UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

FORT MCDERMITTPAIUTE AND SHOSHONE TRIBE, Plaintiff, v. ERIC HARGAN, in his official capacity as Acting Secretary, U.S. Department of Health & Human Services, *et al*. Defendants.	)	Case No. 1:17-cv-00837-TJK

DEFENDANTS' RESPONSE IN SUPPORT OF
THEIR CROSS MOTION FOR SUMMARY JUDGMENT AND OPPOSITION TO
PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT

INTRODUCTION

Unable to reach agreement on several issues through negotiation, the Fort McDermitt Paiute and Shoshone Tribe ("Tribe") submitted a Final Offer to the Indian Health Service ("IHS" or "Agency") to contract for the funding associated with the operation of the Fort McDermitt Clinic pursuant to the Indian Self-Determination and Education Assistance Act ("ISDEAA"), 25 U.S.C. § 450 *et seq*. The principal matter under consideration here concerns the Final Offer request for Hospitals and Clinics ("H&C") funding in an amount not less than $788,927, exclusive of funding for the Emergency Medical Services program. AR at 7. IHS properly declined the requested amount of H&C in the Final Offer because the H&C funding proposed by the Tribe was in excess of the applicable amount of H&C funding for the clinic. *See* 25 U.S.C. § 5387(c)(1)(A)(i) ("the amount of funds proposed in the final offer exceeds the applicable funding level to which the Indian tribe is entitled under this subchapter"). More specifically, the

funding level requested by the Tribe was in excess of the amount of H&C funding that IHS had been spending to operate the clinic and also what IHS intended to spend in the future to operate the clinic. *See Pyramid Lake Paiute Tribe v. Burwell*, 70 F. Supp. 3d 534, 542 (D.D.C. 2014).

The Tribe's arguments attempt to obfuscate the matter by claiming that IHS's own projections show that IHS was spending more to operate the clinic than IHS agreed to provide to the Tribe. The Tribe notes that IHS had already "spent $662,660.37 for Clinic operations—in addition to the amount it was paying for the EMS program—only ¾ of the way through the fiscal year," without acknowledging that the Tribe only submitted a Final Offer for additional H&C funding. For overall clinic operations, IHS was spending third-party revenues generated by the clinic itself, but faster than the clinic could bring such revenue in, making closure inevitable. Even so, the Tribe did not submit a Final Offer for the revenue collected by IHS prior to transfer, and would not have needed to, because IHS already agreed to provide the funding, albeit not on a recurring basis, as the Tribe now seems to be arguing for.[1] Accordingly, IHS properly rejected the Tribe's request for additional H&C funding, summary judgment for IHS is proper.

IHS agrees that it no longer disputes the inclusion of the Tribe's proposed Employee Housing Services on the basis that such functions are inherently Federal, because 25 U.S.C. § 1638a expressly overcomes any other provision of law. Although IHS withdraws its contention that similar functions are inherently federal, IHS has no assurance that the Tribe will adopt standards consistent with 25 U.S.C. § 1638a. Accordingly, IHS does not withdraw its ultimate conclusion that the function of maintaining tribal housing, as currently proposed, is an improper expansion of Federal Tort Claims Act coverage.

[1] IHS was also using a Special Diabetes Program for Indians grant award funded through a separate statutory mechanism, but that funding was not renewed. *See* 42 U.S.C. § 254c–3.

ARGUMENT

a. Standard of Review.

Congress considered and struck a *de novo* standard of review requirement from the Tribal Self-Government Amendments of 2000 P.L. 106-260. IHS testimony, included in a report accompanying S.979, a companion bill, demonstrates that the removal of the *de novo* clause was at the insistence of the Administration. S. Rep. 106-221, at 21 ("After negotiations with Tribal representatives, the House Committee on Resources and Administration Officials, the *de novo* provision was removed. We appreciate that this provision has remained out of the current House and Senate bills.") Ultimately, Congress acknowledged that the standard of review was left for courts to determine. H.R. Rep. 106-477, at 35. Congress suggests that *de novo* review of declination actions is appropriately based on 1994 amendments to the ISDEAA. *See* H.R. Rep. 106-477, at 35. That suggestion, however, amounts to no more than subsequent legislative commentary on the meaning of a law passed during a previous session of Congress.

Although the *de novo* standard has been adopted by this Court, the Government continues to maintain that the Administrative Procedure Act's ("APA's") arbitrary and capricious standard of review is the appropriate standard for claims brought under ISDEAA. *See Citizen Potawatomi Nation v. Salazar*, 624 F. Supp. 2d 103, 109 (D.D.C. 2009) (applying the APA standard of review to claims under the ISDEAA). The adoption of the APA standard is particularly appropriate given that IHS has been held to very specific procedural requirements regarding how the Agency must dispute Contract Proposals and Final Offers, yet tribes may choose multiple venues in which to challenge or appeal such disputes. *See* 25 U.S.C. §§ 5321, 5387(c)(1)(C).

