UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

FORT MCDERMITT PAIUTE AND SHOSHONE TRIBE, a federally-recognized Indian tribe,	)	
PLAINTIFF,	)	
v.	)	**Civil Action No. 1:17-CV-00837-TJK**
THOMAS PRICE, M.D., Secretary, United States Department of Health and Human Services, et al.,	)	
DEFENDANTS.	)	

PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT AND SUPPORTING MEMORANDUM OF POINTS AND AUTHORITIES

Plaintiff Fort McDermitt Paiute and Shoshone Tribe seeks an order enforcing the Tribe's rights under the Indian Self-Determination and Education Assistance Act (ISDEAA or "the Act"), 25 U.S.C. §§ 5301–5423, regarding two disputed provisions of its contract with the Indian Health Service (IHS) to operate a health clinic and related health programs on the Tribe's reservation in rural Nevada and Oregon. The Tribe submitted a final offer to IHS proposing, *inter alia*, the funding required by the Act and an employee housing provision to support recruitment of health care professionals to the Tribe's remote location. IHS rejected this final offer, but the reasons stated in the rejection do not constitute valid grounds under the Act's stringent statutory provisions. Because this rejection violates the ISDEAA, the Act entitles the Tribe to injunctive relief requiring that IHS add the disputed funds and contract term to its Funding Agreement.

This motion raises questions of law based on interpretation of ISDEAA provisions and related legal authority. There are no material facts in dispute with regard to IHS's arguments.

Therefore, pursuant to Federal Rule of Civil Procedure 56 and Local Rule of Civil Procedure 7(h), Plaintiff Fort McDermitt Paiute and Shoshone Tribe respectfully moves for summary judgment holding that Defendants violated the Act by failing to clearly demonstrate the validity of the grounds for rejecting Plaintiff's final offer. The Tribe also seeks an order overturning the agency's rejection of that offer and requiring Defendants to issue an amendment to the Tribe's contract adding funding and the disputed housing provision.

THE INDIAN SELF-DETERMINATION ACT

The Indian Self-Determination and Education Assistance Act of 1975, as amended, 25 U.S.C. §§ 5301–5423, authorizes Indian Tribes and tribal organizations to contract with the Indian Health Service (as well as with the Bureau of Indian Affairs) to operate federal programs and services that the government otherwise would continue to operate directly for the Tribes and their members.[1] The Fort McDermitt Paiute and Shoshone Tribe currently provides health care services on behalf of IHS pursuant to an ISDEAA self-governance Compact authorized by Title V of the Act.

The ISDEAA was enacted to give Indian Tribes more control over the federal services they receive and to assure "maximum Indian participation" so that these services would be "more responsive to the needs and desires of those communities."[2] The Act seeks to achieve this purpose by the "establishment of a meaningful Indian self-determination policy," which

[1] H.R. REP. NO. 93-1600, at 1–2 (1974), *as reprinted in* 1974 U.S.C.C.A.N. 7775, 7776; S. REP. NO. 100-274, at 1 (1987), *as reprinted in* 1988 U.S.C.C.A.N. 2620.

[2] 25 U.S.C. § 5302(a).

encourages the transition from federal dominance of programs serving Indian Tribes to tribal operation of these programs.[3]

To execute that policy, Congress dictated that, at a Tribe's option, it is mandatory for the federal agency to contract with the Tribe in order to transfer operation of the program. That is, "upon the request of any Indian tribe by tribal resolution, to enter into a self-determination contract," the Secretary must by law contract with the Tribe or tribal organization to "plan, conduct and administer" the federal programs that otherwise would be administered by the Secretary.[4] Similarly, the "Secretary shall negotiate and enter into a written compact with each Indian tribe participating in self-governance in a manner consistent with the Federal Government's trust responsibility, treaty obligations, and the government-to-government relationship between Indian tribes and the United States."[5] Furthermore, the statute says that the Secretary must transfer to the Tribe "the amount the Secretary would have expended had the government itself [continued to] run the program."[6] This is called the "Secretarial amount."[7]

Despite the statute's broad mandates, the agencies resisted tribal efforts to exercise their contract rights, and Congress passed a series of amendments to resolve these issues, especially those related to funding. For instance, when discussing what would become the 1988 amendments to the Act, the House Committee acknowledged the Secretarial amount alone was insufficient as:

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[3] 25 U.S.C. § 5302(b).

[4] 25 U.S.C. § 5321(a)(1).

[5] 25 U.S.C. § 5384 (emphasis added).

[6] *Arctic Slope Native Ass'n v. Sebelius*, 629 F.3d 1296, 1298–99 (Fed. Cir. 2010), *vacated on other grounds*, 133 S. Ct. 22 (2012). *See also* 25 U.S.C. § 5325(a)(1).

[7] *See Arctic Slope Native Ass'n*, 629 F.3d at 1298.

> Many tribes feel that they are paying a financial penalty for the right to contract for the administration of a Federal program. Many costs associated with the performance of the contracts are not funded by the Federal government and therefore have to be covered by the tribes at their own expenses.[8]

In response, Congress added "contract support cost" provisions to provide additional funding for certain administrative costs incurred by contracting Tribes.[9] The Senate Committee was also aware of these funding issues and noted that "[i]n many Service Areas, . . . the Indian Health Service makes no attempt at all to cooperatively plan budgets and programs with affected tribes."[10] The Senate Committee explained the new terms of the Act were "intended to insure that the Federal government provides an amount of funds to a tribal contractor that will enable the contractor to provide at least the same amount of services as the Secretary would have otherwise provided."[11] Those same amendments added new appeal provisions. In doing so, the House Committee explained:

> This section is necessary because the Indian Health Service . . . has refused to permit an appeal and hearing on the issue of the amount of funding to which a tribe is entitled under . . . the Act. IHS maintains . . . that the tribe must accept the unilateral determination of the IHS Area Office as to funds available and that the IHS Declination Appeals Board has no jurisdiction to hear tribal arguments about funding level. . . . Such incidents underscore the importance of requiring an appeal and hearing on the important factual issue of the level of funding to which a tribe is entitled under contracts pursuant to the Act.
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> This subsection would not limit the agencies' authority to determine how to allocate funds. It would simply provide tribal contractors with an opportunity for

[8] H. REP. NO. 99-761, at 4 (1986).

[9] *See* 25 U.S.C. § 5325(a)(2).

[10] S. REP. NO. 100-274, at 22.

[11] *Id*. at 16.

> a hearing to determine whether the agency has complied with [the Act] and has not unfairly discriminated against contracted programs in violation of that section.[12]

Thus, Congress ensured that Tribes had a means to appeal IHS funding decisions, and it expressly rejected IHS assertions that funding determinations were unreviewable discretionary decisions.

