No. 21-08046

UNITED STATES COURT OF APPEALS
FOR THE TENTH CIRCUIT

NORTHERN ARAPAHO TRIBE,

Appellant,

v.

XAVIER BECERRA, *et al.*,

Appellees.

On Appeal from the United States District Court for the
District of Wyoming, No. 0:21-cv-00037-NDF
Before the Honorable Nancy D. Freudenthal

BRIEF AMICI CURIAE OF NATIVE AMERICAN TRIBES, TRIBAL ORGANIZATIONS, INDIAN HEALTH BOARDS AND THE NATIONAL CONGRESS OF AMERICAN INDIANS IN SUPPORT OF APPELLANT AND IN SUPPORT OF REVERSAL

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RULE 26.1 DISCLOSURE STATEMENT

The Alaska Native Health Board is a nonprofit organization that has no parent corporation. No publicly held corporation owns 10% or more of its stock.

The Alaska Native Tribal Health Consortium is an intertribal consortium that has no parent corporation. No publicly held corporation owns 10% or more of its stock.

The Arctic Slope Native Association is an intertribal consortium that has no parent corporation. No publicly held corporation owns 10% or more of its stock.

The Copper River Native Association is an intertribal consortium that has no parent corporation. No publicly held corporation owns 10% or more of its stock.

The Kodiak Area Native Association is an intertribal consortium that has no parent corporation. No publicly held corporation owns 10% or more of its stock.

The National Congress of American Indians is a nonprofit organization that has no parent corporation. No publicly held corporation owns 10% or more of its stock.

Navajo Health Foundation – Sage Memorial Hospital is a tribal organization that has no parent corporation. No publicly held corporation owns 10% or more of its stock.

The Northwest Portland Area Indian Health Board is a nonprofit organization that has no parent corporation. No publicly held corporation owns 10% or more of its stock.

Riverside-San Bernardino County Indian Health, Inc. is an intertribal consortium that has no parent corporation. No publicly held corporation owns 10% or more of its stock.

Southeast Alaska Regional Health Consortium is an intertribal consortium that has no parent corporation. No publicly held corporation owns 10% or more of its stock.

Tanana Chiefs Conference is an intertribal consortium that has no parent corporation. No publicly held corporation owns 10% or more of its stock.

All other amici are federally recognized Indian Tribes.

INTEREST OF AMICI[1]

Amici include 19 federally recognized Tribes and tribal organizations (Tribal Amici) that operate Indian Health Service (IHS) hospitals, clinics, facilities and other Federal programs pursuant to contracts awarded under Titles I or V of the Indian Self-Determination and Education Assistance Act of 1975, 25 U.S.C. §§ 5301-5423 (ISDA or Act).[2] Amici also include the Alaska Native Health Board, the Northwest Portland Area Indian Health Board (two regional tribal advocacy organizations) and the National Congress of American Indians (the largest and oldest national tribal advocacy organization in the country).

In carrying out their contracts with IHS, Tribal Amici bill and collect third-party revenues from Medicare, Medicaid, and private insurers—constituting program income under their self-determination contracts—and they in turn spend that program income to fund the Federal programs they operate under those same contracts. Amici therefore have a compelling interest in vindicating Congress's promise that all Tribal Amici's contract support costs associated with operating

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[1] All parties have consented to the filing of this brief pursuant to Federal Rule of Appellate Procedure 29(a)(2). No party's counsel authored this brief in whole or in part; no party or party's counsel contributed money intended to fund preparation or submission of this brief; and 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.

[2] Tribal Amici are listed in the attached Addendum.

those Federal programs will be reimbursed in full, so that no Federal program would either be reduced or required to be subsidized by the Tribes to cover those costs.

INTRODUCTION

The Indian Self-Determination Act empowers Indian Tribes to contract for the operation of federal Indian programs that would otherwise be operated by IHS. 25 U.S.C. §§ 5321(a)(1)-(2); *Cherokee Nation of Okla. v. Leavitt*, 543 U.S. 631, 634 (2005). The Act mandates that IHS shall reimburse a contracting Tribe for the full contract support costs a Tribe reasonably and prudently incurs in the administration of the "Federal program" being carried out under its contract with IHS, i.e., the same "Federal program" that IHS previously operated. 25 U.S.C. § 5325(a)(2), (a)(3)(A)(i)–(ii).

That "Federal program" necessarily means the full Federal program—both the portion of that program funded with appropriated dollars and the portion funded with program income. This result is compelled by the text and history of the Act, which indicate that Congress intended a broad reading of the contract support cost provisions and that it understood program income to be an integral part of the "Federal program." It is also compelled by the plain meaning of the term "Federal program" and IHS's own explanations to Congress of the Federal programs it operates.

The district court erred in ruling otherwise. If Congress had wished to limit IHS's reimbursement obligation to those services funded directly program dollars appropriated to IHS, Congress certainly knew how to do so (as it addressed "appropriations" elsewhere in the Act). Yet Congress did not do so in the contract support cost provisions, choosing to tie the contract support cost obligation broadly to the entire "Federal program."