Whether or not the *de novo* standard is applied here, the Agency has fully complied with the ISDEAA's funding requirement. Accordingly, granting IHS's Motion for Summary

Judgment is appropriate.

b. **IHS awarded the Tribe all of the H&C funding to which it is entitled under the law.**

IHS properly declined the Tribe's Final Offer related to H&C funding because IHS fully funded the Tribe with the amounts that IHS expended and would have expended to operate the clinic. The IHS financial projections relied upon for its determination of the appropriate H&C funding amount were consistent with actual expenditures and provided in response to the Tribe's Final Offer. AR 148. IHS declined the Tribe's Final Offer by relying on actual H&C expenditures made by IHS for clinic operations. Accordingly, IHS responded rejecting the Tribe's request for additional H&C because the amount proposed exceeded the applicable funding level for the contract. 25 U.S.C. §§ 5387(c)(1)(A)(i). The amount of H&C funding requested by the Tribe exceeded the applicable funding level because it was more than IHS had been spending on clinic operations and more than IHS intended to spend in the future. These facts are incontrovertible. IHS was not spending the H&C funding requested by the Tribe's Final Offer for clinic operations. The Tribe appears to have transformed its request for additional H&C funding, post hoc, to a request for any funding that IHS may have used to fund clinic operations; however, that is not what the Tribe requested in its Final Offer nor what IHS was required to address in the Final Offer response.[2] As illustrated by financial projections, clinic operations are funded with not only H&C funding, but also with dental funding, alcohol and substance abuse funding, public health, special diabetes grant funding, and insurance collections. AR 148. IHS awarded the EMS program to Pyramid Lake for FY2016 using H&C funding from the clinic rather than from other sources such as third-party revenue from the clinic.[3] As a consequence,

[2] IHS was careful to assert in its Final Offer response, however, that the Tribe was entitled to no additional funding. AR at 137-138.

[3] When operated by IHS, the EMS program was typically supplemented with third-party revenue

the H&C funding used for the clinic was reduced by the amount used for the EMS program, and IHS began to use the third-party revenue, along with the Special Diabetes Grant, as the primary sources of funding for clinic operations.[4] As explained in the closure report, with the EMS funding no longer available to IHS, IHS determined that it would not be able to continuously maintain clinic operations from the remaining funding sources. AR 145. This determination should not have been a surprise to the Tribe, as it was a central theme of IHS's position in the *Pyramid Lake* case.

b. IHS's position on third-party reimbursements is neither post hoc nor contrary to law.

Contrary to the Tribe's assertions, IHS has not reduced, limited, or otherwise offset the Tribe's funding amount because of the collection of third-party reimbursements, nor did IHS fail to identify third party reimbursements as an issue in its Final Offer response. IHS expressly asserted its position on third-party collections in the Final Offer response and in documents relied upon for IHS's response. Specifically, IHS rejected the H&C funding requested by the Tribe, noting the distinction between H&C and collections, and stating that though "there may be some carryover and third-party revenue" to sustain operations temporarily, it would not be possible to provide the level of services indicated by the Tribe with the amounts of H&C funding that IHS was spending. AR 135. Additionally, IHS expressly rejected transferring any third-party revenue collected by IHS pending the Tribe's acknowledgment that IHS would have no duty to provide such amounts on a recurring basis once the Tribe assumed operations. AR 137.

---

generated by the clinic and savings from elsewhere at the Service Unit. *See Pyramid Lake*, at 538.

[4] The only resources that were no longer made available to support clinic and EMS operations were savings from budgeted activities that were intended to benefit other tribes from IHS's discretionary appropriation. In the past, such funds were periodically used in addition to third-party resources.

