UNITED STATES DISTRICT COURT
DISTRICT OF SOUTH DAKOTA
CENTRAL DIVISION

ROSEBUD SIOUX TRIBE,
a federally recognized Indian tribe,
and its individual members,

Plaintiff,

v.

UNITED STATES OF AMERICA, DEPARTMENT OF HEALTH AND HUMAN SERVICES, an executive department of the United States, ALEX M. AZAR, Secretary of Health and Human Services, INDIAN HEALTH SERVICE, an executive agency of the United States, MICHAEL D. WEAKHEE, Acting Director of Indian Health Service, JAMES DRIVING HAWK, Acting Director of the Great Plains Area Indian Health Service,

Defendants.

Case No.: 3:16-cv-03038-RAL

PLAINTIFF ROSEBUD SIOUX TRIBE'S COMBINED MEMORANDUM IN SUPPORT OF MOTION FOR SUMMARY JUDGMENT AND IN OPPOSITION TO DEFENDANTS' MOTION FOR SUMMARY JUDGMENT

This case is about holding the federal government accountable for completely disregarding its longstanding treaty obligation to provide adequate health care services to the Rosebud Sioux Tribe (the "Tribe"). The government has neglected that duty far too long, causing a shameful dearth of available medical services at Rosebud Indian Health Service Hospital ("Rosebud Hospital"). Despite a wealth of evidence documenting health disparities and inadequate health care services for members of the Tribe, the federal government continues to ignore its obligation to provide health care

services for the Tribe that are sufficient to raise the health status of its members to the highest possible level.

The results of this woeful lack of attention from the government are predictable. Hospitals managed by IHS, including Rosebud Hospital, have a long and troubling record of repeat poor evaluations, are continually at risk of losing their accreditation or certification from the Centers for Medicare & Medicaid Services (CMS), and continue to be affected by long-standing challenges that affect IHS hospitals' ability to provide quality care, ensure access to needed care, maintain clinical competence, recruit and retain essential staff, and keep patients safe.

Rosebud Hospital is no exception. Conditions there have been described as "simply horrifying and unacceptable" and "summed up in one word—malpractice." (Plaintiff's Statement of Undisputed Material Facts, Doc. 90 ("SUF") ¶ 21). Accordingly, the Tribe sued the federal government alleging that it had violated federal law and breached its treaty and trust duties to the Tribe by failing to provide access to the highest possible level of medical services at the Rosebud Hospital.

The federal government must be held accountable. The Court should reject the Government's motion for summary judgment, and grant summary judgment in favor of the Tribe declaring that the Government is violating its treaty and trust duty to the Tribe by failing to provide, pursuant to any reasonable standard, adequate healthcare at the Rosebud Hospital, much less the quantity and quality of health care services necessary to raise the health status of the Tribe to the highest possible level.

FACTUAL BACKGROUND

Throughout this case, the Defendants have focused on the complexity of the IHS and its opaque appropriation process to avoid confronting the stark reality of healthcare at the Rosebud Hospital. Respectfully, how to solve the IHS healthcare crisis is not the issue before this Court. Instead, this Court needs only to resolve two questions. First, what level of healthcare are Defendants providing at the Rosebud Hospital? Second, does the care provided by Defendants at the Rosebud Hospital comply with Defendants' treaty, trust, and statutory responsibilities?[1]

Tellingly, Defendants do not even attempt to address the quality of care currently provided at the Rosebud Hospital. That is likely because the conditions there are simply indefensible. As set forth in this memorandum, the undisputed evidence shows that the quality of care Defendants provide at the Rosebud Hospital are appallingly inadequate. By any standard, the healthcare that Defendants currently provide at the Rosebud Hospital falls far short of the government's legal obligation.

I. Overview of IHS and its failures to provide adequate care for American Indians and Alaska Natives.

The IHS is responsible for providing, administering, and overseeing federal health services to American Indians and Alaska Natives ("AI/ANs") throughout the United States. (*See, e.g.*, Plaintiff's Response to Defendants' Statement of Undisputed Material Fact, Doc. 92, ¶ 5). The mission of the IHS is to raise the physical, mental, social

---

[1] Or, as expressed by this Court, "[b]oth parties agree that the relevant issue in this case is whether the health care services provided to the Tribe are sufficient to meet the Government's treaty and statutory duties to the Tribe." (Doc. 84 at 7.)

and spiritual health of AI/ANs to the highest possible level. (*Id.*; SUF ¶ 1). However, reports of health disparities and inadequate health care services for AI/ANs, including the Tribe, have been of concern to the federal government for almost a century.[2] (SUF ¶ 1.)

According to the HHS initiative Healthy People 2020, access to comprehensive quality health care services is important for promoting and maintaining health, preventing and managing disease, reducing unnecessary disability and premature death, and achieving health equity for all Americans. (SUF ¶ 2). People with a usual source of care have better health outcomes, fewer disparities, and lower costs. (*Id.*) Having a primary care provider who serves as a usual source of care is especially important, and is associated with greater patient trust, better patient-provider communication, increased likelihood that patients will receive appropriate care, and lower mortality from all causes. (*Id.*)

A. National disparities in health outcomes for AI/ANs.

The health disparities between AI/ANs and the rest of the United States population are stark. Every published study on this issue has so found, and IHS has long recognized that AI/ANs experience lower health status, lower life expectancy and

[2] An October 2016 Report by the Inspector General concluded that its review "identified long-standing challenges that may affect IHS hospitals' ability to provide quality care and comply with Medicare standards, including ensuring access to needed care, maintaining clinical competence, recruiting and retaining essential staff, and keeping patients safe despite outdated buildings and equipment. Similar reports date back almost a century, and problems persist despite reported efforts to address them." (SUF ¶ 1.c).

disproportionate disease burdens compared to other Americans. (SUF ¶ 3). AI/ANs have a lower life expectancy than other racial or ethnic groups, one that is 5.5 years less than the U.S. all races population. (*Id.*) Between 2000 and 2010, 70% of American Indians living in South Dakota died before reaching age 70 years, compared to 25% of whites. (SUF ¶ 4). Fatal injuries and chronic diseases were the leading causes of premature mortality. (*Id.*)

The health disparities between AI/ANs and other populations in the United States are not limited to life expectancy. For example, between 2012 and 2014 the infant death rate per 1,000 births in the United States as a whole was 5.9 for all races, 5.0 for the white population, and 7.9 for AI/ANs. (SUF ¶ 5.a). In South Dakota, the rate was 6.8 for all races, 5.5 for the white population and 11.7 for AI/AN. (*Id.*) Between 2013 and 2015 the age-adjusted death rate per 100,000 population in South Dakota was 701.7 for all persons, 664.1 for the white population, and 1,283.2 for American Indians and Alaska Natives. (SUF ¶ 5.b).

The chart below shows the percent change between 1980 and 2015 for leading causes of death, highlighting the disparities between all persons and AI/ANs:

	All Persons	AI/AN population
Diseases of the heart	-20%	+231.79%
Malignant neoplasms	+43.08%	+436.10%
Cerebrovascular disease	-21%	+209.93%
Unintentional injuries	+36.64%	+61.09%

Pneumonia & influenza	+4.47%	+33.07%
Diabetes mellitus	+228.21%	+517.62%
Suicide	+64.48%	+318.78%

(SUF ¶ 5.c).

B. Funding shortfalls have created "unmet needs" in AI/AN health care.

The 2003 report of the U.S. Commission on Civil Rights, "A Quiet Crisis of Federal Funding and Unmet Needs in Indian Country," found that due to the increased size of the service population and increased costs of medical services, the IHS budget has not kept pace, and a large and expanding gap existed between needed and available services. The Commission referred to these as "unmet needs." (SUF ¶ 6).

