No. 21-1226

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

SAGINAW CHIPPEWA INDIAN TRIBE OF MICHIGAN AND ITS WELFARE BENEFIT PLAN,

Plaintiffs-Appellants,

v.

BLUE CROSS AND BLUE SHIELD OF MICHIGAN,

Defendant-Appellee.

On Appeal from the United States District Court
for the Eastern District of Michigan
Case No. 16-cv-10317

BRIEF OF FORTY-ONE AMERICAN INDIAN TRIBES, SIX TRIBAL ORGANIZATIONS, AND SHASTA ADMINISTRATIVE SERVICES AS AMICI CURIAE IN SUPPORT OF APPELLANTS AND IN SUPPORT OF REVERSAL

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UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

Disclosure of Corporate Affiliations and Financial Interest

Sixth Circuit
Case Number: 21-1226 Case Name: Saginaw Chippewa v. Blue Cross

Name of counsel: James K. Nichols

Pursuant to 6th Cir. R. 26.1, Amici Curiae Listed on Following Pages (pp. ii-iv)
Name of Party

makes the following disclosure:

1. Is said party a subsidiary or affiliate of a publicly owned corporation? If Yes, list below the identity of the parent corporation or affiliate and the relationship between it and the named party:

No.

2. Is there a publicly owned corporation, not a party to the appeal, that has a financial interest in the outcome? If yes, list the identity of such corporation and the nature of the financial interest:

No.

CERTIFICATE OF SERVICE

I certify that on May 10, 2021 the foregoing document was served on all parties or their counsel of record through the CM/ECF system if they are registered users or, if they are not, by placing a true and correct copy in the United States mail, postage prepaid, to their address of record.

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This statement is filed twice: when the appeal is initially opened and later, in the principal briefs, immediately preceding the table of contents. See 6th Cir. R. 26.1 on page 2 of this form.

AMICI CURIAE

The following amici appear in this appeal and did not appear in the district court:

Agua Caliente Band of Cahuilla Indians

Alaska Native Health Board

Bois Forte Band of Chippewa Indians

Chickasaw Nation

Chippewa Cree Tribe of the Rocky Boy Reservation

Chitimacha Tribe of Louisiana

Choctaw Nation

Coquille Indian Tribe

Eastern Band of Cherokee Indians

Gila River Indian Community

Grand Traverse Band of Ottawa and Chippewa Indians

Hopi Tribe

Jamestown S'Klallam Tribe

Keweenaw Bay Indian Community

Lower Sioux Indian Community

Mashantucket Pequot Tribal Nation

Match-E-Be-Nash-She-Wish Band of Pottawatomi Indians of Michigan

Menominee Indian Tribe of Wisconsin

Miami Tribe of Oklahoma

Midwest Alliance of Sovereign Tribes

Mississippi Band of Choctaw Indians

Mohegan Tribe of Indians of Connecticut

National Congress of American Indians

National Indian Health Board

Nisqually Indian Tribe

Northwest Portland Area Indian Health Board

Nottawaseppi Huron Band of the Potawatomi

Oneida Nation

Pechanga Band of Luiseño Indians

Poarch Band of Creek Indians

Prairie Island Indian Community

Puyallup Tribe of Indians

Redding Rancheria

Saint Regis Mohawk Tribe

Salt River Pima-Maricopa Indian Community

San Pasqual Band of Mission Indians

Santa Rosa Rancheria Tachi Yokut Tribe

Santa Ynez Band of Chumash Mission Indians

Sault Ste. Marie Tribe of Chippewa Indians

Seminole Tribe of Florida

Shasta Administrative Services

Suquamish Tribe

Swinomish Indian Tribal Community

Table Mountain Rancheria

Tohono O'odham Nation

United South and Eastern Tribes Sovereignty Protection Fund

Ute Mountain Ute Tribe

Winnebago Tribe of Nebraska

Amici, and members of tribal advocacy organizations, are also listed in the Addendum. The tribal advocacy organizations that have signed on to this amici brief represent more than 300 Indian tribes.

CORPORATE DISCLOSURE STATEMENT

Except for the following, all amici are federally recognized Indian tribes.

The Alaska Native Health Board ("ANHB") is a non-profit tribal advocacy organization headquartered in Anchorage, Alaska whose members include all 229 federally recognized Tribal Nations in Alaska. ANHB has no parent company. No publicly held corporation owns 10% or more of its stock.

The National Congress of American Indians ("NCAI") is the oldest and largest national organization of Tribal governments, whose mission is to protect and preserve the relationship between Indian tribes and the United States, and to provide public education on Tribal Nations and the functions they serve. NCAI is a nonprofit organization and has no parent company. No publicly held corporation owns 10% or more of its stock.

The National Indian Health Board ("NIHB") was established by the Tribes to advocate as the united voice of federally recognized American Indian and Alaska Native Tribes on matters of health and public health. NIHB seeks to reinforce Tribal sovereignty, strengthen Tribal health systems, secure resources, and build capacity to achieve the highest level of health and well-being for our People. NIHB has no parent company. No publicly held corporation owns 10% or more of its stock.

The Northwest Portland Area Indian Health Board ("NPAIHB") is a non-profit tribal advocacy organization headquartered in Portland, Oregon, whose

member Tribes include 43 tribes in Washington, Oregon, and Idaho states. NPAIHB has no parent company. No publicly held corporation owns 10% or more of its stock.

The Midwest Alliance of Sovereign Tribes ("MAST") is a nonprofit tribal advocacy organization that represents the 35 sovereign tribal nations of Minnesota, Wisconsin, Iowa, Michigan, and Indiana. MAST has no parent company. No publicly held corporation owns 10% or more of its stock.

Shasta Administrative Services is a corporation whose majority owner is the Confederated Tribes of Grand Ronde, a federally recognized Indian tribe. No publicly held corporation owns 10% or more of its stock.

The United South and Eastern Tribes Sovereignty Protection Fund ("USET SPF") advocates on behalf of 33 federally recognized Tribal nations from the Northeastern Woodlands to the Everglades and across the Gulf of Mexico to advance their inherent sovereign authorities and rights. USET SPF has no parent company. No publicly held corporation owns 10% or more of its stock.

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INTEREST OF AMICI CURIAE

Amici include 41 federally recognized Indian tribes ("the Tribal Amici") that operate health programs, including Purchased/Referred Care ("PRC") programs, pursuant to agreements entered under the Indian Self-Determination and Education Assistance Act of 1975 ("ISDEAA"), 25 U.S.C. §§ 5301-5423, and six tribal advocacy organizations. Some of the Tribal Amici also operate self-insured health programs for their members and employees, including American Indian employees.

Shasta Administrative Services is a tribally owned third-party administrator for tribal self-insured health plans. Shasta administers tribal plans that coordinate benefits with PRC programs and, in some cases, issues payment for services authorized by PRC programs.