These funding and contracting issues continued throughout the 1990s, leading to further amendments to the Act in 1994 and 2000. When considering the 1994 amendments, the House Committee explained:

> The Committee is very concerned about reports from many of the Self-Governance tribes that officials of the Indian Health Service have refused to negotiate for the transfer of central office funds and have exhibited an overall resistance to tribal efforts to redesign programs and reallocate resources and personnel under the authority of Tribal Self-Governance. . . . Therefore, the Committee directs the Indian Health Service to begin to plan for and implement changes that will result in reductions in the Federal bureaucracy which correspond to the transfer of program funds, resources, and responsibilities to Self-Governance tribes.[13]

IHS's reluctance to include all available funds continued despite these warnings from Congress. In 1999, the House Committee returned to the same issue:

> The Committee is concerned with the reluctance of the IHS to include all available federal health funding in self[-]governance funding agreements. We note, as an example, the refusal of the IHS to so include the Diabetes Prevention Initiative funding. As a result, funding was delayed and undue administrative requirements diverted resources from direct services.[14]

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[12] H. REP. NO. 99-761, at 8–9 (emphasis added).

[13] H. REP. NO. 103-653, at 8 (1994).

[14] H. REP. NO. 106-477, at 21, *as reprinted in* 2000 U.S.C.C.A.N. 573, 579.

In response to these concerns, in 2000 Congress made the Act's self-governance provisions permanent as a new Title V.[15] In doing so, Congress expressly acknowledged that "although progress has been made, the Federal bureaucracy . . . has eroded tribal self-governance and dominates tribal affairs" and announced the self-governance provisions were "designed to improve and perpetuate the government-to-government relationship between Indian tribes and the United States and to strengthen tribal control over Federal funding and program management."[16] Congress also reaffirmed its policy "to permit an orderly transition from Federal domination of programs and services to provide Indian tribes with meaningful authority, control, funding, and discretion to plan, conduct, redesign, and administer programs, services, functions, and activities . . . that meet the needs of the individual tribal communities."[17]

In accordance with these congressional policies, the Act contains powerful provisions governing disputes over proposed compact or funding agreement provisions. The Secretary may reject provisions proposed by a Tribe only within a specified time and only for specified reasons. Specifically, if the Secretary and an Indian Tribe "are unable to agree, in whole or in part, on the terms of a compact or funding agreement (including funding levels), the Indian tribe may submit a final offer to the Secretary."[18] If the Secretary wishes to reject that final offer, then within 45 days after receipt of the offer the Secretary must provide:

> written notification to the Indian Tribe that contains a specific finding that clearly demonstrates, or that is supported by a controlling legal authority, that—

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[15] *See* Tribal Self-Governance Amendments of 2000, Pub. L. No. 106-260, 114 Stat. 711 (2000).

[16] *Id*., § 2(3)–(4) (codified at 25 U.S.C. § 5381, note).

[17] *Id*., § 3(2)(F) (codified at 25 U.S.C. § 5381, note).

[18] 25 U.S.C. § 5387(b).

> (i) the amount of funds proposed in the final offer exceeds the applicable funding level to which the Indian tribe is entitled under this part;
>
> (ii) the program, function, service, or activity (or portion thereof) [hereinafter "activity"] that is the subject of the final offer is an inherent Federal function that cannot legally be delegated to an Indian tribe;
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> (iii) the Indian tribe cannot carry out the [activity] in a manner that would not result in significant danger or risk to the public health; or
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> (iv) the Indian tribe is not eligible to participate in self-governance . . . .[19]

Further, the Secretary must provide "technical assistance to overcome the objections stated in the notification."[20] And, if a civil action is commenced challenging the Secretary's rejection of the final offer, "the Secretary shall have the burden of demonstrating by clear and convincing evidence the validity of the grounds for rejecting the offer" and "that the decision is fully consistent with provisions and policies" of Title V.[21] In such an action, "the district courts may order appropriate relief including money damages [or] injunctive relief against . . . any agency" of the United States, including "immediate injunctive relief" to reverse a decision rejecting a Tribe's final offer.[22]

FACTUAL AND PROCEDURAL BACKGROUND

The Fort McDermitt Paiute and Shoshone Tribe is a federally-recognized Indian Tribe composed of Northern Paiute and Western Shoshone peoples. The Tribe is centered in remote McDermitt, Nevada, and its reservation extends across the Nevada border, encompassing lands

[19] 25 U.S.C. § 5387(c)(1)(A).

[20] 25 U.S.C. § 5387(c)(1)(B).

[21] 25 U.S.C. §§ 5387(d), 5398 (emphasis added).

[22] 25 U.S.C. § 5331(a), incorporated into Title V by § 5391(a).

in Humboldt County, Nevada and Malheur County, Oregon. Fort McDermitt is an "Indian tribe" as that term is defined by the Act at 25 U.S.C. § 5304(e).[23]

In January 2013, Fort McDermitt designated the nearby Pyramid Lake Paiute Tribe (Pyramid Lake) as its "tribal organization" for purposes of contracting under the ISDEAA to operate an Emergency Medical Services (EMS) program at the Fort McDermitt Clinic.[24] During the ensuing contract negotiations between IHS and Pyramid Lake, a dispute arose regarding the amount of recurring funds available for that EMS contract.[25] Pyramid Lake requested an annual funding amount of $502,611, which was the amount IHS had been spending to operate that program. Yet IHS claimed the annual amount available for the contract was only $38,746, which constituted what IHS called Fort McDermitt's "tribal share" or budgeted amount for EMS, as shown on an IHS 2013 Service Unit-wide tribal shares table.[26] The Court ruled for Pyramid Lake and eventually directed IHS to pay $502,611 in direct program costs annually for the EMS contract.[27]

In 2014 Fort McDermitt entered a Title I contract with IHS to operate the local community health representative program.[28] At the time, IHS continued operating the Fort McDermitt Clinic, which provides primary medical, dental, and mental health care; as well as

[23] Statement of Facts (SOF) ¶1.

[24] SOF ¶2; *see also Pyramid Lake Paiute Tribe v. Burwell*, 70 F. Supp. 3d 534, 539 (D.D.C. 2014); 25 U.S.C. § 5304(*l*) (defining tribal organization).

[25] SOF ¶3; 70 F. Supp. 3d at 539.

[26] SOF ¶3; 70 F. Supp. 3d at 539, 544–45.

[27] SOF ¶3; 70 F. Supp. 3d at 545; *Pyramid Lake Paiute Tribe v. Burwell*, Case No. 1:13-cv-01771 (CRC) (D.D.C. Jan. 16, 2015) (Final Order) at 3.