The gap in funding found by the 2003 U.S. Commission on Civil Rights report has continued to the present day. A December 2018 report of the Commission, "Broken Promises: Continuing Federal Funding Shortfall for Native Americans," found that AI/AN health care has been chronically underfunded, and that "when adjusted for inflation and population growth, the IHS budget has remained static in recent decades, with little additional funding available to meet chronic health disparities facing Native communities." (SUF ¶ 7).

The Rosebud Hospital has been no exception. Documents produced in discovery by Defendants show that the allocations to the Rosebud Hospital for the line item "hospitals and clinics (clinical services)" declined from 2010 to 2017 by 14 per cent. (SUF ¶ 8). The IHS Deputy Director for Management Operations, Elizabeth Fowler, testified

in her deposition that this line item "is the major funding support for a hospital or clinic operations . . . [which] funds salaries, the providers, the administrative staff, the CEO, the pharmacists, the lab folks, the purchase of pharmaceuticals, the medical supplies. It's the major budget supporting the operations of the hospital." (SUF ¶ 9).

C. Extensive oversight reports and investigations have documented the lack of available medical services, hospital staffing and stable administrative oversight at the Rosebud Hospital.

The severe systemic failures impacting IHS are apparent at the IHS-run Rosebud Hospital, a 35-bed hospital, which is the primary source of health care for the Tribe and its members. The Rosebud Hospital suffers from a number of difficulties, including lack of staff and continual staff turnover, resulting in lack of continuity of care and lack of services provided, and lack of stable senior management, all of which contribute to a poor quality of patient care. (SUF ¶ 10).

1. Lack of medical services and facilities.

The Rosebud Hospital has struggled to maintain high quality care and facilities. In November 2015, CMS surveyors reviewed the Rosebud Hospital to evaluate the hospital's compliance with federal statutory and regulatory conditions of participation (CoPs). Following this review, CMS sent Rosebud Hospital a Notice of Intent to Terminate the Medicare Provider Agreement because of alleged deficiencies in the hospital's emergency room services. The letter stated that the deficiencies did not comply with CoPs and were so serious that they constituted an "immediate and serious threat to the health and safety" of "any individual who comes to your hospital to receive emergency services." (SUF ¶ 11).

The deficiencies in the letter included a Rosebud Hospital patient who delivered a baby unattended on the bathroom floor of the emergency department. (SUF ¶ 11). CMS also found that Rosebud Hospital failed to provide appropriate medical screenings and stabilizing treatment to patients in the emergency room. (SUF ¶ 11).

On December 4, 2015, IHS sent a letter to the Rosebud Tribal President, William Kindle, advising that the Rosebud Hospital Emergency Room was being placed on divert status effective December 5, effectively closing the emergency room, and that persons in need of emergency care should be taken to either Winner, SD, or Valentine, NE, both approximately 50 miles away. (SUF ¶ 12).

On December 17, 2015, IHS issued a media release stating that effective immediately the Rosebud Hospital Urgent Care hours of operation were being reduced to 7:00 am to midnight, seven days a week. (SUF ¶ 13). Previously the Urgent Care was available 24 hours per day, seven days a week. (SUF ¶ 13). The change to limited hours was due to staff shortages. (SUF ¶ 13).

In the summer of 2016, while the emergency room was still closed, IHS also closed obstetrical and surgical services, and diverted obstetrical and surgical patients to other facilities due to a shortage of physicians, nurses and nurse anesthetists (SUF ¶¶ 14.b, 15).

In July 2018, less than a year after IHS completed the Systems Improvement Agreement related to the closure of the Rosebud Emergency Room, CMS found new compliance issues in the Rosebud Emergency Department during a complaint survey. (SUF ¶ 16). In August 2018, CMS issued notice to the acting CEO of the Rosebud

Hospital that based upon the survey findings it determined the deficiencies were so serious that they constitute an immediate and serious threat to the health and safety (immediate jeopardy) of any individual who comes to the hospital. (SUF ¶ 16). CMS notified Rosebud Hospital that CMS was terminating its Medicare provider agreement effective August 30, 2018. (SUF ¶ 16).

Recently, on July 23, 2019, the OIG released a report titled "Case Study: Indian Health Service Management of Rosebud Hospital Emergency Department Closure and Reopening." (SUF ¶ 10). In the Rosebud case study, the OIG found:

- In the months following the IHS completion of the Systems Improvement Agreement following the Rosebud ED reopening, IHS continued to have difficulty securing long-term hospital staff and adequate leadership at Rosebud. In September 2018, the Rosebud Hospital had 69 vacancies (7 in the ED) that were mostly filled by contract providers. Between the reopening of the ED and September 2018 Rosebud had 6 CEOs, 3 Clinical Directors, and 9 Directors of Nursing. (SUF ¶ 10.b).

- Over the years, CMS surveyors noticed a pattern: after citing Rosebud Hospital with deficiencies, IHS would assign top-performing teams from across the agency to resolve the deficiencies, but once these teams were replaced with new and often inexperienced leadership the problems would resurface. (SUF ¶ 10.c).

- The key factors leading to continued compliance issues included continuing turnover in hospital leadership, insufficient transition of new hospital leaders, continuing difficulty maintaining staff, failure of corrective actions to be engrained and lack of IHS sustained attention. (SUF ¶ 10.d).

The OIG Rosebud Case Study concluded:

> There is little question that IHS's handling of the ED closure was problematic and had negative consequences for the affected parties. But it is important to recognize that the closure was preceded by Rosebud's

> inability to remain in compliance with the Medicare [conditions of participation]. The factors that contributed to the noncompliance, including staffing inadequacies and changing leadership, were longstanding and occurred before, during, and after the closure. These issues will require IHS's continued focus.

(SUF ¶ 10.a).

2. Lack of hospital staffing.

There has been a long-standing and severe lack of permanent, qualified medical professionals working at Rosebud Hospital. In May 2018, the vacancy rates for medical providers in the Rosebud Hospital were: Physicians – 45%; Physician Assistants – 33%; Nurse Practitioners – 25%; Dentists – 0%; Nurses – 31%; Pharmacists – 0%. (SUF ¶ 17). In September 2018, the Rosebud Hospital still had 69 vacancies (7 in the ED) that were mostly filled by contract providers. (SUF ¶ 10.b). These vacancies have a significant impact and direct negative effect on the continuity of and patient access to quality health care, including cutting patient services. (SUF ¶ 14.d).

Both the GAO and the OIG have issued reports that find the use of contract providers to fill vacancies is problematic. The OIG found that the wide variation in the experience and training of contract providers, combined with their short tenure, make it difficult for hospitals that rely heavily on such providers to ensure that patients receive needed care. (SUF ¶ 1.a). Additionally, providing training to these contract providers can be a challenge because of their short tenure, and the constant rotation led to problems with monitoring and oversight. (*Id.*)

The GAO found that the persistent turnover of contract providers may jeopardize continuity of care. (SUF ¶ 14.e). The GAO also found that IHS lacks agency-

wide information on the use of contract providers and their cost, and that without such information the agency is "not fully informed about facilities' reliance and expenditures on temporary providers or their potential effect on patient care, which is inconsistent with Federal internal control standards." (SUF ¶ 14.f).

In its August 2018 Report to the Senate Indian Affairs Committee, the GAO stated that IHS facilities staff admitted that long-standing vacancies have a direct negative effect on patient access to quality health care, as well as employee morale. (SUF ¶ 14.a). In addition, officials at several facilities, including the Rosebud Hospital, told GAO that they had to cut patient services due to ongoing provider vacancies. (SUF ¶ 14.b).