Amici have a strong interest in the outcome of this appeal because they, or their members, operate or administer health programs that purchase care at rates known as "Medicare-Like Rates" ("MLR"),[1] resulting in increased access to healthcare for tribal members and other Indians served by tribal health programs,

[1] Access to Medicare Like Rates is provided under the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (42 U.S.C. § 1395cc(a)(1)) and its implementing regulations.

and significant savings to tribal governments. The district court's interpretation of that regulation, should it become controlling law, could impair the ability of Amici to do so in the future.

All parties have consented to the filing of this brief pursuant to Fed. R. App. P. 29(a)(2). No counsel for any party authored this brief in whole or in part or contributed money intended to fund preparation or submission of this brief. No other person or entity other than Amici, their members, and counsel provided any monetary contribution to fund the preparation or submission of this brief.

INTRODUCTION

American Indian tribes have long suffered from a lack of funding for, and access to, health services—even though the United States agreed in treaties and statutes to provide healthcare. To address these problems, tribes contribute their own funds to federal health programs, and even operate self-insured health plans and other health programs for members. Tribes achieve the best results when they coordinate tribal programs with federal programs. This approach is possible because of several important developments in federal law, along with the federal government's recognition that the principles of tribal self-governance and self-determination should guide its policies relating to tribal health services.

ISDEAA and the Indian Health Care Improvement Act ("IHCIA") give tribes a meaningful role in managing health programs for their communities. ISDEAA creates a framework for tribes to enter agreements with the United States to take on responsibility for the design and operation of tribal health programs "responsive to the true needs of Indian communities." 25 U.S.C. § 5301(a)(1). The IHCIA implements measures to further protect tribal resources and tribal rights in managing their health programs. 25 U.S.C. § 1601 *et seq*.

One such program is PRC, in which tribes purchase healthcare from outside providers rather than provide services directly in a tribal health facility. It is an essential element of many tribal health systems because tribal facilities are not always equipped to meet the healthcare needs of all patients, especially those requiring specialized care. Under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 ("the Medicare Modernization Act") and 42 C.F.R. § 136.30-32 ("the MLR Regulation"), tribes "carrying out" a PRC program[2] under an ISDEAA agreement can purchase care from Medicare-participating hospitals at the MLR—much lower than the undiscounted rates, and often lower than the rates

[2] PRC was formerly referred to as Contract Health Services ("CHS"). This brief uses the term "PRC" throughout, including the use of "[PRC]" when quoting material that refers to "CHS."

available to group health insurance plans. The hospitals must accept the MLR as payment in full for all services "authorized" by the tribe, thus allowing tribes to design their PRC programs to coordinate with other resources—such as self-insurance—to pay for the care. By following this blueprint, with variations to adapt to the unique needs of each community, tribes have achieved substantial savings and made great progress in improving the health outcomes for tribal communities. Tribes provide more healthcare, more efficiently, than ever before.

The district court's decision, should it become controlling law, threatens to undo this progress. The district court would permit MLR to apply only to care purchased with IHS-appropriated funds, an amount far below what tribes need. After those funds are exhausted, tribes would have to pay for hospital services at higher rates—or worse, force patients to forego healthcare due to lack of funds. The MLR Regulation was enacted to remedy that exact problem.[3]

SUMMARY OF THE ARGUMENT

The district court's decision should be reversed for three primary reasons.

First, the plain terms of the MLR Regulation state that the MLR is payment in full for all services provided by a Medicare-participating hospital and

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[3] *See* note 11, *infra*.

"authorized" by a tribe "carrying out" a PRC program. There is no requirement that payment come from any particular funding source. Multiple provisions of the MLR Regulation, and other authorities, confirm this.

Second, there is no ambiguity in the MLR Regulation that requires reference to agency interpretation or federal policy—but to the extent those factors are relevant, they show that the MLR Regulation has no "source of funds" requirement. When coordination of PRC with self-insurance for claim payment and administration serves tribal needs, federal law encourages and protects the tribes' right to manage their programs accordingly.

Third, the district court incorrectly relied on *Redding Rancheria v. Hargan*. That case confirms, with persuasive reasoning, that Indian health statutes, regulations, and policies must be interpreted to benefit tribes, and that tribes have the right to design ISDEAA programs, including PRC, to meet the needs of their communities. It is notable for rejecting the Indian Health Service ("IHS") interpretations that would frustrate the ability of tribes to deploy their health resources efficiently.

ARGUMENT

I. THE MLR REGULATION PLAINLY APPLIES TO ALL CARE AUTHORIZED BY A TRIBE CARRYING OUT A PRC PROGRAM.

The MLR Regulation plainly states that the MLR applies to any service provided by a Medicare-participating hospital and "authorized" by a tribe "carrying out a [PRC] program." 42 C.F.R. § 136.30(b). The district court found—correctly—that the MLR Regulation provides "no further explanation" of any requirement regarding the "source of IHS funding" for the services. Feb. 21 Order, RE 202, PageID#12790. On this basis, the district court should have found that the MLR Regulation is not ambiguous, and the plain terms do not impose any requirement regarding the source of funding for the services. Instead, the district court discarded the plain meaning and created ambiguity where none existed before.

A. The Plain Meaning of Statute and Regulations Confirm that the MLR Regulation Applies to all Services Authorized by a Tribe Carrying out a PRC Program.

The plain meaning of the MLR Regulation is overwhelmingly clear and is expressed in statute and multiple regulatory provisions. The Medicare Modernization Act is the statutory authority for the MLR Regulation. It requires hospitals, as a condition of Medicare participation, to be "participating provider[s] of medical care . . . under the [PRC] program funded by the [IHS] and operated by

the [IHS], an Indian tribe, or tribal organization" and to accept the Medicare payment for all "items and services that are covered under such [PRC] program and furnished to an individual eligible for such items and services under such program." 42 U.S.C. § 1395cc(a)(1)(U)(i). While the statute refers to the PRC program "funded by" IHS, it does not impose a requirement that the program be fully or solely funded by IHS, nor does it require that all services "covered" by the program be paid with IHS funds. This is necessary because other statutes authorize tribes to use other sources of funding—not just IHS funds—to cover PRC services. 25 U.S.C. § 5325(m) and 5388(j) (use of program income, including third-party revenue, under ISDEAA contracts and compacts); 25 U.S.C. § 1641(d)(2)(A) (tribes may use income from Medicare and Medicaid for "coverage for a service or service [*sic*] within a [PRC] delivery area"); 25 U.S.C. § 1621f(a)(1) (other sources of income may be used for the purposes set forth in § 1641(d), *i.e.*, coverage for PRC service). Section 1395cc(a)(1)(U)(i) must be read in harmony with these statutes. Thus, a service is "covered" under the program when PRC authorizes the service—thereby committing funds to pay for it—without any "source of funds" requirement.

