot reconcile its interpretation of § 1623(b) with the other provisions of the ACA that encourage tribes to develop health programs to supplement federally-funded programs. The ACA includes provisions designed to facilitate the purchase of ACA exchange health insurance policies for tribal members even though tribal members are exempt from the individual mandate and the purchase of such policies is optional. The individual ACA exchanges provide for tribal sponsorship to ease the ability of tribes to secure supplemental insurance for members otherwise eligible for IHS. Furthermore, Tribes are expressly allowed to use federal IHS and CHS funds to pay for tribal self-insurance programs, including expenses for operating the plan and limiting the financial risks of offering such a plan. 25 U.S.C. § 1642 (added by the ACA). Because tribes can use CHS funds to fund self-insurance programs under § 1642, it makes sense that Congress accorded payer of last resort status to both programs.

For all of these reasons, IHS cannot force the Tribe to make the TSIP the primary payer for healthcare with respect to the Tribe's CHS Program or act as though there is some Congressional intent to prevent federal funds from paying prior to or even supporting tribal self-insurance. Both programs have payer of last resort status under § 1623(b) and the Tribe has the right to determine when its TSIP will provide benefits and how those benefits will be coordinated with the CHS program.[8]

[8] Even under IHS procedures, a payer of last resort, like CHS, can authorize payment based on the determination that no other alternate resources are actually available. Indian Health Manual 2-3.8.B(1).

### B. Under 25 U.S.C. § 1621e, IHS Has a Right of Recovery for Healthcare as to the Tribe Only to the Extent Specifically Authorized by the Tribe.

Likely in recognition of the weakness of its argument under § 1623(b), IHS relies on § 1621e, and policies that IHS adopted under that statute, as an alternative argument that the Tribe's exclusionary clause is unenforceable. In doing so, IHS obscures the significance of § 1621e and the nature of its relationship to the issues in this case. IHS's fundamental mistake is failing to realize that § 1621e(f) constrains IHS's rights with respect to Indian tribes—not vice versa.[9] IHS cannot demand that *any* tribal insurance plan act as a primary payer for any healthcare service provided by an Indian tribe "[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)."). Nevertheless, IHS implemented internal CHS policies (which, under Compact Art. II, § 11 (IHS000328), do not apply to the Tribe) under which tribal self-insurance plans are treated as 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's policies regarding exclusionary clauses are not consistent with § 1621e(f). Indeed, IHS policy is exactly opposite the statutory requirement for specific written authorization to treat tribal resources—including self-insurance—as alternate resources. Accordingly, IHS cannot rely on § 1621e(f), nor IHS policies purportedly based on that statute, to argue that the Tribe's exclusionary clause is invalid.

[9] IHS argues that the Tribe "relies on § 1621e for the proposition that Congress determined tribal

IHS asserts that § 1621e(f) "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." IHS Resp. at 18. This argument is no help to 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(f). IHS has not satisfied those conditions. IHS cannot rely on § 1621e(f) as authority to force the Tribe to make the TSIP primary to CHS Program for all care. That decision is squarely in the hands of the Tribe. *Id*.

## III. IHS BREACHED ITS ISDEAA OBLIGATIONS IN REJECTING THE FINAL OFFER.

The Tribe used ISDEAA's "final offer" process as a means of resolving the dispute over IHS's Compact obligations. IHS's challenge to the Tribe's operation of its health programs 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 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*. The arguments put forth by IHS in its Response Memorandum show that IHS did not seriously consider the Tribe's Final Offer. IHS repeats conclusory assertions that characterize the Final Offer in terms that are far removed from the true substance of the proposal. IHS has not met its obligation to support its rejection of the Tribe's Final Offer with controlling legal authority. 25 U.S.C. § 458aaa-6(c). Likewise, IHS did not

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self-insurance programs are alternate resources with respect to CHS programs only to the extent specifically authorized by a tribe." IHS Resp. at 17. That does not accurately represent the issue—as shown above, it is IHS that must prove the conditions of § 1621e(f) are met before it can assert that tribal resources are primary payers as to IHS.

fulfill its obligation to consider whether any portions of the Final Offer were severable—though IHS now cannot deny that portions of the Final Offer are severable. IHS Resp. at 14.