Given that IHS would no longer be responsible for collecting third-party revenue, the clear reason for IHS's concern is that IHS would have no means to award such sums to the Tribe on a recurring basis. Consequently, while it is true that the Tribe failed to raise third-party collections in its Final Offer in any meaningful way, there is no merit to the contention that IHS likewise failed to identify it as a concern. IHS's concern about such funding has been validated, given the Tribe's newly fashioned but implausible legal argument that the Tribe is entitled to an amount equivalent to the third-party revenue that IHS had been collecting for services provided at the clinic, even though the Tribe is now responsible for such collections and IHS no longer has a role.[5] Under the ruling in *Pyramid Lake*, IHS need only provide the Tribe with "funds available" to the Agency. Once the funds are no longer available, as in this case, they need not be provided. *Pyramid Lake*, at 543.[6]

Despite IHS's express inclusion of third-party revenue as relevant to IHS's rejection of the Final Offer, the Tribe's Final Offer made no request for third-party reimbursements and made no argument that they were entitled to such sums. Rather, in a section of the Final Offer entitled "recurring funding amounts," the Tribe specifically requested additional H&C funding because

[5] The clear distinction between the circumstances present here and *Pyramid Lake* is that in Pyramid Lake IHS retained the billing function and likewise retained control over the allocation and expenditure of the revenue.

[6] If the Tribe is correct and IHS must award an amount for the contract period without regard to the source of funds – i.e., to include an amount based on third-party reimbursements IHS used to sustain clinic operations in previous years – then the amount in subsequent years also must be determined without regard to source of funds. Accordingly, under Plaintiff's interpretation of the statute, because IHS's resources – without regard to source of funds – will be reduced when IHS is no longer collecting third-party reimbursements, at least two provisions in the ISDEAA reductions clause would authorize reduction of the award amount in subsequent years. See 25 U.S.C. § 5325(b)(2)(A) (authorizing a reduction due to a reduction in appropriations from the previous fiscal year); § 5325(b)(2)(D) (authorizing reductions for a change in the amount of pass-through funds available; 25 U.S.C. § 1641(c)(1)(A) expressly refers to Medicare and Medicaid reimbursements as "pass-through" payments).

it did not agree with the amounts that IHS offered though such amounts were consistent with actual expenditures of H&C funding. AR 111-113. The Court should not now entertain the Tribe's arguments regarding third-party revenue because no such request was included in the Final Offer.

Nonetheless, IHS's refusal to provide, on a recurring basis, third-party collections that IHS no longer actually collects is consistent with 25 U.S.C. 1621f(b), which provides that "[t]he Service may not offset or limit any amount obligated to any Service Unit or entity receiving funding from the Service because of the receipt of reimbursements under subsection (a)."[7] IHS is not refusing to provide such reimbursements because of income the Tribe may receive. IHS is refusing to provide such reimbursements because IHS no longer collects them, and thus they are no longer available for the Agency to award.[8] Moreover, nothing in the Indian Health Care Improvement Act ("IHCIA") or the ISDEAA requires IHS to fund an ISDEAA contract on a recurring basis at level equivalent to that which IHS had been collecting as third-party revenue when IHS no longer has the responsibility for collecting such funds, and such funds are no longer available to IHS.[9] Such a reading of the statutes is unreasonable and is not supported by this

[7] The Tribe's reliance on statements in a bill report regarding not using Medicare and Medicaid as "an offset for new budget authority" is misplaced. P. Reply 10 (citing S. Rep. 100-508, 23, 1988 U.S.C.C.A.N. 6183, 6205). That statement is an instruction to appropriators not to consider Medicare and Medicaid recoveries in determining discretionary appropriations for IHS. *See also* 25 U.S.C. § 1641(a) (Medicare and Medicaid "shall not be considered in determining appropriations for the provision of health care and services to Indians."). Congress determines appropriations, not IHS.

[8] The proviso in 25 U.S.C. 1621f (b) would appear to prohibit IHS from reducing or otherwise offsetting discretionary appropriates that IHS would itself have obligated because of the receipt of reimbursements. In other words, Congress was concerned that the agency could penalize programs that are better at collecting reimbursements by reducing or offsetting recurring appropriations. IHS is not doing anything remotely like that here.

[9] The Indian Health Care Improvement Act does provide a mechanism for IHS to pass through third-party collections to a Tribe in the event that a Tribe does not elect to directly bill for services, but in this case the Tribe has elected to directly bill. 25 U.S.C. § 1641(c). Because the Tribe has

Court's decision in *Pyramid Lake,* which clearly limits IHS's funding obligations to the fund that is *available* to the Agency to spend. The Tribe's arguments would essentially result in statutory double-dipping in violation of 25 U.S.C. § 1641(c)(2) (which prohibits such payments) and cause absolute chaos with IHS's appropriation structure. As IHS is not required to seek reimbursement for services, the Tribe's arguments would incentivize IHS to stop billing completely, as continuing to bill would put IHS in the untenable position of being required to fund contracts with money it no longer has.