The lack of available services and medical staffing is especially problematic since, over the last three decades, federally-operated IHS hospitals have experienced a significant increase in their user populations as compared to the overall US population growth, and the number of outpatients often exceeds the number of staff and space available to care for these patients, which ultimately affects patient access. (SUF ¶ 1.b). Between FYs 1986 and 2013, the collective population of registered users across the 28 IHS hospitals increased by 70% (from 695,941 users to 1,181,613 users). (*Id.*) By comparison, the overall US population increased by 32% during the same time. (*Id.*)

3. Lack of administrative oversight.

Rosebud Hospital has also failed to maintain high quality health care professionals and employees in key administrative positions. Between September 2016 and July 2017, during the time when CMS observed that Rosebud Hospital was unable

to provide basic medical services to its patients, the hospital had a number of executive management and staff vacancies, which the IHS failed to address, including the CEO, COO, CNO, Clinical Director, Chief Quality Improvement Officer, and other important leadership positions. (SUF ¶ 18.a). Frequent changes in leadership can create barriers to important patient safety and quality participation by staff. (SUF ¶ 18.b).

Defendants produced a document during discovery identifying the significant and continuous turnover in management at both the Rosebud Hospital and the Great Plains Area Office from 2014 to 2018 (the date of production), which showed the following rates of turnover:

Rosebud Hospital:

- Chief Executive Officer (CEO): 14 persons occupied the position, 7 acting, 4 detailed, 3 permanent.
- Chief Medical Officer (CMO): 10 persons occupied the position, 6 acting, 1 detailed, 3 permanent. The CMO position was also vacant from June to August 2015.
- Chief Nursing Officer (CNO): 14 persons occupied the position, 6 acting, 5 detailed, 3 permanent. The CNO position was also vacant from February
- Chief Operating Officer (COO): 10 persons occupied the position, 5 acting, 3 detailed, 2 permanent. The COO position was also vacant from February 22 to April 2014; from May to October 2015; from April to June 2016; July 2017; and November 24, 2017 to August 2018.
- Chief Quality Management Officer (CQMO): 9 persons occupied the position, 5 acting, 2 detailed, 2 permanent.

- Inpatient Nurse Supervisor (INS): 7 persons occupied the position, 2 detailed, 5 permanent.

(SUF ¶ 19).[3]

On June 23, 2010, Senate Indian Affairs Subcommittee Chairman Byron Dorgan initiated a formal investigation of the IHS Aberdeen Area (now known as the Great Plains Area) in response to years of hearing from individual AI/ANs, Indian tribes and IHS employees about substandard health care services and mismanagement. (SUF ¶ 20). The investigation included reviewing thousands of pages submitted by IHS and the Department of Health & Human Services OIG, visiting three IHS Service Units, meeting with tribes and interviewing individual IHS employees. In addition, nearly 200 individuals contacted the Committee regarding mismanagement of facilities in the area. (SUF ¶ 20).

On December 28, 2010, the Senate Committee on Indian Affairs issued a report on the findings of the investigation, titled "IN CRITICAL CONDITION: The Urgent Need To Reform The Indian Health Services Aberdeen Area," Report of Chairman Byron L. Dorgan to the Committee on Indian Affairs." (SUF ¶ 20). Key findings of this Report are:

- The Aberdeen Area had a history of substantially diverting health care services at its Service Units, including the Rosebud Service Unit, and that these diversions impacted the consistency and level of health care provided. The Report found that at the Rosebud Service Unit, services were diverted nearly every year between 2000 and 2010. (SUF ¶ 20.a).

- The Report identified several IHS hospitals in the Aberdeen Area that were at risk of losing their accreditation or certification from CMS. This included

[3] At the time Defendants produced this document, counsel for Defendants stated that, "There is no one at IHS that keeps track of persons "Acting" in supervisory roles and there is no such document available. The attached document of Senior Leaders was created to the best of our recollection and ability." (SUF ¶ 19).

the Rosebud Hospital, which the Report said had a "troubling record of repeat poor evaluations," finding that from 2004 to 2009 "the facility was routinely cited for being out of compliance with a number of CMS requirements." (SUF ¶ 20.b).

- The Report identified one CMS survey concerning a pregnant patient who had arrived at the Emergency Room with contractions every five minutes and who was triaged as urgent. One and a half hours later, she was discharged from the ER. The patient proceeded to the Outpatient Department where her contractions continued and was told to walk around and go to the bathroom for a urinalysis. Forty-one minutes after the patient was discharged from the ER, she delivered the baby on the Outpatient Clinic bathroom floor. (SUF ¶ 20.c).

Following the closure and diversion of the Rosebud Hospital ER, the Senate Indian Affairs Committee again conducted a study of the Great Plains Area. On February 3, 2016, that Committee held a hearing titled "Reexamining The Substandard Quality Of Indian Health Care In The Great Plains." (SUF ¶ 21). In his opening statement, Committee Chair Senator John Barrasso of Wyoming, who is also a medical doctor, referenced the Dorgan Report, and said:

> Over five years later, the very problems identified in the Dorgan Report have not been resolved. In fact, some issues have become worse over time, and new ones have developed. After hearing loudly from the tribes on the lack of quality of health care in the Great Plains Area, I dispatched Committee staff to the field to understand what is really is happening in the Great Plains Area. <u>What we found is simply horrifying and unacceptable. In my view, the information provided to this Committee and witnessed firsthand can be summed up in one word: malpractice</u>.

(SUF ¶ 21 (emphasis added)).

Other admissions by the federal government illustrate that IHS's failure to provide adequate leadership impacts patient care. In 2016, acting CEO of Rosebud Hospital Michael Weahkee admitted in an email to the Acting Director of the Great

Plains Area that "[w]ithout effective leadership on an on-going basis there is no direction and no consistency in application of policies, rules and regulations." (SUF ¶ 22). The GAO reported that the IHS had "ineffectively administered…health care programs." (SUF ¶ 23). Melissa Emrey-Arras, Director, Education, Workforce, and Income Security, testified before the Senate Committee on Indian Affairs on May 17, 2017, ad noted that the GAO made 14 recommendations to IHS over the prior six years regarding improvements needed in the management of IHS facilities, all 14 of which remained unaddressed. (SUF ¶ 24).

In January 2017, the GAO issued a report concluding that "IHS officials cannot ensure that facilities are providing quality health care to their patients, and therefore that the agency is making steps towards fulfilling its mission to raise the physical, mental, social and spiritual health of AI/AN people to the highest level." (SUF ¶ 25).

II. The undisputed discovery in this case confirms that health care at the Rosebud Hospital is substandard by any measure.

The result of Defendants' longstanding pattern of neglect is predictable and undisputed: health care provided by IHS at the Rosebud Hospital is simply unacceptable. Indeed, Defendants do not even attempt to defend the lack of quality health care at the Rosebud Hospital. Every piece of evidence—much of it from the federal government itself—overwhelmingly supports the conclusion that healthcare at the Rosebud Hospital is inadequate.

A. The Warne Report concludes that health care at the Rosebud Hospital is inadequate.

The Tribe presented the expert opinion of Dr. Donald Warne. (SUF ¶ 26; *see also* Doc. 70-1). As this Court already noted in denying the Defendants' motion to exclude Dr. Warne's opinions, Dr. Warne is well-qualified to offer opinions on the quality of health care provided at the Rosebud Hospital. (*See* Doc. 84 at 5-6 (discussing Dr. Warne's qualifications and noting that the Defendants did not challenge those qualifications)). Moreover, his opinion is undisputed. While the Defendants argued that Dr. Warne's opinion should be excluded for various legal reasons, they never challenged the factual conclusions in his report, nor did they proffer their own expert or otherwise rebut Dr. Warne's opinion or the underlying facts.