**A. IHS Improperly Rejected the Tribe's Final Offer.**

IHS repeats the argument that the Tribe "requested funds which "exceed[ed] the applicable funding level to which [Plaintiff] is entitled and IHS properly rejected the proposed amendment as a result." IHS Resp. at 12. The problem with this premise, however, is that the Tribe did not seek reimbursement for CHS expenditures that were invalid, that were outside of the annual threshold, or that exceeded the CHEF budget. Of course, if IHS's premise is wrong, its conclusion is also wrong. As shown in Part I above and in the Tribe's opening Memorandum, the Tribe was not asking for funds for which it was not eligible to apply and, if available, to receive.

IHS also repeats the argument that it "properly rejected Plaintiff's proposed "Final Offer" as an attempt to contract for" the "administration and allocation of CHEF." IHS Resp. at 12-13. However, this is just a variation on IHS's argument that *administration and allocation* of CHEF are not subject to contract, already shown to be meritless in Part I above. IHS completely ignored its own Compact duties to maintain the Tribe's CHEF *eligibility*, to honor the Tribe's CHS authorizations, and to support the Tribe's redesign of health programs to meet member needs consistent with applicable statutes and regulations. 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.

### B. IHS Breached its Obligation to Implement Severable Portions of the Tribe's Final Offer.

When IHS rejects a tribe's final offer, ISDEAA requires IHS to provide the tribe with the option of entering into the severable portions of a compact or funding agreement that IHS did not reject, subject to alterations necessary to conform the agreement to the severed provisions. 25 U.S.C. § 458aaa-6(c)(D). IHS asserts that "no portion of Plaintiff's 'Final Offer' can be considered severable." IHS Resp. at 13. However, the Tribe identified several provisions that are severable. For example:

- 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.
- 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.
- 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's only response is to say that IHS considers the provisions to be "part and parcel of the same objective." IHS Resp. at 13. IHS provides no reasoning or authority to support this bald assertion. IHS does not, and cannot, explain how these provisions "request[] funds which "exceed the applicable funding level to which [Plaintiff] is entitled" or attempt to contract for the

"administration and allocation of CHEF." IHS Resp. at 12-13. In fact, with respect to the first provision above, IHS has abandoned the argument that the Tribe's use of a common fiscal intermediary or third party Claims administrator to coordinate claim responsibility between the two programs renders any CHS payment invalid. *See* Part I.B.2, *above*. IHS apparently did not give due consideration to whether any portions of the Tribe's Final Offer were severable, and even now IHS cannot identify any reasons to support its conclusion.

In fact, IHS now apparently concedes that the Tribe is correct—IHS says that "nothing prevents Plaintiff from proposing these Compact amendments in a new 'Final Offer' amendment." IHS Resp. at 13-14. IHS presumably would not make this suggestion if it believed that the proposed amendments were inherently unlawful. But that is not how the severability provision of ISDEAA works, and IHS's concession is too little too late. 25 U.S.C. § 458aaa-6(c)(D). The Tribe has expended significant resources and lost out on significant benefits in its efforts to resolve this matter. IHS only makes this worse by clinging to arguments that it knows cannot support the positions it has taken. IHS's failure to comply with its ISDEAA obligations unnecessarily prolonged this dispute.[10] The Tribe respectfully requests that the Court put an end to IHS's unlawful interference with the Tribe's Compact administration.

## IV. IHS CANNOT AVOID LIABILITY WITH ASSERTIONS REGARDING ITS TREATMENT OF OTHER TRIBES.

IHS relies on arguments based on disputed factual issues to oppose the Tribe's motion for summary judgment, claiming that it "would not reimburse another tribe under the same circumstances as those at issue here, and Redding Rancheria has provided no evidence to the

[10] IHS might have realized its mistake sooner if it had undertaken its consultation obligations in good faith. Despite IHS's glib assertions to the contrary, IHS has consistently refused to engage in any meaningful consultation with the Tribe. Redding0001861-64. When IHS representatives did communicate with the Tribe, they refused to engage in meaningful dialogue and simply repeated the same type of conclusory statements that IHS relies on now. *Id.*

contrary."[11] IHS Resp. at 9. Of course, IHS vehemently opposed discovery on this very issue. [12] It cannot now attempt to use a purported lack of evidence to its advantage. IHS itself holds the actual records and evidence of 30 years of approving the CHEF claims from tribes that excluded self-insurance as an alternate resource. In any event, IHS wrong about the available evidence and the inferences that may be drawn from it.