[28] SOF ¶4.

substance abuse treatment; diabetes prevention, treatment and management; and other community wellness programs.[29]

In October 2015 IHS was responsible for submitting the Tribe's application for continued grant funding for the Special Diabetes Program for Indians (SDPI), a grant that IHS used to fund 3.5 of the 8 positions at the Fort McDermitt Clinic. The Tribe had been receiving this grant funding since the program started in 1998.[30] The local IHS staff failed to submit this SDPI renewal application in a timely manner due to a technical glitch and misunderstanding during the submission process. IHS Headquarters would not work with its own local staff to remedy the issue, refused to entertain any appeal on the issue, and terminated the Tribe's grant funding.[31]

On February 23, 2016, the Tribe notified IHS that it intended to contract to operate all activities at the McDermitt Clinic by June 1, 2016.[32] IHS acknowledged that notification, but instead of entering negotiations immediately, IHS sent a notice to Congress at the end of March 2016, indicating it planned to close the Fort McDermitt Clinic.[33] In May 2016 Fort McDermitt communicated to IHS its intent to directly operate the EMS program too, and it rescinded its authorization for the Pyramid Lake Tribe to contract the EMS program on its behalf.[34]

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[29] SOF ¶5.

[30] SOF ¶6.

[31] SOF ¶7.

[32] SOF ¶8.

[33] SOF ¶8.

[34] SOF ¶9.

In June 2016, IHS and Fort McDermitt began exchanging information for the negotiation of a self-governance compact and funding agreement.[35] Throughout the negotiation period, the Tribe agreed to delay the assumption date multiple times at IHS's request.[36] By October 2016, it was clear the parties were at an impasse. The Tribe submitted a final offer on October 13, 2016, addressing the five substantive issues then remaining in dispute.[37] On November 23, 2016, IHS rejected the final offer.[38] The parties were later able to reach agreement on a number of these issues, but two remained unresolved: the recurring funding amount to which the Tribe is entitled, and a proposed employee housing services provision.[39] This action challenges the Secretary's determinations regarding both issues.

STANDARD OF REVIEW

The Court will grant a motion for summary judgment where there is no genuine dispute of material fact and the moving party is entitled to judgment as a matter of law.[40] Here, there is no dispute of material fact as this case presents purely legal questions of statutory interpretation.

This action arises under the ISDEAA, not under the Administrative Procedure Act ("APA"). Since this is a civil action to review the Secretary's decision to decline proposed terms

[35] SOF ¶10.

[36] SOF ¶11.

[37] SOF ¶12.

[38] SOF ¶13.

[39] SOF ¶14.

[40] FED. R. CIV. P. 56(a); *accord Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 247 (1986).

of an ISDEAA agreement, review of the agency's decision is de novo.[41] Moreover, "the Secretary [has] the burden of demonstrating by clear and convincing evidence the validity of the grounds for rejecting the offer" and "that the decision is fully consistent with provisions and policies" of Title V.[42] That is, unlike APA actions, the burden is not on the Tribe to establish the illegality of the agency's action; instead, the burden is squarely on the agency to "clearly demonstrat[e]" its actions satisfy the ISDEAA's high standards. And unlike APA actions, review here is de novo and is not strictly limited to the administrative record.[43]

Additionally, unlike APA actions, here there is no deference to the agency's interpretation of law. To the contrary, the Supreme Court has noted that, in interpreting IHS's obligations, "[c]ontracts made under [the ISDEAA] specify that '[e]ach provision of the [ISDEAA] and each provision of this Contract shall be liberally construed for the benefit of the Contractor . . . .'"[44] The Supreme Court has interpreted this language to mean that the

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[41] 25 U.S.C. § 5331; *Pyramid Lake Paiute Tribe*, 70 F. Supp. 3d at 542. *Accord Seneca Nation of Indians v. U.S. Dep't of Health & Human Servs.*, 945 F. Supp. 2d 135, 141–42 & n.5 (D.D.C. 2013); *Cheyenne River Sioux Tribe v. Kempthorne*, 496 F. Supp. 2d 1059, 1067 (D.S.D. 2007); *Cherokee Nation of Okla. v. United States*, 190 F. Supp. 2d 1248, 1256–1258 (E.D. Okla. 2001), *aff'd* 311 F.3d 1054 (10th Cir. 2002), *aff'd in part, rev'd in part on other grounds* 543 U.S. 631 (2005); *Shoshone-Bannock Tribes of the Fort Hall Reservation v. Shalala*, 988 F. Supp. 1306, 1316–17 (D. Or. 1997). *But see Citizen Potawatomi Nation v. Salazar*, 624 F. Supp. 2d 103, 109 (D.D.C. 2009) (finding APA standard appropriate for particular set of procedural facts in that case, where Plaintiff stated claims for relief under both the ISDEAA and APA, and Plaintiff had not raised the Indian canon of construction).

[42] 25 U.S.C. §§ 5387(d), 5398.

[43] *See Cherokee Nation*, 190 F. Supp. 2d at 1256–57 ("It is clear from the plain language of the [ISDEAA] there is no such language indicating that review under the [ISDEAA] is limited to the restrictive APA standard."); *Shoshone-Bannock Tribes of the Fort Hall Reservation*, 988 F. Supp. at 1318 (Defendants' request to limit the record denied because APA does not govern standard of review in ISDA cases.).

[44] *Salazar v. Ramah Navajo Chapter*, 576 U.S. 182, 194 (2012) (quoting 25 U.S.C. § 5329(c) (Model Agreement, § 1(a)(2))).

government "must demonstrate that its reading [of the ISDEAA] is clearly required by the statutory language."[45] And, Title V of the Act goes even further, explicitly stating that "[e]ach provision of this part and each provision of a compact or funding agreement shall be liberally construed for the benefit of the Indian tribe participating in self-governance and any ambiguity shall be resolved in favor of the Indian tribe."[46]

ARGUMENT

I. The Tribe is Entitled to Judgment as a Matter of Law That its Service Unit Level "Hospitals & Health Clinics" Recurring Funding Amount Should Be $1,106,453.

The ISDEAA mandates that Tribes and tribal organizations that contract with IHS are paid two types of funding to operate the contracted program. First, tribal contractors are entitled to be paid the Secretary's program funds: "the amount the Secretary would have expended had the government itself [continued to] run the program."[47] This is called the "Secretarial amount" and it is paid on a recurring basis.[48] Second, beginning in 1988, Congress required the agency to add to the Secretarial amount a second type of funding called "contract support costs,"[49] which include both "indirect administrative costs, such as special auditing or other financial management costs" that are part of a contractor's general overhead, and also certain "direct costs,

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[45] *Id*.

[46] 25 U.S.C. § 5392(f) (emphasis added).

[47] *Arctic Slope Native Ass'n, v. Sebelius*, 629 F.3d 1296, 1298–99 (Fed. Cir. 2010), *vacated on other grounds*, 133 S. Ct. 22 (2012). *See also* 25 U.S.C. § 5325(a)(1).

[48] *Arctic Slope Native Ass'n*, 629 F.3d at 1298–99; 25 U.S.C. §5385(g).

[49] Pub. L. No. 100-472, title II, § 205, 102 Stat. 2285, 2292–94 (Oct. 5, 1988).

such as workers' compensation insurance," that are attributable directly to the personnel and facilities associated with a particular program.[50] This action addresses the "Secretarial amount."