Based on Dr. Warne's review of publicly available data, the discovery produced in this case, his personal and professional experience, and his direct observations, Dr. Warne opines that Defendants "are NOT providing the quantity and quality of health services which will permit the health status of American Indians served at the Rosebud Service Unit to be raised to the highest possible level." (SUF ¶ 27). Dr. Warne further opines that "there has been a failure on behalf of the United States to provide the resources, processes, leadership, and structure that will enable Rosebud Sioux Tribe members to obtain the quantity and quality of health care services and opportunities that will eradicate their health disparities." (SUF ¶ 27).

Dr. Warne reviewed overwhelming documentary evidence and analysis of the inadequacy of healthcare offered at the Rosebud Service Unit. Dr. Warne noted the following:

- AI/ANs have a worse health status compared to other Americans. (SUF ¶ 26.a).
- "The failure to provide important health services such as surgical and obstetrical department services, coupled with the vacancies in, and temporary status and high turnover of, health care providers, represents significant evidence of the failure of IHS to provide the highest quantity and quality of health care services to the Rosebud Tribal members." (SUF ¶ 26.b).
- Rosebud has suffered from a "longstanding lack of continuity of leadership[.]" (SUF ¶ 26.c). "Leadership has an impact on the quality of care, the culture of organizations, the morale of staff generally, and the supervision of personnel and facilities management." (*Id.*)
- "[A]ppropriated dollars [for the Rosebud Hospital] are either declining, or at best flat." (SUF ¶ 26.d). "With declining or flat appropriations dollars, an increasing service population, and a general inflationary increase in health costs annually, the per capita disparity for the Rosebud Tribal Members compared to other per capital health care spending will undoubtedly grow, and the disparities in their health status will grow." (*Id.*)

Again, Defendants have not disputed any of Dr. Warne's conclusions, nor have they provided any evidence that creates a question of material fact regarding the abysmal level of care at the Rosebud Hospital.

B. Undisputed discovery confirms the woeful inadequacy of care provided at the Rosebud Hospital.

Members of the Tribe depend heavily on the Rosebud Hospital and its staff for all healthcare services. There are no other resources in the area from which patients can seek care. (SUF ¶18.c). Unfortunately, every witness deposed

in this case has testified that the care provided at the Rosebud Hospital is substandard.

Dr. LeRoy Clark is a licensed physician who started working at the Rosebud Hospital in December of 2015. (SUF ¶ 28). As of the date of Dr. Clark's deposition on July 13, 2018, Dr. Clark had served at the Rosebud Hospital as the acting clinical director, acting deputy clinical director, outpatient director, and the clinical director. (SUF ¶ 28). When questioned about specific patient care failures documented by CMS, Dr. Clark testified as follows:

> Q: Does failing to stabilize a patient's emergency medical condition prior to discharge fall below an acceptable standard of care?
>
> A: Failure to stabilize to the capability of your emergency room would fall below that standard.
>
> . . .
>
> Q: What about failing to provide a medical screening examination sufficient to determine whether an emergency medical condition existed? Does that fall below [a] reasonable standard of care?
>
> A: Yes.

(SUF ¶ 28). Referencing the events that led to the Rosebud Hospital's emergency room closure in November 2015, Dr. Clark acknowledged that the Rosebud Hospital "failed to provide appropriate emergency care for four patients who presented with cardiac events, preterm labor and delivery, and trauma after a motor vehicle accident[.]" (SUF ¶ 28). He further admitted that such failures did not meet the standard for adequate care. (SUF ¶ 28).

Even after the Rosebud Hospital's emergency room had re-opened, Dr. Clark acknowledged that care continued to be inadequate. Addressing one CMS report that found 10 of 30 emergency room patients in a particular sample received inadequate or unsafe care, Dr. Clark testified as follows:

> Q: And it says "It was determined the hospital failed to meet the condition of participation for emergency services when they failed to ensure the patients evaluated and treated in the emergency department were provided appropriate, timely, and safe medical care based on acceptable standards of practice. This failure represented a failure to provide appropriate emergency care for 10 of 30 emergency department patients who presented with emergency medical conditions." Did I read that correctly?
>
> A: Yes.
>
> Q: And this was from March of 2017, correct?
>
> A: Yes.
>
> Q: So this is after the Rosebud emergency department had reopened?
>
> A: Yes.
>
> . . .
>
> Q: And does that fall below the highest possible standard of care?
>
> A: It, yes, falls below the CMS standard.
>
> Q: Are these problems still ongoing at the Rosebud emergency department?
>
> A: There continue to be issues with appropriate, timely, safe -- yes, there could be.

(SUF ¶ 28).

Dr. Clark's testimony is consistent with the testimony of Lieutenant Brandy Bridgewater, a registered nurse and, for a short period of time in 2018, the acting quality manager at the Rosebud Hospital. (SUF ¶ 29). Lt. Bridgewater testified regarding a CMS survey of the Rosebud Hospital in July of 2018, in which CMS found again that the care at the Rosebud Hospital created an immediate jeopardy to its patients:

> A: This is a [report] from CMS findings from a visit that occurred in July – July the – the document is dated as completed survey July 26 of 2018.
>
> . . .
>
> Q: And this relates to the immediate jeopardy; right?
>
> A: Yes, it does.
>
> . . .
>
> Q: Okay. And you see right below those three bullet points it says, "The facility failed to ensure a culture of safety for patients coming into the emergency room with an emergency medical conditions [sic] for care and services." Is that right?
>
> A: Yes.
>
> Q: So as someone who was the acting quality manager at Rosebud, do the conditions listed on the first page of this report, in your opinion, represent the highest possible standard of care?
>
> . . .
>
> A: Based on the information provided here, I would say these are not examples of the highest quality of care.

(SUF ¶ 29).

Evelyn Espinoza provided a unique perspective on the operations of the Rosebud Hospital. She is a registered nurse who began working at the Rosebud Hospital in 2005. (SUF ¶ 30). Among other jobs, she was the supervisory clinical nurse and, starting in 2009, she was the accreditation specialist at the Rosebud Hospital, in which position she "was responsible for the risk management, for hospital-wide quality assurance, performance improvement. I processed in, did intake on all patient complaints, utilization review. . . . Chaired multiple committees, sat of different committees, member of the governing body." (SUF ¶ 30). She took on additional administrative duties, including serving repeated stints as acting CEO. (SUF ¶ 30). Later, Ms. Espinoza worked as the Tribal Health Administrator for the Rosebud Sioux Tribe, in which role she served as "[p]rimary advocate for all members of our tribe, health and safety advocate. And I oversaw the master health contract with the Indian Health Service, 638 master health contract." (SUF ¶ 30). She has testified before Congress regarding the state of healthcare on the Rosebud reservation. (SUF ¶ 30).

Ms. Espinoza testified that, during her time working for IHS, she became aware of a poison control issue raised by a contractor for the Rosebud Hospital. (SUF ¶ 31). She described that incident:

> Practices that were being done on a couple different incidents in the Emergency Room weren't safe. They didn't follow standard of care. And so this contractor brought it to the attention of the permanent nursing leadership, who chose not to address it. . . . And so the issue was such a

> safety concern, this individual felt he needed to bring it to the attention of tribal leadership and, as a result of doing that, he was immediately fired."

(SUF ¶ 31).