First, IHS's argument that it "would not reimburse another tribe under the same circumstances as those at issue here" is not plausible on its face. As shown in detail above, IHS's decision not to reimburse the Tribe is based on an interpretation of law that either did not exist, or was kept secret, until this dispute arose. In the meantime, nothing in IHS's public guidance on CHS or CHEF supports IHS's treatment of the Tribe's CHEF applications.

Second, as a result of the Tribe's efforts—and in the face of IHS's threats to suppress it—the record does include resolutions and correspondence from another tribe that expressly coordinated its self-insurance program based on the CHEF threshold, and that IHS agreed to honor those provisions. AR at Redding001774-91. Thus, there is evidence that IHS would reimburse another tribe under the circumstances at issue here.

Third, while this litigation was pending, IHS published proposed CHEF regulations that constitute the first proposed regulation or guidance to include tribal programs as alternate

[11] This argument relates only to the claim that IHS breached the Compact by denying the Tribe's CHEF eligibility; it is not relevant to the question of whether IHS breached the Compact by interfering with the Tribe's CHS program design and operations, breached ISDEAA by improperly rejecting the Tribe's Final Offer, or is liable for the Tribe's declaratory judgment claims.

[12] IHS also argues that they "provided Redding Rancheria with ample opportunity for consultation." IHS Resp. at 10. Again, this is an attempt by IHS to introduce a purported contested issue of fact in an attempt to avoid summary judgment after IHS claimed that discovery was not necessary. The facts in the record show that IHS did not provide any meaningful consultation opportunities.

resources, and which would preclude CHEF eligibility for any claim that could be covered by a tribal program. Proposed Regulation 42 C.F.R. §§ 136.501, .506. These proposed regulations purport to legitimize, after the fact, the breaches of Compact and statute alleged here. Numerous tribes submitted comments critical of the proposed CHEF regulations. The comments include objections to IHS's attempt curtail CHEF eligibility for tribes that treat their tribal self-insurance programs as a supplement to—not replacement of—CHS and CHEF coverage just as the Tribe does in this case.[13] Tribes also object to IHS's attempt to change long-standing policy regarding payer of last resort rules and to IHS's attempt to re-write the statutory rights of Indian tribes. IHS clearly hopes to apply its newly-created unlawful policies to other tribes in the future, but IHS failed to show that it has done so in the past.[14]

**CONCLUSION**

Based on the arguments set forth above and in the Tribe's opening Memorandum, 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 the Court on April 12, 2016. While the Court has indicated that it will determine money damages in

[13] The public comments are available at www.regulations.gov, docket ID: IHS-2016-0002, and the Tribe respectfully requests that the Court take judicial notice of same. The Court may take judicial notice of facts "capable of ready and accurate determination by resort to sources whose accuracy cannot reasonably be questioned," including public documents. Fed. R. Evid. 201(b); *Peart v. Latham & Watkins LLP*, 985 F. Supp. 2d 72, 81 (D.D.C. 2013) (holding that "a court may take judicial notice of public documents from other proceedings," including "a public agency proceeding"); *see also Tovar v. Midland Credit Mgmt.*, 2011 WL 1431988, at *1-2 (S.D. Cal. Apr. 13, 2011) (quoting *Lee v. City of L.A.*, 250 F.3d 668, 689 (9th Cir. 2001) (holding that "a court may take judicial notice of 'matters of public record,'" including comments on proposed amendments to various regulations); *N.W. Envtl. Advocates v. EPA*, 537 F.3d 1006, 1026-27 (9th Cir. 2008) (taking judicial notice of contents of EPA's request for public comment).

[14] If the Court is inclined to deny the Tribe's Motion on this basis (and it should not), the Tribe should first be permitted to address this additional issue by conducting targeted discovery. Fed. R. Civ. P. 56(d), (e).

a future proceeding, the Court can and should grant the requested injunctive and declaratory relief immediately, to prevent IHS from avoiding this Court's decision by enacting a regulation that is not consistent with federal law and the Compact.

DATE: May 13, 2016

s/James K. Nichols

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