The MLR Regulation was enacted to carry out the Medicare Modernization Act and it applies to "all items and services authorized by IHS, Tribal, and urban

Indian organization entities." 42 C.F.R. § 136.30(a). Medicare-participating hospitals must accept the MLR as payment in full for any care "authorized by a Tribe or Tribal organization carrying out a [PRC] program of the IHS under [ISDEAA]." 42 C.F.R. § 136.30(b). The key word in both provisions is *authorized*.[4] The regulation does not require payment from any specific program or funding source. Where the MLR Regulation addresses payment, it refers to "payment by I/T/Us [IHS/Tribe/Urban Indian Organizations]" and the amount "I/T/Us shall pay"—not payment with PRC funds or even payment by the PRC program. 42 C.F.R. § 136.30(e).

The MLR Regulation includes coordination of benefits provisions that specifically contemplate circumstances in which the MLR would apply to care that a tribe authorizes, but does not pay for (or pays only part of). If a health insurance plan (or other third-party payor) covers some portion of the cost of a service to a

[4] This is an important distinction for the additional reason that a PRC program might authorize a service before it is determined who will ultimately pay for the service. PRC is a payer of last resort under statute and regulation. 25 U.S.C. § 1623(b); 42 C.F.R. § 136.61. A PRC program may authorize a service, but require the provider to exhaust all alternative sources of payment before the PRC program pays a claim. The use of the word "authorized" is also consistent with the statutory protection for patients from liability for "authorized" PRC services. 25 U.S.C. § 1621u ("[a] patient who receives [PRC] services that are authorized by the Service shall not be liable for the payment of any charges or costs").

PRC-eligible patient, then the tribe will "pay the amount for which the patient is being held responsible after the provider of services has coordinated benefits and all other alternative resources have been considered and paid" up to the MLR. 42 C.F.R. § 136.30(g)(2). If the other payers paid amounts less than the MLR, then the tribe would only need to authorize payment of the remaining amount. *Id*. If the other payers paid amounts equal to or more than the MLR, then the tribe would not issue any payment, but would need to *authorize* the service in order to impose the MLR payment cap and preclude the provider from attempting additional collections from the tribal member who received the service. *Id*.; *see also* 25 U.S.C. § 1621u (PRC authorization protects patient from liability to provider).

In addition to the MLR Regulation, a separate regulation requires Medicare-participating hospitals to accept the MLR as payment in full for services to a "[PRC] program under 42 CFR part 136, subpart C, carried out by an Indian Tribe or Tribal organization pursuant to [ISDEAA]." 42 C.F.R. § 489.29(a)(2). Like the Medicare Modernization Act and the MLR Regulation, § 489.29 does not impose any requirement regarding the source of funds; the regulation simply obligates the hospitals to accept MLR as payment in full for all services provided to a PRC program.

Tribes have had to supplement IHS funding since ISDEAA was first enacted in 1975, and they were supplementing PRC with tribal funds and other sources of funding in 2003 when Congress enacted the Medicare Modernization Act. In drafting the statute and regulations, Congress, the Department of Health and Human Services, and IHS all had ample opportunity to include a "source of funding" requirement if they intended one to apply. The lawmakers did not do so. There is nothing to suggest that Congress intended to protect only a narrow subset of the funds that tribal programs rely upon, and disregard other sources that are integral to the programs. In fact, in 2016, nine years after enacting the MLR Regulation, IHS confirmed its intent by enacting a second payment-limitation regulation that applies to non-hospital providers based on "authorization," again with no "source of funds" requirement. 42 C.F.R. § 136.203.

B. The District Court's Interpretation of the MLR Regulation Creates Ambiguity.

The district court's decision to add a "source of funding" requirement overrides the plain meaning of multiple statutes and regulations, thereby creating—rather than resolving—ambiguity.

The district court is not clear on the precise meaning of "funded by [PRC]," a phrase the court coined. Aug. 7 Order, RE 197, Page ID #12655. It could mean that payments must come from a specific PRC bank account, as the district court

suggests. *Id*. But it is equally plausible that "funded by [PRC]" only requires that PRC have the authority to obligate funds to pay for service. If a PRC program has the power to authorize a service and require payment, then that demonstrates control of the funds to be disbursed, and the service is arguably "funded by PRC." The district court does not accept that outcome—but also does not articulate any principled reason why "funded by [PRC]" requires payment from a specific bank account.

The district court compounds the ambiguity in its "source of funds" requirement by variously referring to payment with "PRC funds" and "IHS funds." The district court failed to explain its understanding of the difference between the two, but it appears that "IHS funds" refers only to IHS appropriations (Aug. 7 Order, RE 197, PageID#12649), and "PRC funds" could include "tribal dollars" (Feb. 21 Order, RE 202, PageID#12781). To the extent that the district court meant to require payment from "IHS funds" (as it understood the term) for the MLR Regulation to apply, that is directly contrary to federal law regarding funding and budgeting for ISDEAA programs. 25 U.S.C. § 5325(m); § 5388(j); 25 U.S.C. § 1641(d)(2)(A); 25 U.S.C. § 1621f(a)(1). Tribes are expressly authorized to use third-party revenues to pay for PRC-covered services and "any health care-related" purpose. 25 U.S.C. § 1641(d)(2)(A).

In contrast to the district court's vague "source of funds" requirement, "authorization" for a service is easily ascertained and administered by providers, patients, and third-party health program administrators. It is a standard part of the interaction among those groups—virtually every service covered by private insurance, Medicare, Medicaid, and other programs requires some form of authorization. The district court would have patients and providers confirm the bank account that issued payment, and the source of funds in the account, in order to determine whether the obligation on the provider to accept MLR as payment in full, and protection for the patient against balance billing, apply. The district court inflicts confusion and administrative burden on tribes, providers, patients, and administrators who have long relied on the plain meaning of the MLR Regulation.

II. TO THE EXTENT THAT THE MLR REGULATION IS AMBIGUOUS, IT MUST BE INTERPRETED TO SUPPORT TRIBAL INTERESTS.

Instead of applying the plain text of the Medicare Modernization Act and MLR Regulation to conclude that there is no "source of funding" requirement in the MLR Regulation, the district court shifted its focus to sub-regulatory agency guidance and policy arguments—and got those wrong too. The district court disregarded the canons of construction that apply to statutes and regulations enacted for the benefit of Indian tribes. It disregarded agency guidance that

supports the tribal position. And it undermined self-governance policies and imposed the paternalism and federal domination that the policies are meant to displace.

A. The Indian Canons of Construction Apply to Interpretation of the Medicare Modernization Act and the MLR Regulation.

It is well-established that in cases involving American Indians courts have applied the canon of construction that "statutes are to be construed liberally in favor of the Indians, with ambiguous provisions interpreted to their benefit." *Montana v. Blackfeet Tribe of Indians*, 471 U.S. 759, 766, (1985). If legislation "can reasonably be construed as the Tribe would have it construed, it *must* be construed that way." *Muscogee (Creek) Nation v. Hodel*, 851 F.2d 1439, 1444–45 (D.C. Cir. 1988), *cert. denied*, 488 U.S. 1010 (1989).