This type of failure to address serious issues was not isolated. Ms. Espinoza testified that, in her role as a tribal health advocate, she submitted numerous complaints to IHS on behalf of patients at the Rosebud Hospital, but that IHS never responded. (SUF ¶ 31). As a result, she testified, "a lot of people get frustrated and then they don't complain. They just take the substandard care and they just live like that because they have complained for years and nothing has happened." (SUF ¶ 31).

Ms. Espinoza testified about a personal incident that happened in August of 2018, in which one of Ms. Espinoza's relatives nearly died at 19 years old from substandard care at the Rosebud Hospital and had to be stabilized at another facility. Ms. Espinoza summarized the experience as follows:

> "So these are my blood relatives that this kind of stuff is happening to. That would be in our culture my grandchild. And so it's – it's more, this happens every day. Every day. I wouldn't want this for your family. I don't like going through this with my family. I just had a baby and I had to go somewhere else for care. I couldn't even go [to the Rosebud Hospital]. And it's always defended, and to me there is no defense for this. None. People are being mistreated at levels that [are] inhumane. Unbelievable. Unless you witness it yourself, you wouldn't believe it."

(SUF ¶ 31).

Ms. Espinoza also testified regarding the impact the substandard care has had on her community as a whole. Because the Rosebud Hospital was unable to provide certain services, and because the IHS would not pay for referrals to other

providers unless there was an immediate risk of loss of life, limb, or a sense, often patients with treatable conditions did not receive proper care and were instead simply medicated. "And then subsequently they get addicted to those pain meds and then they become addicted and now they become drug seekers. And then they are taken off those pain medications and then they withdraw and then they go seek alternative resources in the community and it just becomes a huge nightmare. I have witnessed this in several accounts in my career as a nurse." (SUF ¶ 32).

Ms. Espinoza further testified that the poor care provided by the Rosebud Hospital led to the unnecessary deaths of tribal members:

Q: And you said that the substandard care was causing –

A: That's my belief.

Q: -- was causing what, the deaths of Rosebud members, tribal members?

A: Yeah. People have died in our tribe because of the substandard care they received at our hospital.

Q: And what do you base that statement on?

A: Lived experience.

Q: I don't understand that. People have died. How can you live the experience?

> A: It's my – I witnessed it. I witnessed people that sought care from [IHS] and didn't get it and, as a result, had died prematurely. The conditions weren't treated appropriately or maybe treated with medications that were not the medications they should have been treated with."

(SUF ¶ 32).

Ms. Espinoza noted that other rural hospitals were able to provide services that the IHS has been demonstrably unable to provide at the Rosebud Hospital, concluding, "it goes back to the system. The entire Indian Health System [sic] is not set up to provide standard quality of care to modern medicine today. It's not compatible." (SUF ¶ 33).

*****

In short, the evidence compiled from the federal government, the opinion of Dr. Warne, and the testimony of the people who worked at the Rosebud Hospital and live in the Tribe's community all overwhelmingly and undisputedly demonstrate that the service provided at the Rosebud Hospital is unacceptably poor.

ARGUMENT

I. Legal standard.

Summary judgment is appropriate if a movant "shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(a). To avoid summary judgment, "the nonmoving party may not 'rest on mere allegations or denials, but must demonstrate on the record the

existence of specific facts which create a genuine issue for trial.' " *Mosley v. City of Northwoods, Mo.*, 415 F.3d 908, 910 (8th Cir. 2005) (quoting *Krenik v. Cty. of Le Sueur*, 47 F.3d 953, 957 (8th Cir. 1995)). Although the facts and reasonable inferences therefrom are viewed in a light favorable to the nonmoving party, the nonmoving party "must substantiate [its] allegations with sufficient probative evidence [that] would permit a finding in [its] favor based on more than mere speculation, conjecture, or fantasy." *Barber v. C1 Truck Driver Training, LLC*, 656 F.3d 782, 801 (8th Cir. 2011).

II. The Tribe has established that Defendants have an enforceable duty to provide health care services to the Tribe.

A. The Tribe is entitled to summary judgment on the existence of Defendants' treaty and statutory duty to provide health care services to the Tribe.

The U.S. Supreme Court has acknowledged "the undisputed existence of a general trust relationship between the United States and the Indian people." *United States v. Jicarilla Apache Nation*, 564 U.S. 162, 176 (2011) (quoting *United States v. Mitchell*, 463 U.S. 206, 225 (1983)). Where, as here, a tribe seeks equitable relief for breach of the government's trust duty, courts look to relevant federal statutes, regulations, and treaties to determine the scope of the duty. *See Blue Legs v. U.S. Bureau of Indian Affairs*, 867 F.2d 1094, 1100 (8th Cir. 1989). "In order 'to establish a trust duty,' the burden is on the Tribe to 'identify a substantive source of law that establishes specific fiduciary or other duties, and allege that the Government has failed faithfully to perform those duties.'" *Cheyenne River Sioux Tribe v. Jewell*, No. 3:15-CV-03018-KES, 2016 WL 4625672, at *7 (D.S.D. Sept. 16, 2016) (quoting *Navajo Nation*, 537 U.S. at 506).

The Government's specific trust obligation to provide adequate health care to Indians repeatedly has been codified through legislation, including in the Snyder Act of 1921, the Indian Health Care Improvement Act of 1976 ("IHCIA"), and most recently, the Affordable Care Act ("ACA").

The Snyder Act expressly provides Congress with the authority to appropriate funds specifically for Indian health care and obligates the federal government to act "for the benefit, care, and assistance of Indians throughout the United States . . . for the relief of distress and conservation of health to Indians." 25 U.S.C. § 13.

The IHCIA identifies the same duty owed by the federal government to Indian tribes, requiring the federal government to provide "the highest possible health status for Indians" and "the quantity and quality of health services which will permit the health status of Indians to be raised to the highest possible level." 25 U.S.C. § 1621(a)(1); 25 U.S.C. § 1601(3). Congress first passed the IHCIA in 1976, finding that the "most basic human right must be the right to enjoy decent health," and that "any effort to fulfill Federal responsibilities to the Indian people must begin with the provision of health services." H.R. Rep. No. 94-1026(I), at 13 (1976).

Most recently, the ACA reaffirmed the federal government's trust duty to Indians, stating that "it is the policy this nation, in fulfillment of its special trust responsibilities and legal obligations to Indians – [] to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy." 25 U.S.C. § 1602 (2009).

Through legislation such as the Snyder Act, the IHCIA, and the ACA, "Congress has unambiguously declared that the federal government has a legal responsibility to provide health care to Indians." *White v. Califano*, 581 F.2d 697, 698 (8th Cir. 1979) (quoting *White v. Califano*, 437 F. Supp. 543, 555 (D.S.D. 1977)).

The 1868 Treaty of Fort Laramie provides the underlying legal obligation of the federal government's trust duty to provide health care services to the Tribe. The Treaty specifically requires the government to provide health care services to the tribes—indeed, the Treaty provides that the federal government will provide health care services *in exchange for* the tribes ceding tribal land to the federal government. To suggest that no duty results from the Treaty is not only contrary to the language of the Treaty itself, but minimizes the sacrifice made by the Tribes in agreeing to exchange their lands for the provision of health care services. Defendants argue that the Tribe's reliance on the Treaty is misplaced because treaty rights are distinct from trust rights and that there has been no breach of the Treaty. But the Tribe relies on the Treaty as another source of the federal government's obligation to provide health care services to the Tribe.