The IHS budget is broken down into a number of different categories based on different services the agency provides, such as "Hospitals & Health Clinics," "Alcohol & Substance Abuse," "Health Education," "Direct Operations," etc.[51] Funds are appropriated into each category, and those amounts can generally be used only for the specified purposes of each category. So, for example, IHS cannot use funds from the Dental Services category to provide mental health services. The final offer and this case only address the amount for one category of services funding, Hospitals & Health Clinics (H&C) funding.[52] The H&C category is the largest in the IHS budget, and it provides funds for medical and surgical inpatient care, routine and emergency ambulatory care, and medical support services including laboratory, pharmacy, nutrition, diagnostic imaging, medical records, physical therapy, ophthalmology, orthopedics, emergency medicine, radiology, and other core health services.[53] It also includes funds for specialty programs like those addressing diabetes, maternal and child health, youth services, geriatric health, communicable disease treatment and surveillance and other quality improvement initiatives.[54]

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[50] *Cherokee Nation v. Leavitt*, 543 U.S. 631, 635 (2005) (citing 25 U.S.C. § 5325(a)(3)(A)(i), (ii)).

[51] *See, e.g.*, INDIAN HEALTH SERV., 2017 CONGRESSIONAL BUDGET JUSTIFICATION, at CJ-9, *available at* https://www.ihs.gov/budgetformulation/includes/themes/newihstheme/documents/FY2017CongressionalJustification.pdf (last accessed Nov. 2, 2017).

[52] SOF ¶15; Docket 1 (Compl.), at 11–13, ¶¶ 46–59.

[53] *See* 2017 CONGRESSIONAL BUDGET JUSTIFICATION, at CJ-56.

[54] *Id*. at CJ-54.

The Tribe proposed $1,106,453 for the Tribe's H&C recurring Service Unit level funding amount.[55] This amount was calculated by adding two numbers. The first number came from the most recent expenditure data the parties had at the time for the McDermitt Clinic(from FY 2015), which showed total expenditures of $603,842.[56] IHS used this same amount to create its expenditure plan for FY 2016 for the Clinic.[57] However, this amount did not include any funds for the EMS program, because that program was operated by the Pyramid Lake Tribe on behalf of Fort McDermitt during FY 2015 and most of 2016. Therefore, to arrive at the total H&C amount, the Tribe added to the $603,842 in local expenditures the additional $502,511 in EMS funding.[58] The $502,611 is the amount IHS paid the Pyramid Lake Tribe to operate the EMS program for Fort McDermitt in FY 2015 and 2016 and, since this is a recurring figure, it represents the amount for that program owed to the Tribe for FY 2017 operations.[59] Since the Tribe had withdrawn its authorization for Pyramid Lake to operate the EMS program on its behalf, the Tribe was entitled to operate the EMS program directly and to receive all of the funding associated with the program.

Towards the end of negotiations, IHS insisted that the Fort McDermitt H&C amount would also need to be pro-rated to provide a "tribal share" for the nearby Winnemucca Indian

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[55] SOF ¶15.

[56] SOF ¶15.

[57] SOF ¶15.

[58] SOF ¶15.

[59] *See* 25 U.S.C. §§ 5325(b) (only permissible reasons for reductions in recurring funding amounts); 5385(g) (stable base budget provision only allows for reductions if appropriations decrease); SOF ¶15.

Colony.[60] Winnemucca tribal members, like all eligible IHS beneficiaries, were able to receive care at the McDermitt Clinic pursuant to IHS policy.[61] In its final offer, the Tribe noted that to the extent IHS wished to pro-rate any H&C amount to provide a "tribal share" for the Winnemucca Indian Colony, this would be inappropriate because both figures used in its calculation were solely based on the amounts the Secretary was expending on behalf of Fort McDermitt tribal members at the Fort McDermitt Clinic.[62] This point was supported by IHS's own historical data, showing Winnemucca members were primarily served outside the Clinic using contract health (CHS)[63] funds not at issue here, and IHS's own user data that showed only two Winnemucca users of the Clinic in the three years prior to the proposed assumption. The Tribe also raised questions regarding how IHS was counting "Winnemucca users" for the purpose of any pro-ration.[64]

IHS rejected this H&C amount on the grounds that "the amount of funds proposed in the final offer exceeds the applicable funding level to which the tribe is entitled[.]"[65] IHS claimed

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[60] SOF ¶17.

[61] SOF ¶18.

[62] SOF ¶19.

[63] The CHS program, also referred to as Purchased/Referred Care, purchases health care services for IHS beneficiaries from private providers instead of IHS and tribal health care facilities. *See* 2017 CONGRESSIONAL BUDGET JUSTIFICATION, at CJ-54, CJ-104.

[64] SOF ¶19.

[65] SOF ¶20. In its final offer response, IHS also rejected the Tribe's proposal to operate the Clinic entirely on the ground that the Tribe "cannot carry out the complete list of [activities] 'in a manner that would not result in significant danger or risk to the public health.'" R. 135-37. IHS issued this decision because it had determined there was "not adequate funding to operate an EMS program," as well as "the clinic, and additional [activities] that IHS had not previously operated" if the EMS funding amounts stayed at the levels ordered by the Court. R. 136. After issuing that letter, however, IHS did enter into contracts with the Tribe to operate the Clinic,

that "[a]lthough typically based on prior year budgets for the service area in question, there must be room for the Secretary to exercise her discretion in determining the Secretarial amount, in light of annual lump sum appropriations and the varying needs of other Tribes who rely on the IHS for services."[66] In other words, instead of relying on prior-year expenditure information for Fort McDermitt to determine how much it had actually historically been spending for the Tribe, IHS asserted the power to choose to re-distribute its appropriated funds as it wished. IHS then rejected the funding amounts proposed by the Tribe "to the extent they exceed[ed] amounts identified" in a document titled "Four-Year Financial Projection" for the Fort McDermitt Clinic.[67] That projection showed an H&C amount for the Clinic in FY 2016 of $685,834, but then subtracted the EMS program funds of $502,611, despite the fact that the Tribe would be operating both programs.[68] IHS then explained this amount should be pro-rated further to "reflect shares allocable to Winnemucca."[69] IHS explained this pro-ration was based on the user population split reflected in IHS's 2013 Service Unit-wide "tribal shares" table.[70] After issuing the rejection letter and later resuming negotiations, IHS ultimately awarded $555,275 to the Tribe in Service Unit H&C funds.[71]

EMS program and other activities proposed. R. 1-52; Compl. ¶37; Ans. ¶37. As this alternate ground no longer appears to be a basis for rejection, we do not address it further here.

[66] SOF ¶21.

[67] SOF ¶22.

[68] SOF ¶23.

[69] SOF ¶24.

[70] SOF ¶24.