The Indian canon applies to regulations as well as statutes. *HRI, Inc. v. E.P.A.*, 198 F.3d 1224, 1245 (10th Cir. 2000), *as amended on denial of reh'g and reh'g en banc* (Mar. 30, 2000) ("The trust relationship and its application to all federal agencies that may deal with Indians necessarily requires the application of a similar canon of construction to the interpretation of federal regulations."); *Navajo Health Found.-Sage Mem'l Hosp., Inc. v. Burwell*, 100 F. Supp.3d 1122, 1176 (D.N.M. 2015) ("The canon of construction favoring Indian tribes and tribal organizations trumps . . . deference" to agency interpretation of regulations).

ISDEAA explicitly incorporates this rule of construction, requiring that each provision of the statute, and agreements entered under it, "be liberally construed for the benefit of the Indian tribe" and "any ambiguity shall be resolved in favor of the Indian tribe." 25 U.S.C. §§ 5321(g), 5392(f) (Title V compacts), 5324(b) (Title I agreements). The rule applies with particular force to regulations relating to tribal administration of ISDEAA programs.[5] *See* 25 C.F.R. § 900.3(a)(5) ("each provision of the [ISDEAA] and each provision of contracts entered into thereunder shall be liberally construed for the benefit of the tribes or tribal organizations . . . ."); 25 C.F.R. § 900.3(b)(11) ("Indian self-determination requires that [ISDEAA] regulations be liberally construed for the benefit of Indian tribes and tribal organizations . . . ."). This includes the MLR Regulation, because it specifically applies to tribes carrying out ISDEAA programs. 42 C.F.R. § 136.30(b).

The Indian canon of construction controls over the general principle of deference to agency interpretations of ambiguous law. *Ramah Navajo Chapter v. Lujan*, 112 F.3d 1455, 1462 (10th Cir. 1997) (holding that "the canon of construction favoring Native Americans controls over the more general rule of

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[5] In *Maniilaq Association v. Burwell*, 170 F. Supp.3d 243 (D.D.C. 2016), the court found the IHS interpretation of statute and regulations "plausible" but, "[m]indful of its obligation to construe the Act liberally in favor of Maniilaq," the court adopted Maniilaq's reasonable interpretation. 170 F.3d at 252-53, 255.

deference to agency interpretations of ambiguous statutes"). When "[t]he governing canon of construction" favoring tribes conflicts with agency deference, "statutes are to be construed liberally in favor of the Indians, with ambiguous provisions interpreted to their benefit," and an agency's interpretation is given consideration but not deference. *Cobell v. Norton*, 240 F.3d 1081, 1101 (D.C. Cir. 2001) (quoting *Blackfeet Tribe of Indians*, 471 U.S. at 766)).[6]

B. The District Court Improperly Relied on a Non-Binding FAQ Document to Override the Plain Meaning of the MLR Regulation.

After creating ambiguity in the MLR Regulation where none existed, the district court turned to a 2008 "FAQ" document from the IHS website for guidance. Relying on this document to the detriment of tribal interests not only violates the Indian canons of construction, it also violates substantive tribal rights under ISDEAA. Tribes operating ISDEAA programs "shall not be subject to any agency circular, policy, manual, guidance, or rule adopted by the Indian Health Service, except for the eligibility provisions"—unless the tribe expressly agrees

[6] This Circuit has not addressed the question of whether the Indian canon prevails over the principle of agency deference. It does not need to do so now. The statute and regulations are not ambiguous, and even if they were, the agency interpretation at issue—contrary to the district court's conclusion—supports the tribal interpretation.

otherwise. 25 U.S.C. § 5397(e); *see also* 25 U.S.C. § 5329(c) (a tribe operating health programs under Title I contract "is not required to abide by program guidelines, manuals, or policy directives of the Secretary [of Health and Human Services], unless otherwise agreed to by the [tribe] and the Secretary, or otherwise required by law").[7] IHS cannot use informal policy guidance to "add requirements" applying to tribes "that are not specified in the regulations." *Maniilaq Ass'n v. Burwell*, 72 F. Supp. 3d 227, 237 (D.D.C. 2014). Nevertheless, the district court believed that the FAQ was "worthy of some deference" because IHS issued it. Aug. 7 Order, RE 197, Page ID #12650. This was error. But it should have resulted in harmless error, because the FAQ supports the tribal position. The FAQ repeatedly confirms that only "authorization," not payment from PRC funds, is all that is required for MLR to apply.

The district court acknowledged that two of the FAQs expressly support the Tribal position. One of those, FAQ No. 28, is particularly significant because it squarely addresses the conditions that must be met to compel a hospital to accept MLR as payment in full:

> Q: Does my local hospital have to accept these rates?

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[7] Informal agency guidance may be applied *against* the agency when the guidance is favorable to the tribal position. *Morton v. Ruiz*, 415 U.S. 199, 235-236 (1974).

> A: Yes, if the local hospital is a Medicare participating hospital and if your [PRC] program has authorized payment for the services.
>
> FAQ, RE 173-27, PageID#9278.

When asked to identify all conditions for the MLR Regulation to apply, IHS confirmed that only authorization is required. There is no "source of funding" requirement.

FAQ No. 17 similarly confirms that the MLR applies based on authorization, with no "source of funds" requirement:

> Q: If a Tribe pays for patients outside its [PRC Delivery Area] with Tribal funds can they pay using Medicare-like Rates?
>
> A: Yes, as long as they meet [PRC] eligibility requirements within the regulations and services are authorized by the [PRC] program.
>
> FAQ, RE 173-27, PageID#9277.

Nevertheless, the district court dismissed with no explanation FAQ Nos. 17 and 28, and their specific confirmation that only "authorization" is required. The district court also ignored six additional FAQs—Nos. 15, 16, 18, 40, 41, and 42—that confirm the MLR applies to services "authorized" by PRC with no "source of funds" requirement. RE 173-27, Page ID #9277, 9281. Altogether, there are *nine* FAQs specifically confirming that no "funding source" requirement applies to the MLR Regulation.

Instead of following these clear statements in the IHS FAQ, the district court relied on three other FAQs that purportedly—but do not in fact—impose a requirement for payment with PRC funds (whatever that term might mean). The district court's reliance on these FAQs does not withstand scrutiny.

FAQ No. 10 addresses patient eligibility:

> Q: We use Third Party funds to pay costs for certain members who do not qualify for [PRC] funding. Do the Medicare-like rates apply for these services?
>
> A: No. Medicare-like rates only apply for services payable through the [PRC] program, for individuals who are eligible for [PRC] coverage, as defined by 42 CFR Part 136.

FAQ, RE 173-27, PageID#9276.

This FAQ answer is not based on the use of third-party funds. The distinction is between eligible and ineligible patients, not funding sources. Indeed, FAQ No. 11, discussed below, confirms that the MLR Regulation applies to claims paid with third-party funds. "Payable" here means that service is *eligible* for payment by PRC, as compared to a service provided to a patient who does not qualify for PRC.