Under established Indian law canons of construction, the treaty and statutes on which the Tribe relies must be construed liberally in favor of the Tribe, and any ambiguous provisions must be resolved to the Tribe's benefit. *See Montana v. Blackfeet Tribe of Indians*, 471 U.S. 759, 767 (1985); *Oneida Cty. N.Y. v. Oneida Indian Nation of N.Y. State*, 470 U.S. 226, 247 (1985). Taken together, the Treaty and statutes make clear that the Government has acknowledged that it has an enforceable legal duty to provide

health care to the Tribe to the extent necessary "to ensure the highest possible health status for Indians." 25 U.S.C. § 1602 (2009).

Defendants claim that the Tribe is unable to identify a trust corpus and therefore that no trust duty exists. Their argument, however, is dependent on a finding that the appropriation for IHS funding be a gratuitous, lump sum appropriation. (Defs. Br. at 12). But the IHS appropriation here is not gratuitous. The Supreme Court has repeatedly distinguished between funds appropriated for a treaty obligation, like the funds at issue here, and gratuitous annual appropriations. *See Lincoln v. Vigil*, 508 U.S. 182, 195 (1993) (citing *Quick Bear v. Leupp*, 210 U.S. 50, 80 (1908)). As the Supreme Court has clearly stated, because IHS provides health care services pursuant to the treaty obligation created when it agreed to accept ceded tribal lands *in exchange for* providing health care services to the tribes, the IHS appropriation cannot constitute a gratuitous lump sum. In *Quick Bear v. Leupp*, 210 U.S. 50 (1908), the court drew a clear distinction between a "Trust Fund" and a "Treaty Fund" as follows:

> But the "Treaty Fund"…are moneys really belonging to the Indians. They are the price of land ceded by the Indians to the Government. The only difference is that in the "Treaty Fund" the debt to the Indians created and secured by the treaty is paid by annual appropriations. They are not gratuitous appropriations of public moneys, but the payment, as we repeat, of a treaty debt in installments.

Id. at 81.

B. Defendants' arguments that they have no enforceable duty to the Tribe miss the mark and its Motion for Summary Judgment on the non-existence of such a duty should be denied.

There are many problems with the Government's arguments that no enforceable duty exists. To begin, this Court has already ruled on this specific issue and the

Government's arguments here are essentially identical to those that it presented at the motion to dismiss stage. (Doc. 36 at 22 (recognizing the Government's trust duty and noting that Plaintiff's "dedicate[d] roughly five pages of its Complaint to detailed allegations that IHS has a trust responsibility to provide an adequate level of care to its enrolled members, as evidenced by specific statutory language and a specific treaty").) In denying the Government's motion to dismiss Count III of the Tribe's complaint, this Court concluded that the Government has a treaty and statutory duty sufficient to support the Tribe's claim for relief. (Doc. 36 at 15-22). And the Court reiterated its conclusion that "there exists some duty" in its Rule 16 Scheduling Order. (Doc. 46 at 2). Likewise, the Court also recognized "the Government has some duty to the Tribe to provide health care" in its Order denying Defendants' motion to exclude Dr. Warne's report. (Doc. 84 at 7). Although the Court did not rule as to the scope of the Government's duty, there is no doubt that a duty exists. It is well established in this Court that "Congress has unambiguously declared that the federal government has a legal responsibility to provide health care to Indians," *White v. Califano*, 437 F. Supp. 543, 555 (D.S.D. 1977).

Notwithstanding this Court's repeated rejection of the Government's position, it continues to march forward. And in so doing, the Government misconstrues the nature and basis of the Tribe's claim.

First, the Government fails to acknowledge how several substantive sources of law work together to create the special trust relationship the federal government has with the Tribe. Taken together, the obligations laid out in Snyder Act and the IHCIA

along with the special status the Tribe enjoys under the 1868 Treaty of Fort Laramie confer upon the federal government a trust duty and establish that the Government has a clear obligation to ensure that health care provided to the Tribe permits the health status of the Tribe and its individual members to be raised to the highest possible level.

Second, the Government argues that the Tribe has failed to identify a trust corpus, by which they mean "tribal assets such as tribally-owned land or timber," (Doc. 81 at 8 *citing United States v. Navajo Nation*, 537 U.S. 488, 506 (2003) (Navajo I)*; Yankton Sioux Tribe v. U.S. Dep't of Health & Human Servs.*, 533 F.3d 634, 644 (8th Cir. 2008) (internal citation omitted)). In so doing, the Government distorts the applicable law, effectively rewriting the Treaty and statutes in a manner that allows the Government to avoid entirely its obligation to provide health care to the Tribe.

1. The Snyder Act, the IHCIA, and the 1868 Treaty of Fort Laramie, taken together, establish an enforceable duty, not just broad aspirational policy statements.

First, the Government continues to misapprehend its obligation by stubbornly reading the Snyder Act, the IHCIA, and the Treaty all in isolation. Presumably, the Government does this to argue that the Tribe has identified only "broad aspirational policy statements." (Doc. 81 at 12-17).

But a tribe can rely on a comprehensive framework of "statutes and regulations [that] clearly establish fiduciary obligations of the Government." *Jicarilla*, 564 U.S. at 177 (cleaned up); *see United States v. Mitchell* ("*Mitchell II*"), 463 U.S. 206, 222, 224 (1983) (holding statutes that established a comprehensive framework for management of Indian timber resources for the benefit of the Indian landowner "and his heirs," created

a fiduciary trust relationship). The language of the Snyder Act and the IHCIA mandates that the government ensure that health care provided to the Tribe permits the health status of the Tribe and its individual members to be raised to the highest possible level. This obligation was recognized by this Court in *White v. Califano*. There, this Court concluded that "Congress has unambiguously declared that the federal government has a legal responsibility to provide health care to Indians." *White,* 437 F. Supp. 555.

Furthermore, Congress confers upon the Tribe special statutory protections due to its proactive leadership in the federal tribal relationship. 154 Cong. Rec. S10709 (2008) (statement of Sen. Reid). Congress's special recognition of the Treaty, entered into by the federal government and the tribes of South Dakota to end hostilities and cede tribal land to the government in exchange for the federal government providing healthcare and other necessities to the tribes, is just one example of the Tribe's special status. *Id.*

The Government would conveniently like this Court to read these substantive sources of law in isolation by limiting its analysis to searching for "a specific statutory duty" in each of the substantive sources of law separately. (Doc. 81 at 13). But the standard, as established by the Supreme Court, is not so exacting. The Supreme Court's precedent favors function over form and the standard is not simply one that requires identification of a "specific, applicable, trust-creating statute." *Jicarilla*, 564 U.S. at 177 (cleaned up). "Where the relevant *sources* of substantive law create all of the necessary elements of a common-law trust, there is no need to look elsewhere for the source of a trust relationship." *United States v. White Mountain Apache Tribe*, 537 U.S. 465, 474 n.3, 123 S. Ct. 1126, (2003) (cleaned up) (emphasis added).

Mitchell II illustrates this point. There, the Supreme Court analyzed a "network" of statutes and regulations to conclude that the federal government had a duty to "manage Indian resources and land for the benefits of the Indians." *Mitchell II*, 463 U.S. at 224. Ultimately, the Court concluded the statutes and regulations at issue "clearly establish[ed] fiduciary obligations of the Government in the management and operation of Indian lands and resources," and held the tribes could pursue their claim for damages based on the breach of that trust obligation. *Id.* at 226. Similarly here, there are a network of statutes and a treaty that establish Congress's clear intention to obligate the federal government to provide for the highest level of health care services possible to tribes in exchange for the tribes ceding lands to it. To meet its duty, Congress appropriates a lump sum each year that IHS must use to provide medical services to tribes and to maintain facilities.