[71] SOF ¶25. The Complaint notes the overall amount of H&C funds awarded by IHS was $633,417. Compl. ¶¶ 51, 54. However, that amount included funds not only at the Service Unit

IHS has not met its high burden to demonstrate by clear and convincing evidence the validity of its grounds for rejecting the Tribe's proposal as to the H&C funding amount. IHS has not shown why the Tribe is not entitled to the amounts the Secretary was otherwise providing, i.e., actually spending for the Clinic, rather than arbitrary amounts IHS formulated in its "discretion." IHS's reliance on its tribal shares table and projected financial plan is the exact argument rejected by the Court in the Pyramid Lake EMS program litigation. As Judge Cooper stated in that case:

> The Secretary's tribal share argument posits that what IHS "would have otherwise provided" for a program is the amount it allocated in its budget for a particular program, rather than what it would have actually spent. Neither the Act nor IHS's apparent practice supports the Secretary's interpretation. The clearest meaning of [the] term "would have otherwise provided" in the context of the Act is what the IHS would have otherwise *spent* on the program. Because IHS may spend more than a tribe's budgeted tribal share if the agency itself runs a particular program — as it did here — it cannot limit funding of an ISDEAA proposal to a tribal share amount. IHS acknowledges as much, stating that it generally determines the applicable funding level for an ISDEAA contract "based on the amount the Agency previously spent to operate the program[.]" Accordingly, even if IHS had advanced this argument in its declination letter, it would not have justified the denial of the Tribe's proposal.[72]

Based on the Act and IHS's past practice, IHS was required to accept the Tribe's proposal to base the recurring H&C amount off of actual expenditures for the Clinic, plus the amounts already agreed upon for the EMS program. But instead IHS rejected the proposal, contending that once the Tribe decided to exercise its right to take over operation of the Clinic,[73]

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or "program" level, but also Area Office and Headquarters level. However, the final offer and these numbers only focused on the Service Unit amount. Therefore, we address solely the amount IHS awarded for H&C at the Service Unit level here. *See* R. 149.

[72] *Pyramid Lake Paiute Tribe*, 70 F. Supp. 3d at 544–45 (internal citation omitted) (emphasis added).

[73] Notably, IHS submitted its closure notice to Congress only after the Tribe notified IHS it intended to contract for the clinic functions. Moreover, IHS's own errors resulted in increased

IHS had the right to unilaterally reduce the Clinic budget and move funds around that it would have otherwise spent on clinic operations. This is not a permissible basis to reject the Tribe's final offer under the statute. Indeed, IHS's own data shows it was well on track to spend even more in FY 2016 than the Tribe proposed (EMS funding aside), as it had already spent $662,660.37 for clinic operations only ¾ of the way through the fiscal year—and again those amounts were separate from the amounts it was paying to Pyramid Lake for the EMS program.[74]

IHS claims that to rely on any figures other than its own *post hoc* calculations means it would have to take funds from other Tribes to fund the Fort McDermitt Clinic. But that cannot be the case—first, because, as explained above, IHS was spending the funds the Tribe identified at the Clinic and on the EMS program, and, second, because IHS could have addressed other funding pressures by drawing upon discretionary Headquarters, Area Office or Service Unit administrative funds that do not go to direct care services at Fort McDermitt. It could even have freed up money by reducing the federal bureaucracy, as the Act intended, and used those savings to provide additional funds for tribal contractors.[75] In other words, even if pressures to serve other Tribes were a valid ground for rejecting the final offer—and it was not—IHS has other

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funding pressure for the Clinic as it failed to properly renew the Tribe's diabetes grant, which funded nearly half the positions at the Fort McDermitt Clinic.

[74] SOF ¶16.

[75] *See* Pub. L. No. 106-260, § 3(2)(G), 114 Stat. 711, 712 (2000) (codified at 25 U.S.C. § 5381, note) ("It is the policy of Congress . . . to call for full cooperation from the Department of Health and Human Services and its constituent agencies in the implementation of tribal self-governance to provide for a measurable parallel reduction in the Federal bureaucracy as [activities] are assumed by Indian tribes."); *see also* 25 U.S.C. § 5394(b)(2)(C) (reports to Congress must include reduction in federal bureaucracy).

sources and tools to assure that funding the Tribe's assumption of the Clinic at the statutorily-mandated amount would not harm other Tribes.[76]

The bottom line is that IHS deviated from its statutory obligations and its past practice by failing to provide a recurring H&C funding amount based on historical expenditures (i.e., what the Secretary was actually spending), and unlawfully relied on "tribal share" budget estimates that it further manipulated to lower the funding amount it would have to award to the Tribe.

II. The Tribe is Entitled to Judgment as a Matter of Law That the Proposed Employee Housing Services Provision Must Be Included in its Funding Agreement.

The Tribe proposed including the following provision in section 3.1 of its Funding Agreement, which describes the health care and related support activities the Tribe would carry out under the Compact:

> **Employee Housing Services** provides management and maintenance of tribally-owned housing units near the Fort McDermitt Clinic site provided to tribal health program employees.[77]

The Tribe was already providing this housing for the Clinic practitioner employed by IHS. The Tribe explained in its final offer that tribal housing services were "an essential part of the Tribe's recruitment and retention of medical professionals and are provided in direct support of the Fort McDermitt tribal health program." The Tribe further explained that "without such housing units made available by the Tribe, the Tribe would be unable to attract health care

[76] In any event, IHS's effort to reallocate Clinic funds effectively reduces the amount available for McDermitt Clinicpatients in order to make funds available for the Winnemucca Indian Colony. This too runs afoul of the Act, as the ISDEAA provides only limited circumstances under which the agency can reduce a Tribe's funding amount, and it expressly states "the Secretary is not required to reduce funding for programs, projects, or activities serving a tribe to make funds available to another tribe or tribal organization." 25 U.S.C. § 5325(b).

[77] SOF ¶26.

providers to its remote reservation as the nearest city that may provide housing is over 75 miles away."[78] The Tribe also emphasized that this provision aligned with congressional policies aimed at providing more flexibility for tribal health programs to recruit and retain medical professionals, and gave several examples of Indian Health Care Improvement Act provisions intended to meet those goals.[79]

IHS rejected the housing provision on the grounds that "the amount of funds proposed in the final offer exceeds the applicable funding level to which the Tribe is entitled" (even though the Tribe sought no funding in this provision) and because the activity "is an inherent Federal function that cannot be legally delegated to an Indian tribe."[80] IHS explained further that maintenance of federal quarters is an inherent federal function under 5 U.S.C. § 5911, a statute that authorizes federal agencies to provide quarters for federal employees.[81] IHS based its funding level rejection on the argument that the "proposed language could be interpreted to extend [Federal Tort Claims Act] coverage to an activity that is not authorized by the ISDEAA. As such, the proposed language is an improper imposition or extension of the federal government's legal and financial liability under the FTCA."[82]

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[78] SOF ¶27.

[79] *See* 25 U.S.C. § 1611 ("The purpose of this subchapter is to increase the number of Indians entering the health professions and to assure an adequate supply of health professionals to the Service, Indian tribes, tribal organizations, and urban Indian organizations involved in the provision of health care to Indian people."); *see also* 25 U.S.C. §§ 1611–1616r (Indian Health Care Improvement Act, Subpart I).