According to the district court, FAQ No. 11 purportedly imposes a "source of funds" requirement. But FAQ No. 11 addresses circumstances in which, based on the premise of the question, PRC funds are used to pay for a service—it does not ask whether they *must* be used.

> Q: We use Third Party funds to add to our [PRC] funds. Do Medicare-like rates apply for these services?
>
> A: Yes, as long as the [PRC] pays for the services and follows the regulations that apply to [PRC] and client eligibility (42 CFR Part 136).
>
> FAQ, RE 173-27, PageID#9276.

The answer reflected the premise of the question, that PRC funds were used, and cannot fairly be read as imposing a requirement to circumstances outside the scope of the question.[8] The answer confirms that PRC funds can be supplemented with third-party sources and directly refutes the notion of a "source of funds" limitation.

The third FAQ that the district court relied on, No. 29, also does not support a "source of funds" requirement:

> Q: What services are payable at Medicare-like rates?
>
> A: Any service or supply for which Medicare would otherwise pay . . . . In addition, the service or supply must be provided to a [PRC] eligible individual and paid by an IHS or tribal [PRC] program or by an Urban Indian program.
>
> FAQ, RE 173-27, PageID#9278.

[8] The district court indicates it does not agree that tribes can use third-party funds. Aug. 7 Order, RE 197, PageID#12649. This is directly contrary to multiple federal statutes. *See* part III.C.2, *infra*.

While this response refers to claims being "paid by" PRC, it does not impose any "source of funds" requirement for such payment. If authorization of a claim results in the disbursement of payment from funds designated by the tribe, then it is paid by PRC. This is the only reasonable interpretation of FAQ No. 29, especially in the context of the nine other FAQs that expressly exclude a "source of funds" requirement.

C. Tribal Self-Governance and Indian Health Statutes and Policies Support the Tribal Interpretation of the MLR Regulation.

The district court failed to understand, and actively interfered with, tribal self-governance rights. Its interpretation of the MLR Regulation, should it become controlling law, would severely limit tribes' ability to manage their health programs efficiently. The district court claimed to recognize the rights of tribes to manage their health programs, conserve health funds, and even to supplement their health program funds—but it made findings that directly undermine those rights. There is no countervailing policy goal, or any other justification, for the district court's decision.

1. Federal Self-Governance Statutes and Policy Encourage and Protect Tribal Rights to Design and Manage Health Programs to Meet Community Needs.

It is the policy of the United States to encourage Indian participation in "the planning and management" of the health services that the federal government is

otherwise obligated to provide to Indians under its trust and statutory obligations. 25 U.S.C. § 1601(3). This federal policy is accomplished in large part through ISDEAA, which created the framework for tribes to enter agreements with the United States to take on responsibility for the design and operation of tribal health programs. Self-determination requires that tribes have an "effective voice . . . in the planning and implementation of programs for the benefit of Indians which are responsive to the true needs of Indian communities." 25 U.S.C. § 5301(a)(1). It calls for a "transition from the Federal domination of programs for, and services to, Indians to effective and meaningful participation by the Indian people in the planning, conduct, and administration of those programs and services." 25 U.S.C. § 5302(b).

Under ISDEAA, the federal government transfers the operation of direct healthcare, PRC programs, and other services to individual tribes. The tribes receive federal funding for the transferred health programs and become responsible for the design and administration of those programs to meet the needs of the tribes and their members—in contrast to the one-size-fits-all approach of federally operated programs. To this end, ISDEAA guarantees the tribes' right to "redesign or consolidate programs . . . in any manner which the Indian tribe deems to be in the best interest of the health and welfare of the Indian community being served."

25 U.S.C. § 5386(e). For tribes that operate programs under ISDEAA Title V, this right is not subject to the United States' review or consent. *Id*.[9]

The district court claimed to uphold the principle that "the Tribe has the authority to manage its own plan to maximize the use of PRC dollars as well as any other resource available to the Tribe" and "to create and manage the program in a way it sees fit." Feb. 21 Order, RE 202, Page ID #12794. But, according to the district court, a tribe's right "to create and manage the program in a way it sees fit" somehow "requires a different process than the one created by the [Saginaw Chippewa] Tribe to manage its PRC Program" and that tribes must instead "create a system similar to Redding Rancheria." Feb. 21 Order, RE 202, Page ID #12791. The court was referring to the *Redding Rancheria v. Hargan* decision, which upheld a tribe's right to redesign its ISDEAA health programs—including significant changes to the procedures for authorizing PRC services and issuing payment. 296 F. Supp. 3d 256 (D.D.C. 2017). Redding Rancheria's system worked well for that tribe, but that does not mean it is appropriate to impose it on other tribes as a "one size fits all" system. Redding Rancheria's system was designed to

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[9] Proposals for program modification under Title I must be submitted to the Secretary for approval, and the Secretary may only decline under limited circumstances. 25 U.S.C. 5324(j).

meet the needs of its community, as discussed in greater detail in Part III, below, but there are multiple ways for tribes to design their health programs, including PRC. A different approach may be more suitable for other tribes.

The district court begrudgingly acknowledged "Congress' general intention 'to expand tribal access to federal resources, programs, and benefits.'" Feb. 21 Order, RE 202, Page ID #12791 (citing RE 199, PageID#12683-84). But according to the district court, "adopting the interpretation proposed by Plaintiffs (that actual [PRC] qualification and payment [by a PRC Program] is not required for MLR to apply) would not always further the intent of the legislation, specifically to conserve IHS funds." Feb. 21 Order, RE 202, Page ID #12791. The district court's position was based on a hypothetical and convoluted arrangement under which a tribe might apply the MLR Regulation and not save money. *Id*. It is not appropriate for the court to foreclose a mechanism that Tribes may use when it is effective on the basis that it *might* be possible to implement the mechanism in a way that is not effective. The district court's substitution of its judgment for that of the tribes about what is in their best interest is an affront to the principles of self-governance and, because it assumes that tribes will not be responsible with their money, it is a sad remnant of the paternalism that long characterized federal Indian policy. Amici submit this brief to protect their right to implement efficient health care programs,

and the district court's decision, should it become controlling law, takes that right away.

2. The District Court's Decision Undermines and Interferes with Tribes' Exercise of their Self-Governance Rights.

Self-governance includes tribal authority over budgeting and funding allocation. 25 U.S.C. §§ 5386(e); 5325(o). Tribes may "reallocate or redirect funds" for ISDEAA programs "in any manner which the Indian tribe deems to be in the best interest of the health and welfare of the Indian community being served." § 5386(e). The district court's treatment of "PRC Funds" or "IHS funds" as something distinct and separate from the funds that support other tribal health programs is factually incorrect, inconsistent with the realities of tribal government budgeting, and antithetical to federal Indian health and self-governance policies and the statutes enacted to carry out those policies.