The Government relies on *Quechan Tribe of the Ft. Yuma Reservation v. United States* as support for its argument that the language in the Snyder Act and the IHCIA is insufficient to create a trust duty on the federal government. (*See* Doc. 81 at 14); *see also Quechan Tribe*, No. CIV 10-02261-PHX-FJM, 2011 U.S. Dist. LEXIS 36778, at *7-8 (D. Ariz. Mar. 31, 2011), aff'd, 599 F. App'x 698 (9th Cir. 2015). But *Quechan Tribe* is not binding on this Court and contradicts precedent established by this Court in *White v. Califano*, a case not undermined by Supreme Court precedent as explained in more detail below.

Ultimately, the Snyder Act, IHCIA, and the Treaty are not just broad aspirational policy points. Taken together, the Snyder Act, the IHCIA, and the Treaty create an enforceable duty and thus an actionable breach of trust claim, especially in light of the

special relationship between the Federal government and Indian tribes generally. For all these reasons, this Court should reject the Government's argument that the Snyder Act, IHCIA, and Treaty do not impose an enforceable trust duty on the federal government to provide medical serves to the tribe.

2. The Tribe need not establish a trust corpus. Nonetheless, the congressional appropriations to IHS qualify as a trust corpus.

Despite the Government's argument to the contrary, no trust corpus is required to establish a trust duty where the appropriations for IHS funding are not "gratuitous appropriations." Even if a trust corpus is required, the congressional appropriation to IHS to fulfill treaty obligations satisfies the trust corpus requirement.

The Tribe is not required to identify a trust corpus to establish that the Government owed it a trust duty. The Government contends that an enforceable trust duty requires a trust corpus consisting of identifiable property belonging to an Indian tribe. (Doc. 81 at 11, citing *United States v. Mitchell*, 463 U.S. 206, 225 (1983) ("*Mitchell II*")). The Supreme Court has held, however, that when money is appropriated pursuant to treaty duties, trust responsibility attaches. *See Lincoln v. Vigil*, 508 U.S. 182, 195 (1993) (citing *Reuben Quick Bear v. Leupp*, 210 U.S. 50, 80 (1908)). Notably, the Court has not conditioned this trust attachment on the finding of a trust corpus. *See, e.g.*, *Lincoln*, 508 U.S. at 195; *Quick Bear*, 210 U.S. at 80; *White*, 437 F. Supp. 543, 557-58 (D.S.D. 1977), *aff'd* 581 F.2d 697 (8th Cir. 1978).

In the alternative, the Tribe has established that the congressional appropriations to IHS satisfy the trust corpus requirement. It is undisputed that Congress appropriates

money to fund the IHS. The Government improperly characterizes these appropriations as "gratuitous appropriations," arguing that they cannot serve as a trust corpus. (Doc. 81 at 12.) The appropriations for IHS funding are not "gratuitous appropriations," as explained *supra II.A.* Rather, these are funds appropriated to satisfy the federal government's and IHS's obligations under the Snyder Act, IHCIA, and the Treaty. The Supreme Court, contrary to Defendants' arguments, has never held that annual appropriations cannot form the basis of a trust corpus.

To the extent that the Supreme Court required the existence of trust corpus *before* it found a special trust relationship, it did so using common-law elements. *See Mitchell II*, 436 U.S. at 225 (noting that all the necessary elements of a common-law trust were present, including a trust corpus). The Tribe is not relying solely on the common-law trust, but also statutory and treaty trust obligations. The Government has cited no case in which the Supreme Court required a trust corpus in a situation where the special trust relationship arises from substantive sources of law, including a treaty obligation.

The Government relies on, and misinterprets, *Lincoln v. Vigil*, arguing that *Lincoln* stands for the proposition that annual appropriations are not trust resources because the IHS retains discretion on which services and programs to spend the monies. (*See* Doc. 81 at 12, 22, citing *Lincoln*, 508 U.S. at 194-95). But, the Supreme Court did not make the leap the Government implies—in *Lincoln* or any other case—that annual appropriations are always discretionary, gratuitous appropriations and cannot therefore qualify as a trust corpus. Rather, both the Supreme Court and this Court have held that "[w]here money is appropriated to fulfill a treaty obligation, a trust

responsibility attaches." (Doc. 36 at 19; *see also Lincoln*, 508 U.S. at 195 (citing *Quick Bear*, 210 U.S. at 80).)

In *Lincoln*, the Court addressed an Administrative Procedure Act challenge to IHS's decision to defund a local program benefitting one Tribe's children in favor of creating a comparable nationwide program. *Lincoln*, 508 U.S. at 189. The local Tribe argued that IHS violated its trust duty by discontinuing the original program. *Id.* The Court held only that the courts could not review the IHS's decision about the funds pursuant to the APA. *Id.* at 193. While the Supreme Court did observe that "both the Snyder Act and the [IHCIA] . . . speak about Indian health only in general terms," it in no way held that either of these statutes could not create a special trust duty on the federal government. *See id.* at 194.

The Government's reliance on *Allred* is equally misplaced. The Government cites *Allred* to suggest that IHS's management of Congress's annual appropriations does not create a trust corpus. (Doc. 81 at 12; *Allred v. United States*, 33 Fed. Cl. 349 (Fed. Cl. 1995).) The IHCIA appropriations at issue in *Allred* are not analogous to the congressional appropriations to IHS at issue here. *See Allred*, 33 Fed. Cl. at 351, 356-57 (finding that there was no trust corpus based on plaintiffs' APA claim and underlying assertion that the Snyder Act and IHCIA gave plaintiffs a right to receive health care services). In *Allred*, plaintiffs argued that the government had breached "a general duty of trust that it owes Indian nations" and pointed to "no property interest or corpus that the government is required to manage under the statutes cited [by plaintiffs]." *Id.* at 356-57. The Tribe here, however, identifies specific property, *i.e.*, the congressional

appropriations to IHS, which are to be used to fulfill the Government's trust duties to the Tribe, as detailed in the Snyder Act, the IHCIA, and the Treaty, to ensure that health care provided to the Tribe permits the health status of the Tribe and its individual members to be raised to the highest possible level. Further, *Allred* is non-precedential and has not been adopted by any court in the Eighth Circuit.

The Government seeks to undermine the Tribe's position by arguing that the Supreme Court has "superseded and invalidated" *White v. Califano*. (Doc. 81 at 21-23.) The Court's holding in *White*, however, does not ignore the Court's enumerated requirements for finding that a trust responsibility exists; rather, the Court implicitly acknowledges that the IHS annual appropriations are sufficient to establish a trust corpus. *See White*, 437 F. Supp. at 557-58.

Taken together, the Snyder Act, the IHCIA, and the Treaty create an enforceable duty. In light of the trust duties owed to the Tribe by the federal government and because the congressional appropriations to IHS fulfill treaty obligations, the Tribe has established a trust corpus.

III. The undisputed facts established in discovery demonstrate that Defendants have breached their duty to provide health care to the Tribe.

As discussed in the Factual Background section, the undisputed facts demonstrate that the health care provided at the Rosebud Hospital fails to meet even the most basic standard of care for medical services. The Defendants have not provided a single piece of evidence, expert or otherwise, to dispute Dr. Warne's report or his conclusions. Instead, all the evidence developed in this case points to a single

conclusion: the Rosebud Hospital fails to meet the minimum standards for quality health care.

As discussed *supra*, the Government has a treaty and statutory duty to provide health care to the Tribe. Defendants' duty is to provide health care services that raise the health status of members of the Tribe to the highest possible level. Under any reasonable interpretation of what that duty requires, the facts established in this case clearly demonstrate that Defendants have breached their duty to the Tribe. Indeed, the "care" provided at the Rosebud Hospital jeopardizes the safety of its patients, harms the community, and in the words of Senator Barrasso, amounts to medical "malpractice."