[80] SOF ¶28.

[81] SOF ¶29.

[82] SOF ¶30.

In its Answer, IHS revised its objections to this provision. There, IHS denies "that IHS is exclusively authorized to manage federal quarters."[83] IHS explains "Tribes are authorized to manage federal quarters pursuant to 25 U.S.C. § 1638a, which ensures that . . . sufficient funds are generated from rents 'to prudently provide for the operation and maintenance of the quarters' in accordance with federal standards."[84] IHS now claims its objection to the Tribe's proposed language is that the statutory provision it cited does not apply to tribally-owned housing and therefore the proposed language "does not ensure that the service will be conducted in accordance with applicable standards to avoid an improper extension of the government's tort liability."[85] It appears IHS no longer objects to including such a program in the Tribe's contract, and only remains concerned whether the proposed language will ensure compliance with "applicable standards."

Again, IHS has failed to establish the validity of the grounds for its rejection by clear and convincing evidence. IHS's arguments invoking 25 U.S.C. § 1638a and 5 U.S.C. § 5911 are based on the premise that this activity (operation and maintenance of employee housing units) is not contractible or is not "authorized" under the ISDEAA. But no activity is specifically authorized by the ISDEAA—the ISDEAA merely authorizes IHS to award Tribes contracts for activities that IHS would otherwise undertake. The specific activities that can be included in those contracts are all authorized by other statutes, such as the Snyder Act, the Indian Health

[83] *Compare* R. 133 *with* Ans. ¶42.

[84] Ans. ¶42.

[85] Ans. ¶42.

Care Improvement Act, annual appropriations Acts, and other non-Indian specific authorities.[86] Accordingly, the ISDEAA permits a broad range of activities to be included in a Funding Agreement so long as they are carried out for the benefit of Indians. And, there is no "requirement that an Indian tribe or Indians be identified in the authorizing statute for a program or element of a program to be eligible for inclusion in a compact or funding agreement."[87] Additionally, the ISDEAA states that "the Secretary shall interpret each Federal law and regulation in a manner that will facilitate . . . the inclusion of programs, services, functions, and activities in the agreements entered into under this section."[88]

IHS's reliance on 5 U.S.C. § 5911, a statute that authorizes federal agencies to provide quarters for federal employees, is therefore misplaced. Because that statute authorizes IHS to provide quarters, and because IHS does so for the benefit of Indians because of their status as Indians, the statute establishes the Tribe's authority to provide housing under an ISDEAA agreement.[89] In other words, the ISDEAA authorizes Tribes to step into the shoes of IHS. The fact that Indians are not expressly referenced in the authorizing statute is not relevant because the ISDEAA does not "require[] that an Indian tribe or Indians be identified in the authorizing

[86] *See* 25 U.S.C. § 5385(b)(2) (A Funding Agreement may include all programs for "which Indian tribes or Indians are primary or significant beneficiaries" authorized by a number of specific statutes, including the Indian Health Care Improvement Act, 25 U.S.C. § 1601 et seq., or "any other Act of Congress" that authorizes the Department "to administer, carry out, or provide financial assistance" for such activities that are "carried out for the benefit of Indians because of their status as Indians.").

[87] 25 U.S.C. § 5385(c).

[88] 25 U.S.C. § 5363(i) (emphasis added).

[89] *See* 25 U.S.C. § 5385(b)(2).

statute for a program or element of a program to be eligible for inclusion in a compact or funding agreement."[90]

That this activity is contractible is demonstrated by similar provisions that are included in tribal funding agreements across the country. Maintenance and operation of staff quarters—whether federally-owned or tribally-owned—are a routine part of health programs run by Tribes under compacts or contracts with IHS. The ISDEAA contains no basis for drawing a distinction between employee housing programs run by Fort McDermitt and those run by other Tribes and tribal organizations that contract with IHS, and it is unlawful for IHS to do so.

And IHS itself has acknowledged the need for this housing in order to be able to provide quality health care, especially in remote areas. Indeed in 2017 alone, IHS requested $12 million to "fund the replacement and the addition of new housing quarters in isolated and remote locations for healthcare professionals to enhance recruitment and retention."[91] IHS identified the same need for employee housing as that advanced by the Tribe, explaining:

> Many of the 2,700 quarters across the IHS health delivery system [a system that includes both IHS directly-operated and tribally-operated facilities] are more than 40 years old and in need of major renovation or total replacement. Additionally, in a number of locations the amount of housing units is insufficient. The identified unmet need, of housing units in isolated, remote locations is a significant barrier to the recruitment and retention of quality healthcare professionals across Indian Country. The greatest need is in the Great Plains, Navajo and Alaska Areas; $12.0 million is being requested in FY 2017 to initiate the replacement and addition of quality housing for healthcare professionals in these three Areas.[92]

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[90] 25 U.S.C. § 5385(c).

[91] 2017 CONGRESSIONAL BUDGET JUSTIFICATION, at CJ-175; *see also id.* at CJ-190 (reiterating importance of providing staff quarters as a necessary recruitment and retention tool in areas where housing is limited).

[92] *Id*. at CJ-176.

The reference to the Alaska Area is significant as IHS provides no direct care in the Alaska Area, meaning all quarters there are operated by Tribes and tribal organizations pursuant to ISDEAA contracts and compacts.[93] There are also provisions in both the ISDEAA and the Indian Health Care Improvement Act that speak to how rental rates are determined for tribally-managed, but federally-owned, housing units, which assume these units are included in ISDEAA compacts and contracts.[94]

Simply put, operation of such housing is not "an inherently Federal function" a term intended to describe functions that are vested by Congress solely in the Secretary and cannot legally be delegated to Tribes.[95] And IHS now acknowledges that operating employee housing is not "inherently federal" as it expressly denied that it is "exclusively authorized" to manage federal quarters.[96] These provisions for employee housing are routinely included in the funding agreements of Tribes and tribal organizations, which would not be legally possible if operating housing was an "inherently federal function."

These provisions for employee housing also cover units owned by Tribes, not only those owned by the federal government. For instance, IHS operates a "Joint Venture Construction Program" under the Indian Health Care Improvement Act, which authorizes the construction of health care facilities by Tribes and requires the construction of tribally-owned staff quarters if

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[93] *See Alaska Area*, INDIAN HEALTH SERV., https://www.ihs.gov/alaska/ (last accessed Nov. 2, 2017); INDIAN HEALTH SERV., ALASKA AREA PROFILE 6–7 (2017), https://www.ihs.gov/alaska/includes/themes/responsive2017/display_objects/documents/hf/area.pdf (last accessed Nov. 2, 2017).

[94] *See* 25 U.S.C. § 5324(n); 25 U.S.C. § 1638a.

[95] *See* 140 Cong. Rec. 28833–36 (Oct. 7, 1994) (statement of Sen. McCain).