IHS funding and programs alone are not adequate to meet the healthcare needs of American Indian patients.[10] Tribes contribute their own funds to their

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[10] DEP'T OF HEALTH & HUMAN SERVS., INDIAN HEALTH SERV., JUSTIFICATION OF ESTIMATES FOR APPROPRIATIONS COMMITTEES, FISCAL YEAR 2021 at CJ-188 (Feb. 5, 2020) ("Public and private collections represent a significant portion of the IHS and Tribal health care delivery budgets."), *available at* https://www.ihs.gov/sites/budgetformulation/themes/responsive2017/display_objects/documents/FY_2021_Final_CJ-IHS.pdf; U.S. GAO, *Indian Health Service:*

healthcare budgets to make up the shortfall—a major factor behind Congress passing the Medicare Modernization Act[11]—by supplementing direct care programs and providing self-insured health plans so that covered patients can efficiently obtain care from outside providers.

PRC funding is supported by IHS funds allocated in the federal budget and other sources of funding. Tribal and IHS health programs generate revenues by billing private insurance, Medicare, Medicaid, or similar sources, for services provided in their facilities. This is referred to as "third-party revenue" or "program income" and it must be used for the tribe's health programs. 25 U.S.C. § 5388(j) ("program income earned by an Indian tribe shall be treated as supplement funding to that negotiated in the funding agreement"); § 5325(m) (use of program income under Title I contract); 25 U.S.C. § 1641(d)(2)(A) (tribes may use income from

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Actions Needed to Improve Oversight of Federal Facilities' Decision-Making About the Use of Funds, GAO-21-20 (Washington, D.C.: Nov. 12, 2020) ("IHS and tribal leaders have reported that the total amount of funding available to support the provision of health care to [American Indians and Alaska Natives] has been insufficient").

[11] H.R. Rep. No. 108-391, at 656 (2003) ("[PRC] funding across all IHS programs has been insufficient to cover all IHS and tribal costs. When the costs are not reimbursed through appropriations, the tribes and IHS use program funds to make up the difference.").

Medicare and Medicaid billing for "coverage for a service or service [*sic*] within a [PRC] delivery area"); 25 U.S.C. § 1621f(a)(1) (other sources of income may be used for the purposes set forth in § 1641(d), *i.e.*, coverage for PRC service).[12] This is true for IHS-operated programs as well; they rely on program income for as much as 60% of their funding.[13]

Critically, there is no generally applicable requirement that tribes use any specific mechanism to supplement their PRC program. Making those decisions is an exercise of self-governance and sovereignty. The statutes that enable tribes to supplement their health programs impose no requirement to make advance designation or allocation to a specific account—purpose matters, not internal accounting procedures. *E.g.*, 25 U.S.C. §§ 5386(e); 5325(o) (power to reallocate funds to meet needs of the community). Thus, tribes may pay for PRC obligations from, among other things, funds set aside for emergencies or general health program expenditures, even if the account is not designated solely for PRC program use. This approach could be useful to tribes that need to maintain financial flexibility by not committing funds to a specific purpose until they know

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[12] ISDEAA agreements often confirm a tribe's right to contribute and use supplemental funding for ISDEAA programs.

[13] *See* footnote 10, *supra*.

they are needed. Tribal self-insurance itself may be a form of supplemental PRC funding. If care is authorized under PRC program standards, then payment by self-insurance—*i.e.*, from tribal funds—is supplemental PRC funding. The district court would give more significance to the name on a bank account than purpose of an expenditure. It is an exercise in micromanagement of tribal government, contrary to all fundamental principles of self-governance.

III. *REDDING RANCHERIA* CONFIRMS TRIBAL SELF-GOVERNANCE RIGHTS AND SUPPORTS THE TRIBAL INTERPRETATION OF THE MLR REGULATION.

The district court claimed to rely on *Redding Rancheria v. Hargan*. But *Redding Rancheria*, unlike the district court's decision, is notable for decisively *rejecting* IHS interpretations of statute, regulation, and policy that limited tribal rights to design PRC programs to meet the needs of their communities. *Redding Rancheria* supports the ability of tribes to coordinate self-insurance and PRC to maximize healthcare efficiencies. 296 F. Supp.3d at 268-69. The district court somehow missed these important points and concluded that its interpretation of the MLR Regulations was "supported by" *Redding Rancheria*—it cited the case repeatedly and claimed to follow it closely. Aug. 7 Order, RE 197, PageID#12652. It is therefore important to clarify what *Redding Rancheria* decided, and what the district court got wrong.

In *Redding Rancheria*, the Tribe operated a self-insurance program and a PRC program. It designed its PRC program to coordinate with self-insurance to provide healthcare efficiently, pay providers promptly, and ensure that high-cost care would be eligible for reimbursement from the IHS Catastrophic Health Emergency Fund ("CHEF"). Claims were submitted first to the self-insurance plan, which would identify PRC-eligible claims, and issue provisional payment at MLR. PRC reviewed the claims for final authorization and the self-insurance plan reserved the right to seek reimbursement from PRC. IHS refused to recognize that the claims were paid on behalf of PRC for purposes of CHEF applications. IHS contended that in order to qualify as valid PRC obligation, payments must be issued directly to providers from the PRC program—on *paper* checks, no less—and could not be administered through the self-insurance plan. 296 F. Supp.3d at 262, 268. IHS insisted that the Tribe operate its PRC program exactly like an IHS program, and refused to consider the Tribe's CHEF applications unless it complied. *Id*. at 268. The *Redding Rancheria* court rejected IHS' interpretation and agreed with the Tribe. *Id.* at 273.

The district court's conclusions here are contrary to the specific details and fundamental principles of the case. According to the district court:

> [I]n [*Redding*] *Rancheria*, the parties understood that MLR would only apply to [PRC] services that were funded

> by [PRC]. . . If the source of funds had been irrelevant, it would have made little sense for the tribe to have differentiated between the two sources as it did. The specific structuring of the self-insurance plan in relation to the [PRC] indicates that only services paid for by the [PRC], not a self-insurance plan, are eligible for MLR. . . the *Rancheria* court did not note anything unusual about [the Tribe' system] and presumed that it was structured specifically to comply with the laws governing MLR.
>
> Aug. 7 Order, RE 197, PageID#12654.

In fact, Redding Rancheria's self-insurance plan made payments "on behalf of and as a distribution agent for the [PRC] program," and MLR applied to the payments. 296 F. Supp.3d at 262. Redding Rancheria implemented reimbursement arrangements from PRC to self-insurance (among other measures) in an effort to satisfy IHS' demands for CHEF applications—not for MLR eligibility. *Id*. at 263, 273. There was no dispute regarding eligibility for MLR. The IHS Director, in her official capacity, was a party to the case and never contended that the MLR Regulation imposed a "source of funds" limitation. *Redding Rancheria* is a decision that confirms tribal self-governance rights to "plan, conduct and administer" its health programs, enables efficient implementation of tribal health programs, and protects tribal health resources. 296 F. Supp.3d at 260, 273.