The Tribe also argues that IHS should simply find the money from somewhere else, from other Service Units or from other available discretionary funds, presumably from funding currently benefiting another tribe. P. Reply 10 n. 40. That is similar to what IHS did to sustain the EMS program in some years following an IRS issue,[10] but as IHS learned, the funds were then subject to contract by Pyramid Lake, and unavailable to the tribes that IHS originally intended to benefit. Indeed, the Tribe's argument that IHS should find a way to reduce operating expenses elsewhere to fund an ISDEAA contract is exactly what IHS did by choosing to close the clinic in order to fund the EMS program, except that the Tribe seems to be arguing that IHS should reduce operating expenses serving a different tribe in order to fund the Tribe's contract. *Id*. The ISDEAA does not require IHS to reduce funding that benefits another tribe. 25 U.S.C. § 5325(b).

c. IHS properly allocated a portion of H&C funding to the Winnemucca Tribe.

Unlike many IHS Service Units which serve only one tribe, the Schurz Service Unit, within

elected to directly bill, IHS may not make payment for the same services. § 1641(c)(2).

[10] "The cost of operating the EMS program increased unexpectedly beginning in 2010 as a result of an IRS determination that IHS must classify personnel working for the program under individual service contracts as employees, rather than independent contractors." *Pyramid Lake*, at 538.

which the Fort McDermitt Clinic is operated, was organized to provide services to multiple tribes, including the Winnemucca Indian Colony and the Fort McDermitt Tribe. The ISDEAA permits each tribe to contract for programs (or portions thereof) serving that tribe at all administrative levels of the Service, including the Service Unit level. IHS must determine how to calculate the resources available to each tribe at each level. This determination can be more complicated in a Service Unit such as Schurz, where multiple tribes are served. With respect to the Schurz Service Unit, the IHS Phoenix Area distributes or allocates resources to each tribe served based on Service Unit user totals assigned to each tribe. The user totals for each tribe are calculated based on Service Unit users that reside in each tribe's geographic service delivery area within the Service Unit, regardless of tribal affiliation. AR 244. So, for example, the Fort McDermitt Tribe's user total of 479 from the 2013 shares table includes Service Unit users that reside in Fort McDermitt's area. AR 244. These users may belong to multiple Tribes and not just the Fort McDermitt Tribe, but users are still credited to Fort McDermitt. The calculation of 216 users for the Winnemucca Indian Colony is no different because it includes all users that reside in Winnemucca's area, whether or not they are Winnemucca Tribal members. AR 244. Contrary to the Tribe's representations, IHS did not allocate a portion of clinic H&C resources to Winnemucca "simply because the agency so decided." P. Reply at 16. As noted in the Administrative Record, the Service Unit tables were updated in 2013 after extensive consultation with the Tribes served by the Schurz Service Unit. AR 243.

The Court in *Pyramid Lake* rejected IHS's reliance on the shares tables as a basis to limit funding because the argument was not set forth in the declination letter and because IHS was spending more than the "tribe's budgeted tribal share" for the EMS program, as reflected on the

table. *Pyramid Lake* at 544.[11] The decision required IHS to abandon its reliance on the shares tables to identify amounts which could be contracted for specific programs by specific Tribes, because those amounts were not always representative of the amount IHS had actually spent on the program in question. Contrary to the Tribe's assertions, IHS's actions following the decision were neither in bad faith nor retaliatory. Rather, IHS's actions were a necessary and logical response to the *Pyramid Lake* decision, taken by IHS to ensure compliance with the decision and to ensure that each Tribe served by the Schurz Service Unit could continue to benefit from and potentially contract for an equitable share of Service Unit resources. Indeed, the Court has acknowledged that the equitable allocation of federal funds is a "precise interest" of each tribe. *Id*. at 541.

There is also no merit to the contention that IHS acted in bad faith by issuing the Fort McDermitt Clinic Closure Report. P. Reply. 14. IHS had already asserted in the *Pyramid Lake* that closure of the clinic was likely, because IHS did not have sufficient recurring funds to pay for a $500K EMS program with Pyramid Lake and sustain operations of the clinic. Moreover, the closure report itself was not a catalyst for changing the allocation of funds to Fort McDermitt; as explained in the closure report itself, the catalyst was the award of the Pyramid Lake EMS program, which required IHS to rebudget resources and ultimately reduce operating expenses. Even so, after issuing the report, IHS continued to fully engage in good faith with the Tribe on its request to assume operation of the clinic, even though IHS had already concluded it could not continue to operate the clinic directly.[12] IHS's good faith is further evidenced by the fact that it

[11] The money IHS was spending to support the EMS program, but discontinued, was drawn from third-party revenues collected by the Fort McDermitt Clinic and also occasionally from unexpended funds originally budgeted for services to other tribes provided through the Service Unit.