[96] Ans. ¶ 42.

adequate housing is not available in the Area.[97] Once the facility is open, operation of these tribally-owned employee housing units is then included as an activity in tribal funding agreements. Similarly, per the ISDEAA, "[u]pon the request of an Indian tribe or tribal organization, the Secretary shall enter into a lease with the Indian tribe . . . that holds title to . . . a facility used by the Indian tribe or tribal organization for the administration and delivery of services . . . ."[98] Thus, the Tribe could request a lease from IHS for the costs of operations, maintenance, and any other "reasonable expenses" related to these units, and these funds too would be included in the Tribe's Funding Agreement. These examples defeat IHS's contention that operation of staff quarters is an inherently federal function that cannot be carried out by Tribes.

IHS's FTCA argument is similarly misguided and is not a valid ground for rejecting the proposed language.[99] First, it is based on IHS's erroneous conclusion that employee housing is not "authorized." Second, FTCA coverage is expressly provided for in the Act, so the fact that adding an activity may (or may not) expand the government's FTCA liability is not a valid basis

[97] *See* INDIAN HEALTH SERV., JOINT VENTURE CONSTRUCTION PROGRAM PRE-APPLICATION KIT, Section 1-Program Announcement, Staff Quarters, at 10 (2014) https://www.ihs.gov/dfpc/includes/themes/responsive2017/display_objects/documents/jvcp/Joint_Venture_Pre-Application_Kit.pdf (last accessed Nov. 2, 2017).

[98] 25 U.S.C. § 5324(*l*)(1) (emphasis added).

[99] In its rejection letter, IHS asserted that "[d]uring the parties' negotiations, the Tribe's legal counsel indicated that the goal of the proposed language was to obtain [FTCA] coverage for the Tribe's tribally-owned employee housing." R. 133. However, the Tribe's final offer expressly stated the goal of including employee housing services was to use it as a medical provider recruitment and retention tool. R. 109.

for rejecting a final offer.[100] Indeed, Congress was aware of the potential for such increased liability when it expanded FTCA coverage to tribal contractors, and it accepted that risk.[101]

Consequently, IHS has failed to meet its burden to prove the validity of the grounds for rejecting the Tribe's proposed employee housing provision.

CONCLUSION

IHS's November 23, 2016 decision constitutes an illegal rejection of the Fort McDermitt Paiute and Shoshone Tribe's final offer and must be overturned. Pursuant to the ISDEAA, the Tribe is entitled to an order reversing the Secretary's rejection and awarding the contract as proposed in its final offer. Accordingly, the Tribe requests a declaration that the Tribe's proposed recurring H&C amount and the proposed employee housing services provision are approved by operation of law. Additionally, the Tribe requests immediate injunctive relief compelling IHS to enter into the proposed contract terms and awarding the Tribe additional recurring Service Unit level H&C funds in the amount of $551,178 ($1,106,453 minus the $555,275 already awarded), and compelling the immediate payment of these funds.

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[100] 25 U.S.C. §§ 5321(d); 5396(a) (setting forth only limited grounds for rejection).

[101] *See* H. REP. NO. 99-761, at 12 (CBO Analysis) ("This provision would increase the federal government's liability. However, CBO has no basis to estimate the additional liability that would be taken on by the federal government or the additional cost that could be incurred by the Justice Department for defending more liability cases. This provision could also reduce federal costs to the extent that tribal malpractice insurance is currently paid for by the federal government as an indirect cost component of administrative contract agreements.").

Respectfully submitted this 3rd day of November 2017.

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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

FORT MCDERMITT PAIUTE AND SHOSHONE TRIBE, a federally-recognized Indian tribe,	)	
PLAINTIFF,	)	
v.	)	**Civil Action No. 1:17-CV-00837-TJK**
THOMAS PRICE, M.D., Secretary, United States Department of Health and Human Services, et al.,	)	
DEFENDANTS.	)	

PLAINTIFF'S STATEMENT OF FACTS

Pursuant to Local Rule of Civil Procedure 7(h)(1), Plaintiff Fort McDermitt Paiute and Shoshone Tribe sets forth the following facts that are not in dispute:

1. The Fort McDermitt Paiute and Shoshone Tribe is a federally-recognized Indian Tribe composed of Northern Paiute and Western Shoshone peoples. The Tribe is centered in remote McDermitt, Nevada, and its reservation extends across the Nevada border, encompassing lands in Humboldt County, Nevada and Malheur County, Oregon. Fort McDermitt is a "Tribe" as that term is defined by the Act at 25 U.S.C. § 5304(e). Compl. ¶5; Ans. ¶5.

2. In January 2013, Fort McDermitt designated the nearby Pyramid Lake Paiute Tribe (Pyramid Lake) as its "tribal organization" for purposes of contracting under the ISDEAA to operate an Emergency Medical Services (EMS) program within the Fort McDermitt area. Compl. ¶20, Ans. ¶20; *Pyramid Lake Paiute Tribe v. Burwell*, 70 F. Supp. 3d 534, 539 (D.D.C. 2014).

3. During the contract negotiations between IHS and Pyramid Lake, a dispute arose over the amount of funds available for the Fort McDermitt EMS contract. Pyramid Lake requested $502,611 for the contract, as that was the amount IHS had been spending to operate that program, but IHS claimed the amount available for the contract was $38,746, which constituted Fort McDermitt's "tribal share." The Court ruled for Pyramid Lake and eventually directed IHS to pay $502,611 in direct program costs annually for the EMS contract. Compl. ¶¶21-22; Ans. ¶¶21-22; 70 F. Supp. 3d at 539, 542, 544–45; *Pyramid Lake Paiute Tribe v. Burwell*, Case No. 1:13-cv-1771 (CRC) (D.D.C. Jan. 16, 2015) (Final Order) at 3.

4. In 2014 Fort McDermitt entered a Title I contract with the Indian Health Service to operate the community health representative program serving its members. Compl. ¶23; Ans. ¶23.

5. At the time, IHS continued operating the McDermitt Clinic, which provides primary outpatient medical, dental, and mental health care; as well as substance abuse treatment; diabetes prevention, treatment and management; and other community wellness programs. R. 144, 580; *see also Schurz Service Unit: The Fort McDermitt Clinic*, *"Services,"* INDIAN HEALTH SERV., https://www.ihs.gov/phoenix/healthcarefacilities/schurz/ (last accessed Nov. 2, 2017).

6. In October 2015 IHS was responsible for submitting the Tribe's application for continued funding for the Special Diabetes Program for Indians (SDPI) grant, a grant that the Tribe had been receiving since the program started in 1998. According to IHS documents, this funding supported approximately 3.5 of the 8 positions at the McDermitt Clinic when IHS was operating the Clinic. Compl. ¶24; Ans. ¶24.

7. The local IHS staff failed to submit this SDPI renewal application in a timely manner due to a technical glitch and misunderstanding during the submission process. IHS Headquarters refused to entertain any appeal on the issue and denied the grant application, thereby terminating this funding. Compl. ¶25; Ans. ¶25; R. 580.