CONCLUSION

Amici curiae request that this Court reverse the district court and confirm that the MLR Regulation applies to services "authorized" by a tribe carrying out a PRC program, with no "source of funding" requirement.

Respectfully submitted,

May 10, 2021

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CERTIFICATE OF COMPLIANCE

I certify that this brief complies with the type-volume limitations of Fed. R. App. P. 29(a)(5) and 32(a)(7)(B) because, excluding the items permitted by Fed. R. App. P. 32(f) and Circuit Rule 32(b), this brief contains 6,441 words, including footnotes.

This Brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) because it has been prepared in a proportionally spaced typeface in Microsoft Word using Times New Roman, 14-point font. As permitted by Federal Rule of Appellate Procedure 32(a)(7)(C), I have relied upon the word count feature of Microsoft Word Office 365 in preparing this certificate.

Dated: May 10, 2021 By: s/ James K. Nichols
James K. Nichols

CERTIFICATE OF SERVICE

I hereby certify that on May 10, 2021, I electronically filed the foregoing brief with the Clerk of the Court using the CM/ECF system. I certify that the participants of this case are registered CM/ECF users and that service will be accomplished by the appellate CM/ECF system.

s/ James K. Nichols

ADDENDUM

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(INCLUDING TRIBAL ORGANIZATION MEMBERS)

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Alaska Native Health Board

Bois Forte Band of Chippewa Indians

Chickasaw Nation

Chippewa Cree Tribe of the Rocky Boy Reservation

Chitimacha Tribe of Louisiana

Choctaw Nation

Coquille Indian Tribe

Eastern Band of Cherokee Indians

Gila River Indian Community

Grand Traverse Band of Ottawa and Chippewa Indians

Hopi Tribe

Jamestown S'Klallam Tribe

Keweenaw Bay Indian Community

Lower Sioux Indian Community

Mashantucket Pequot Tribal Nation

Match-E-Be-Nash-She-Wish Band of Pottawatomi Indians of Michigan

Menominee Indian Tribe of Wisconsin

Miami Tribe of Oklahoma

Midwest Alliance of Sovereign Tribes

Mississippi Band of Choctaw Indians

Mohegan Tribe of Indians of Connecticut

National Congress of American Indians

National Indian Health Board

Nisqually Indian Tribe

Northwest Portland Area Indian Health Board

Nottawaseppi Huron Band of the Potawatomi

Oneida Nation

Pechanga Band of Luiseño Indians

Poarch Band of Creek Indians

Prairie Island Indian Community

Puyallup Tribe of Indians

Redding Rancheria

Saint Regis Mohawk Tribe

Salt River Pima-Maricopa Indian Community

San Pasqual Band of Mission Indians

Santa Rosa Rancheria Tachi Yokut Tribe

Santa Ynez Band of Chumash Mission Indians

Sault Ste. Marie Tribe of Chippewa Indians

Seminole Tribe of Florida

Shasta Administrative Services

Suquamish Tribe

Swinomish Indian Tribal Community

Table Mountain Rancheria

Tohono O'odham Nation

United South and Eastern Tribes Sovereignty Protection Fund

Ute Mountain Ute Tribe

Winnebago Tribe of Nebraska

The National Congress of American Indians ("NCAI") members include many of the 574 federally recognized Indian tribes. Founded in 1944, the NCAI is the oldest, largest, and most representative American Indian and Alaska Native organization serving the broad interests of tribal governments and communities.

The Midwest Alliance of Sovereign Tribes, (MAST), founded in 1996, represents the 35 sovereign tribal nations of Minnesota, Wisconsin, Iowa, and

Michigan. Altogether, MAST represents nearly 134,000 American Indian people. MAST's mission is to advance, protect, preserve, and enhance the mutual interests, treaty rights, sovereignty, and cultural way of life of the sovereign nations of the Midwest throughout the 21st century. The organization coordinates important public policy issues and initiatives at the state, regional and federal levels, promotes unity and cooperation among member tribes and advocates for member tribes.

The Alaska Native Health Board members include all 229 federally recognized Tribal Nations in Alaska:

Agdaagux Tribe of King Cove
Akiachak Native Community
Akiak Native Community
Alatna Village
Algaaciq Native Village (St. Mary's)
Allakaket Village
Alutiiq Tribe of Old Harbor
Angoon Community Association
Anvik Village
Arctic Village (See Native Village of Venetie Tribal Government)
Asa'carsarmiut Tribe
Atqasuk Village (Atkasook)
Beaver Village
Birch Creek Tribe
Central Council of the Tlingit & Haida Indian Tribes
Chalkyitsik Village
Cheesh-Na Tribe (previously listed as the Native Village of Chistochina)
Chevak Native Village
Chickaloon Native Village

Chignik Bay Tribal Council (previously listed as the Native Village of Chignik)
Chignik Lake Village
Chilkat Indian Village (Klukwan)
Chilkoot Indian Association (Haines)
Chinik Eskimo Community (Golovin)
Chuloonawick Native Village
Circle Native Community
Craig Tribal Association
Curyung Tribal Council
Douglas Indian Association
Egegik Village
Eklutna Native Village
Emmonak Village
Evansville Village
Galena Village
Gulkana Village
Healy Lake Village
Holy Cross Village
Hoonah Indian Association
Hughes Village
Huslia Village
Hydaburg Cooperative Association
Igiugig Village
Inupiat Community of the Arctic Slope
Iqurmuit Traditional Council
Ivanoff Bay Tribe
Kaguyak Village
Kaktovik Village (aka Barter Island)
Kasigluk Traditional Elders Council
Kenaitze Indian Tribe
Ketchikan Indian Corporation
King Island Native Community
King Salmon Tribe
Klawock Cooperative Association
Knik Tribe
Kokhanok Village
Koyukuk Native Village

Levelock Village
Lime Village
Manley Hot Springs Village
Manokotak Village
McGrath Native Village
Mentasta Traditional Council
Metlakatla Indian Community, Annette Island Reserve
Naknek Native Village
Native Village of Afognak
Native Village of Akhiok
Native Village of Akutan
Native Village of Aleknagik
Native Village of Ambler
Native Village of Atka
Native Village of Barrow Inupiat Traditional Government
Native Village of Belkofski
Native Village of Brevig Mission
Native Village of Buckland
Native Village of Cantwell
Native Village of Chenega (aka Chanega)
Native Village of Chignik Lagoon
Native Village of Chitina
Native Village of Chuathbaluk (Russian Mission, Kuskokwim)
Native Village of Council
Native Village of Deering
Native Village of Diomede (aka lnalik)
Native Village of Eagle
Native Village of Eek
Native Village of Ekuk
Native Village of Ekwok
Native Village of Elim
Native Village of Eyak (Cordova)
Native Village of False Pass
Native Village of Fort Yukon
Native Village of Gakona
Native Village of Gambell
Native Village of Georgetown
Native Village of Goodnews Bay