[12] *Pyramid Lake* adopted a rigid rule that limits the Agency's ability to make discretionary funding

ultimately withdrew many of its objections and entered into the compact and funding agreement with the Tribe, albeit not for the amount of H&C funding requested by the Tribe.[13]

d. The Tribe may add housing management services of tribally-owned housing to its contract.

The IHCIA was amended in 2010 to expressly allow tribes to contract for the management of federal quarters. *See* 25 U.S.C. § 1638a. Prior to this amendment, the only express authority for the management of federal quarters was found at 5 U.S.C. § 5911. As explained in the Final Offer response, IHS lacked authority to contract with a Tribe to transfer the authority codified at 5 U.S.C. § 5911. The amendments in 25 U.S.C. § 1638a overcome this limitation, because they expressly included a "notwithstanding any other provision of law" clause. Although IHS does not construe 25 U.S.C. § 1638a as providing direct authority for the transfer of 5 U.S.C. § 5911, such a transfer is unnecessary because 25 U.S.C. § 1638a alone provides sufficient authority to manage federal quarters.

Despite the change in law, there is no express authority for the inclusion of the management of tribally owned quarters, even when used for the same purposes and under similar conditions. IHS believes it may be reasonable to construe the law as authorizing tribes to undertake the same sort of management services for tribally owned housing serving tribal health employees, which

---

decisions based on the date of the ISDEAA contract proposal. *Pyramid Lake*, at 543. This rule would seem to encourage tribes to rush in with a contract proposal as soon as they get wind of the Agency's inclination to terminate or reduce funding to the program in question. We believe that the better rule would be for the Court to consider the facts and circumstances surrounding the programs at issue. A flexible approach would not help the Tribe here, however, since IHS did not "cut" funding once it received the Tribe's notice of intent. Moreover, by the time the closure report was issued, IHS's funding allocation decisions had already been made and the Tribe had not even applied, much less been approved for, entry into the Self-Governance Program.

[13] IHS determined the total annual H&C Funding amount to be $633,417, based on actual expenditures of H&C funding. AR 138. Tribe is requesting H&C funding based on total expenditures.

is what the Tribe has proposed. IHS remains concerned, however, that without appropriate standards, an improper expansion of the government's tort liability will occur. Because indemnification necessarily results in the government assuming financial responsibility for subsequent negligent acts or omissions, any improper indemnification request[14] must be rejected on the grounds that "the amount of funds proposed in the final offer exceeds the applicable funding level to which the Indian tribe is entitled." 25 U.S.C. § 5387(c)(1)(A)(i). IHS's analysis of the Tribe's proposed activity has changed, but that change in analysis is merely an evolution of the same basic concern about tort liability, and not a newly fashioned objection to the Tribe's Final Offer.

Assuming employee housing services in tribally owned housing is legally contractible under the ISDEAA, IHS would not object to its inclusion if appropriate standards are adopted by the Tribe. Standards are particularly important in this context, where tort liability is the primary concern, because the ISDEAA directs IHS to reassume a function or activity upon "a finding of imminent substantial and irreparable endangerment of the public health caused by an act or omission of the Indian tribe. . . ." 25 U.S.C. § 5387(C)(i)(I). A single tort claim arising from this activity could give rise to such a finding. Because IHS has no express path to "reassume" management of quarters it does not own and has never managed, it is possible that the housing function will simply be struck from the funding agreement, and the Tribe will no longer be assured that it will receive tort coverage for any act or omission.

CONCLUSION

There is no reasonable support for the assertion that IHS spent more in H&C funding than

[14] It is IHS's understanding that the Tribe wants this activity included in its funding agreement primarily for indemnification under the Federal Tort Claims Act.

the amounts set forth in IHS's Final Offer Response. The funding IHS used to operate the clinic has been provided to the Tribe, with the sole exception of the portion which IHS allocated and reserved for the Winnemucca Tribe. IHS has no legal duty to fund the clinic with third-party reimbursements that IHS no longer collects, nor with diabetes grant funding that is governed by a separate statutory mechanism and is not funded through ISDEAA. IHS has therefore awarded the Tribe all of the funding to which it is entitled under the law. Accordingly, summary judgment for IHS is appropriate.

Respectfully Submitted,

JESSIE K. LIU
D.C. BAR # 472845
United States Attorney
for the District of Columbia

DANIEL F. VAN HORN
D.C. BAR # 924092
Civil Chief

By: /s/
BENTON G. PETERSON, BAR # 1029849
Assistant United States Attorney
U.S. Attorney's Office
555 4th Street, N.W. - Civil Division
Washington, D.C. 20530
(202) 252-2534