IV. The Tribe has standing because its injury can be redressed by a favorable decision from this Court.

As this Court previously ruled when denying, in part, Defendants' motion to dismiss (*see* Order, Doc. 36 at 12), the Tribe has standing because the Tribe has suffered an actual injury, there is a causal relation between the Tribe's injury and Defendants' conduct, and a favorable decision by the Court will redress the Tribe's injury. *See also Lujan v. Defenders of the Wildlife*, 504 U.S. 555, 560–61, 119 L. Ed. 2d 351, 112 S. Ct. 2130 (1992).

Defendants argue the Tribe cannot establish the redressability element of standing. (Defs. Br. at 27). A plaintiff "satisfies the redressability requirement when he shows that a favorable decision will relieve a discrete injury to himself. He need not

show that a favorable decision will relieve his every injury." *Larson v. Valente*, 456 U.S. 228, 243 n.15, 72 L. Ed. 2d 33, 102 S. Ct. 1673 (1982) (plurality opinion).

Defendants suggest the relief the Tribe seeks "could require that IHS dedicate additional resources to RSU, which is not within the Court's power to grant." (Defs. Br. at 28). Defendants' argument mischaracterizes the relief sought by the Tribe. The Tribe has not and is not asking the Court to review or change IHS's allocation of funds to the Rosebud Hospital or Congress's appropriation to IHS. The Tribe does not ask that the Court solve every issue with IHS. Instead, Count III of the Complaint and this Summary Judgment Motion seek only a declaratory judgment that IHS has violated its trust duty to ensure that health services provided to the Tribe's members permit the health status of Indians to be raised to the highest possible level. (Doc. 1, ¶ 65).[4]

This relief is within the Court's power and would redress the Tribe's injuries. In fact, the Court previously ruled the Tribe has standing to pursue declaratory relief, finding: "a declaratory judgment stating that defendants, which include IHS and others directly responsible for providing health care to the Rosebud Sioux Tribe, have failed to comply with the trust and treaty responsibilities … could be the settling of a dispute that would have an effect on the defendants' behavior towards the Tribe, even if indirectly." (*See* Order on Defendants' Motion to Dismiss, Doc. 36 at 12).

---

[4] Count III of the Complaint was plead in a way that could also allow the Tribe to seek injunctive relief requiring IHS to comply with its trust duties as some later time. However, the Tribe is now moving for summary judgment only on its claim for declaratory judgment relief and does not seek a ruling on its claim for an injunctive remedy.

The Declaratory Judgment Act allows courts to "declare the rights and other legal relations of any interested party seeking such declaration, whether or not further relief is or could be sought." 28 U.S.C. § 2201(a). The United States Supreme Court has held that courts can assume a declaration will affect a government official's behavior—that is, that officials will behave in accordance with a court's ruling—regardless of whether injunctive relief is available. *Franklin v. Massachusetts*, 505 U.S. 788, 803, 112 S. Ct. 2767, 120 L. Ed. 2d 636 (1992). In *Franklin*, the State of Massachusetts and two voters challenged Congress's reapportionment of seats in the House of Representatives as unconstitutional and inconsistent with the Administrative Procedures Act. *Id.* at 796. The plurality found the plaintiffs had standing to seek a declaratory judgment, even without any available injunctive relief, finding it "substantially likely" that executive and Congressional officials "would abide by an authoritative interpretation of the … statute and constitutional provision by the District Court, even though [the officials] would not be directly bound by such a determination." *Id.* at 803.

Similarly, here, the parties and Court can assume IHS and the other Defendants will abide by a determination that they are in breach of their trust duty owed to the Tribe, and that Defendants will act accordingly. The *Ashley* case cited by Defendants is inapplicable. *Ashley v. United States*, 408 F.3d 997 (8th Cir. 2005). There, the Court found tribal members lacked standing to sue over a tribe's alleged improper use of trust money. This is not the situation at hand. First, the *Ashley* plaintiffs sought a different remedy (a rescission order voiding the government's approval of a specific tribal agreement), which the Court found would not redress the injuries because it would not

prevent the tribe from entering into a similar agreement in the future. *Id.* at 1000. Second, the *Ashley* plaintiffs failed to name the subject tribe as a defendant and otherwise failed to prove the named defendants could control the tribe's behavior. *Id.* at 1003. Here, the Tribe seeks declaratory relief against government actors who are responsible for the Tribe's injuries. Thus, a declaratory judgment in favor of the Tribe will effect Defendants' behavior toward the Tribe and redress the Tribe's injuries, even if indirectly. (*See* Order, Doc. 36 at 12).

V. This Court has jurisdiction to adjudicate the Tribe's claim.

Defendants' sole argument regarding jurisdiction is that this Court cannot hear claims against the United States requiring the payment of money. (Defs. Br. at 29). But that is not what this case is about. The Tribe is not seeking a forced expenditure of funds. Instead, the Tribe seeks a declaratory judgment that Defendants are in breach of their trust duty owed to the Tribe. As discussed above, this remedy can be achieved without ordering allocation of additional funds.

CONCLUSION

It comes as no surprise that health care provided at the Rosebud Hospital is woefully inadequate. It is surprising, however, that the Government claims it has no obligation to provide health care to the Tribe, despite a treaty and statutes imposing exactly that requirement. The Tribe does not ask the Court to appropriate money or solve a health care crisis. Instead, the Tribe simply asks this Court to declare that the Government is not fulfilling its treaty and statutory obligations to provide the quantity and quality of health care that will raise the health of tribal members to the highest

level, and eliminate health disparities suffered by the Tribe. Accordingly, the Tribe respectfully requests that Defendants' motion for summary judgment be denied and that summary judgment be entered in the Tribe's favor in the form of a declaratory judgment.

REQUEST FOR ORAL ARGUMENT

Pursuant to D.S.D. Civ. L.R. 7.1(C), the Tribe respectfully requests oral argument on this motion.

Dated: August 26, 2019

ROBINS KAPLAN LLP

By: */s/ Timothy W. Billion*

Brendan V. Johnson (S.D. #3263)
Timothy W. Billion (S.D. #4641)
140 North Phillips Avenue, Suite 307
Sioux Falls, SD 57104
Tel: 605-335-1300
Fax: 605-740-7199
BJohnson@RobinsKaplan.com
TBillion@RobinsKaplan.com

Denise S. Rahne (S.D. #4708)
Bruce A. Finzen (*Pro Hac Vice*)
800 LaSalle Avenue, Suite 2800
Minneapolis, MN 55402-2015
Tel: 612-349-8500
Fax: 612-339-4181
DRahne@RobinsKaplan.com
BFinzen@RobinsKaplan.com

Timothy Q. Purdon (*Pro Hac Vice*)
1207 West Divide Avenue, Suite 200
Bismarck, ND 58503
Tel: 701-255-3000
Fax: 612-339-4181
TPurdon@RobinsKaplan.com

ATTORNEYS FOR PLAINTIFF ROSEBUD SIOUX TRIBE

CERTIFICATE OF COMPLIANCE

I, Timothy W. Billion, hereby certify that the foregoing memorandum complies with the limits in D.S.D. Civ. LR 7.1(B)(1). I further certify that, in preparation of this memorandum, I used Microsoft Word 2016 and this word processing program has been applied specifically to include all text – including headings, footnotes, and quotations – except the caption, signature block, and this certification. I further certify that this document contains 10,627 words.

/s/ *Timothy W. Billion*