Native Village of Hamilton
Native Village of Hooper Bay
Native Village of Kanatak
Native Village of Karluk
Native Village of Kiana
Native Village of Kipnuk
Native Village of Kivalina
Native Village of Kluti Kaah (aka Copper Center)
Native Village of Kobuk
Native Village of Kongiganak
Native Village of Kotzebue
Native Village of Koyuk
Native Village of Kwigillingok
Native Village of Kwinhagak (aka Quinhagak)
Native Village of Larsen Bay
Native Village of Marshall (aka Fortuna Ledge)
Native Village of Mary's Igloo
Native Village of Mekoryuk
Native Village of Minto
Native Village of Nanwalek (aka English Bay)
Native Village of Napaimute
Native Village of Napakiak
Native Village of Napaskiak
Native Village of Nelson Lagoon
Native Village of Nightmute
Native Village of Nikolski
Native Village of Noatak
Native Village of Nuiqsut (aka Nooiksut)
Native Village of Nunam Iqua
Native Village of Nunapitchuk
Native Village of Ouzinkie
Native Village of Paimiut
Native Village of Perryville
Native Village of Pilot Point
Native Village of Pitka's Point
Native Village of Point Hope
Native Village of Point Lay
Native Village of Port Graham

Native Village of Port Heiden
Native Village of Port Lions
Native Village of Ruby
Native Village of Saint Michael
Native Village of Savoonga
Native Village of Scammon Bay
Native Village of Selawik
Native Village of Shaktoolik
Native Village of Shishmaref
Native Village of Shungnak
Native Village of Stevens
Native Village of Tanacross
Native Village of Tanana
Native Village of Tatitlek
Native Village of Tazlina
Native Village of Teller
Native Village of Tetlin
Native Village of Tuntutuliak
Native Village of Tununak
Native Village of Tyonek
Native Village of Unalakleet
Native Village of Unga
Native Village of Venetie Tribal Government (Arctic Village and Village of Venetie)
Native Village of Wales
Native Village of White Mountain
Nenana Native Association
New Koliganek Village Council
New Stuyahok Village
Newhalen Village
Newtok Village
Nikolai Village
Ninilchik Village
Nome Eskimo Community
Nondalton Village
Noorvik Native Community
Northway Village
Nulato Village

Nunakauyarmiut Tribe
Organized Village of Grayling (*aka* Holikachuk)
Organized Village of Kake
Organized Village of Kasaan
Organized Village of Kwethluk
Organized Village of Saxman
Orutsararmiut Traditional Native Council (aka Bethel)
Oscarville Traditional Village
Pauloff Harbor Village
Pedro Bay Village
Petersburg Indian Association
Pilot Station Traditional Village
Platinum Traditional Village
Portage Creek Village (aka Ohgsenakale)
Pribilof Islands Aleut Communities of St. Paul & St. George Islands
Qagan Tayagungin Tribe of Sand Point Village
Qawalangin Tribe of Unalaska
Rampart Village
Saint George Island (See Pribilof Islands Aleut Communities of St. Paul & St. George Islands)
Saint Paul Island (See Pribilof Islands Aleut Communities of St. Paul & St. George Islands)
Seldovia Village Tribe
Shageluk Native Village
Sitka Tribe of Alaska
Skagway Village
South Naknek Village
Stebbins Community Association
Sun'aq Tribe of Kodiak
Takotna Village
Tangimaq Native Village (formerly Lesnoi Village (aka Woody Island))
Telida Village
Traditional Village of Togiak
Tuluksak Native Community
Twin Hills Village
Ugashik Village
Umkumiut Native Village
Village of Alakanuk

Village of Anaktuvuk Pass
Village of Aniak
Village of Atmautluak
Village of Bill Moore's Slough
Village of Chefornak
Village of Clarks Point
Village of Crooked Creek
Village of Dot Lake
Village of Iliamna
Village of Kalskag
Village of Kaltag
Village of Kotlik
Village of Lower Kalskag
Village of Ohogamiut
Village of Red Devil
Village of Salamatoff
Village of Sleetmute
Village of Solomon
Village of Stony River
Village of Venetie (See Native Village of Venetie Tribal Government)
Village of Wainwright
Wrangell Cooperative Association
Yakutat Tlingit Tribe
Yupiit of Andreafski

The Northwest Portland Area Indian Health Board member Tribes include:

Burns-Paiute Tribe
Chehalis Tribe
Coeur d'Alene Tribe
Colville Tribe
Coos, Siuslaw, & Lower Umpqua Tribe
Coquille Tribe
Cow Creek Tribe
Cowlitz Tribe
Grand Ronde Tribe
Hoh Tribe

Jamestown S'Klallam Tribe
Kalispell Tribe
Klamath Tribe
Kootenai Tribe
Lower Elwha Tribe
Lummi Tribe
Makah Tribe
Muckleshoot Tribe
Nez Perce Tribe
Nisqually Tribe
Nooksack Tribe
NW Band of Shoshoni Tribe
Port Gamble S'Klallam Tribe
Puyallup Tribe
Quileute Tribe
Quinault Tribe
Samish Indian Nation
Sauk-Suiattle Tribe
Shoalwater Bay Tribe
Shoshone-Bannock Tribe
Siletz Tribe
Skokomish Tribe
Snoqualmie Tribe
Spokane Tribe
Squaxin Island Tribe
Stillaguamish Tribe
Suquamish Tribe
Swinomish Tribe
Tulalip Tribe
Umatilla Tribe
Upper Skagit Tribe
Warm Springs Tribe
Yakama Nation

The United South and Eastern Tribes Sovereignty Protection Fund member Tribes include:

Alabama-Coushatta Tribe of Texas

Aroostook Band of Micmacs
Catawba Indian Nation
Cayuga Nation
Chickahominy Indian Tribe
Chickahominy Indian Tribe – Eastern Division
Chitimacha Tribe of Louisiana
Coushatta Tribe of Louisiana
Eastern Band of Cherokee Indians
Houlton Band of Maliseet Indians
Jena Band of Choctaw Indians
Mashantucket Pequot Indian Tribe
Mashpee Wampanoag Tribe
Miccosukee Tribe of Indians
Mississippi Band of Choctaw Indians
Mohegan Tribe of Indians of Connecticut
Monacan Indian Nation
Nansemond Indian Nation
Narragansett Indian Tribe
Oneida Indian Nation
Pamunkey Indian Tribe
Passamaquoddy Tribe – Indian Township Reservation
Passamaquoddy Tribe – Pleasant Point Reservation
Penobscot Indian Nation
Poarch Band of Creek Indians
Rappahannock Tribe, Inc.
Saint Regis Mohawk Tribe
Seminole Tribe of Florida
Seneca Nation of Indians
Shinnecock Indian Nation
Tunica-Biloxi Tribe of Louisiana
Upper Mattaponi Indian Tribe
Wampanoag Tribe of Gay Head (Aquinnah)