8. On February 23, 2016, the Tribe notified IHS that it intended to assume all PSFAs at the McDermitt Clinic by June 1, 2016. IHS acknowledged that notification. At the end of March 2016, IHS sent a notice to Congress indicating it planned to close the Fort McDermitt Clinic. R. 58–59 (notice of intent); 270 (acknowledgment); 142–147 (closure notice); Compl. ¶¶27–28; Ans. ¶¶27–28.

9. In May 2016 Fort McDermitt rescinded its authorization for Pyramid Lake to contract the EMS program on its behalf and communicated to IHS its intent to directly operate that program as well. Compl. ¶30; Ans. ¶30.

10. IHS and Fort McDermitt began exchanging information to begin negotiation of a self-governance compact and funding agreement in June 2016. R. 577. Formal negotiations began in July 2016. Compl. ¶32; Ans. ¶32.

11. Throughout the negotiation period, the Tribe agreed to delay the assumption date multiple times at IHS's request. Compl. ¶33; Ans. ¶33; R. 287, 311, 338.

12. By October 2016, the parties were at an impasse as little progress had been made since August 2016. Compl. ¶33; Ans. ¶33. The Tribe submitted a final offer on October 13, 2016, addressing the five substantive issues remaining in dispute. Compl. ¶34; Ans. ¶34; R. 108–115.

13. On November 23, 2016, IHS issued a decision, rejecting many of the proposals in the final offer. Compl. ¶35; Ans. ¶35; R. 130–141.

14. The parties were later able to reach agreement on a number of these issues, but two remained in dispute. Compl. ¶36; Ans. ¶36.

15. The Tribe proposed a recurring funding amount of $1,106,453 for the Tribe's Service Unit level Hospitals and Health Clinics (H&C) funding. Compl. ¶49; Ans. ¶49; R. 113; *see also* R. 111 (Tribe's amount was proposed in response to the lower "program" or Service Unit level H&C number in draft funding table provided by IHS (citing Ex. 2 (R. 120))). This number was a combination of two numbers: the Secretary's anticipated expenditure amount in FY 2016 for the Clinic, which was based on FY 2015 expenditure data, of $603,842; and the amount the Court ruled was the EMS program funding amount of $502,611. R. 112–113. IHS had paid this Court-ordered amount to Pyramid Lake for the EMS program in both 2015 and 2016. R. 268.

16. IHS's expenditure data for FY 2016 shows it had already spent $662,660.37 for Clinic operations only ¾ of the way through the fiscal year. R. 574.

17. IHS insisted that the McDermitt H&C amount would also need to be pro-rated to provide a "tribal share" for the nearby Winnemucca Indian Colony. R. 430 (IHS lead negotiator discussing "need to separate the Winnemucca and Fort McDermitt information"); 443 (IHS sends draft funding tables for Fort McDermitt and Winnemucca and the "combined table of all shares").

18. Winnemucca tribal members, like all eligible IHS beneficiaries, were able to receive care at the McDermitt Clinic (or any other IHS clinic) pursuant to IHS policy. 42 CFR § 136.12(a); Letter from Michael H. Trujillo, Director, Indian Health Service, to Tribal Leaders (Jan. 10, 2000) at 2, *available at* https://www.ihs.gov/newsroom/includes/themes/

responsive2017/display_objects/documents/2000_Letters/01-10-2000_Letter.pdf (last accessed Nov. 2, 2017).

19. In the final offer, the Tribe stated it was improper to lower the McDermitt H&C amount to provide a "tribal share" for the Winnemucca Indian Colony because both figures used in its calculation were solely based on the amounts the Secretary was expending on behalf of McDermitt tribal members at the McDermitt Clinic. R. 112–113. Additionally, IHS's own historical data showed Winnemucca members were historically served outside the Clinic using contract health services (CHS) funds, and IHS's own user data showed only two Winnemucca users of the Clinic in the past three years. R. 112, n.2; 113; 453 (Tribe raises objections based on fact that Winnemucca members historically served using CHS funds); 575–76 (noting "Winnemucca is covered by CHS for Medical, Dental, Pharmacy and Mental Health Services"), 579 (showing only two Winnemucca clinic users in 2014, 2015 and 2016). The Tribe also raised questions regarding how IHS was counting "Winnemucca users." R. 112 n.2.

20. IHS rejected the proposed H&C amount on the grounds that "the amount of funds proposed in the final offer exceeds the applicable funding level to which the tribe is entitled." R. 138.

21. IHS stated in its decision that "[a]lthough typically based on prior year budgets for the service area in question, there must be room for the Secretary to exercise her discretion in determining the Secretarial amount, in light of annual lump sum appropriations and the varying needs of other Tribes who rely on the IHS for services." R. 138.

22. IHS rejected the funding amounts proposed "to the extent they exceed[ed] amounts identified" in a document titled "Four Year Financial Projection" for Fort McDermitt Health Station. R. 138.

23. The projection in the document entitled "Four Year Financial Projection" showed an H&C amount for the Clinic in FY 2016 of $685,834, but then subtracted the EMS program funds of $502,611 from that figure. R. 148.

24. IHS explained the H&C amount also must be lowered by $190,197 because the proposed amount "reflects shares allocable to Winnemucca." R. 138. IHS derived this amount from the user population split in the 2013 Service Unit wide "tribal shares" table. R. 244.

25. IHS eventually awarded $555,275 to the Tribe in Service Unit level H&C funds. R. 39.

26. The Tribe proposed including the following provision in section 3.1 of its Funding Agreement:

> **Employee Housing Services** provides management and maintenance of tribally-owned housing units near the Fort McDermitt Clinic site provided to tribal health program employees.

Compl. ¶40; Ans. ¶40; R. 109.

27. The Tribe explained in its final offer that these housing services were "an essential part of the Tribe's recruitment and retention of medical professionals and are provided in direct support of the Fort McDermitt tribal health program. Indeed, without such housing units made available by the Tribe, the Tribe would be unable to attract health care providers to its remote reservation as the nearest city that may provide housing is over 75 miles away." R. 109.

28. IHS rejected the offered housing provision on the grounds that "the amount of funds proposed in the final offer exceeds the applicable funding level to which the Tribe is entitled" and because this activity "is an inherent Federal function that cannot be legally delegated to an Indian tribe." Compl. ¶42; Ans. ¶42; R. 132.

29. IHS stated the operation of federal quarters is an inherent federal function, and because the Tribe's housing is not authorized by 5 U.S.C. § 5911, the Tribe has no legal authority to operate tribal employee housing under the ISDEAA. R. 133.

30. IHS based its funding level rejection on the rationale that the "proposed language could be interpreted to extend [Federal Tort Claims Act] coverage to an activity that is not authorized by the ISDEAA. As such, the proposed language is an improper imposition or extension of the Federal government's legal and financial liability under the FTCA." R. 133.

Respectfully submitted this 3rd day of November 2017.

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