Congress enacted the ISDA's contract support cost provisions precisely "[b]ecause of 'concern with [the] Government's past failure adequately to reimburse tribes' indirect administrative costs.'" *Salazar v. Ramah Navajo Chapter*, 567 U.S. 182, 186 (2012) (quoting *Cherokee Nation of Okla.*, 543 U.S. at 639). IHS's attempt to exclude the program income-funded portion of the "Federal program" represents yet another attempt by the agency to avoid its contract support cost obligations in defiance of Congress's command. IHS's actions violate the ISDA's contract support cost provisions and directly cut the level of Federal health care services Tribes are able to provide under their contracts, contrary to the statutory design. The district court's decision endorsing that approach should be reversed.

I. THE HISTORY OF CONGRESSIONAL ACTIONS AUTHORIZING THE COLLECTION AND EXPENDITURE OF PROGRAM INCOME CONFIRM THAT PROGRAM INCOME IS AN INTEGRAL PART OF THE "FEDERAL PROGRAM."

This dispute turns on whether the "Federal program" under § 5325(a)(3)(A) includes services that are funded with program income, or is limited to only services funded directly by the appropriated funds the "Secretary would have otherwise provided for the operation of the [contracted] programs," 25 U.S.C. §§ 5325(a)(1) (also known as the "secretarial amount"). *See also* Aplt. App. at 117–18 (Order Granting Defs.' Mot. to Dismiss, at 2–3). The IHS position implicitly assumes that the services funded by program income are a separate class of services distinguishable from those funded by the secretarial amount. The distinction is a false one.

Program income funds services in the same facilities, by the same providers, and to the same patients as the secretarial amount. 25 U.S.C. §§ 1621f(a)(1), 1641(c)(1)(B), 1641(d)(2)(A), 5325(m)(1), 5388(j); 42 U.S.C. § 1395qq(c). IHS and Tribes must serve all eligible patients, and the obligation to do so is not contingent on the source of funds. 25 U.S.C. § 5324(h); 42 C.F.R. § 136.12. Tribes cannot favor patients who have Medicare or Medicaid coverage. 25 U.S.C. § 1641(b). There is no separate class of services that uniquely generate program income or that are uniquely funded with program income. IHS seeks to impose a false distinction between the two as if a Tribe's contracted programs were limited

to those services funded with the secretarial amount—not the full scope of services that Tribes actually provide under their ISDA agreements with IHS.

IHS has invented this distinction to avoid its funding obligations. It defies the plain text of the ISDA, as thoroughly explained in the Northern Arapaho Tribe's principal brief. It also defies Congressional intent, undermining the foundation of the ISDA. The development of the program income collection provisions was driven by Congressional recognition that the funding for Indian health programs was not adequate; as a direct result, Congress enacted provisions requiring both Tribes and the IHS to earn, bill, and collect program income. It has consistently been Congress's intent that program income would be used to remedy the deficiencies in funds appropriated to IHS, and, as a corollary, would be used to carry out IHS and ISDA-contracted Federal programs. At the same time, with the statutory requirement that IHS provide funds for contract support costs and related measures, Congress has gone to great lengths to avoid imposing a self-governance penalty—that is, to avoid putting Tribes in a position where they are forced to either cut or subsidize federal programs. Unfortunately, IHS has gone to equally great lengths to defy that mandate.

A. Congress Established Program Income as a Foundational Funding Source for IHS and Tribal Programs.

When the ISDA was first enacted in 1975, IHS programs were severely underfunded, and could not even come close to fulfilling the healthcare needs of

American Indians and Alaska Natives. H.R. Rep. No. 94-1026(III), at 21 (1976). At the same time, Congress recognized another problem in delivering healthcare to Indian patients. Medicare and Medicaid covered many Indians, but these existing "national health programs, designed to assist the general population, are difficult or impossible to apply to Indians" and "afford little relief because, given the unique social situation of most Indians, very few know they are eligible for Medicare." H.R. Rep. No. 94-1026(I), at 16. Federal funds had already been allocated to fund care for these individuals, but those funds were not being used. Meanwhile, the IHS and tribal facilities where those patients did receive care were not yet authorized to bill Medicare or Medicaid, even for services to patients who would otherwise be covered by the programs. In this context, a measure that otherwise seems like a circuitous route to address the lack of funding—as compared to simply increasing IHS appropriations—makes sense.

Thus, in 1976 Congress authorized IHS to bill Medicare and Medicaid for services provided by IHS and tribal facilities. Indian Health Care Improvement Act (IHCIA), Pub. L. No. 94-437, tit. IV, secs. 401 (Medicare), 402 (Medicaid), 90 Stat. 1400, 1408-10 (1976). Congress emphasized this measure was meant to increase the budget for under-funded tribal health programs: it specifically confirmed that "Medicare and Medicaid funds received by [IHS] be used to supplement—and not supplant—current IHS appropriations," and "that funds from

Medicare and Medicaid will be used to expand and improve current IHS health care services." H.R. Rep. No. 94-1026(I), at 108. To that end, Congress directed that the funds IHS collected were to be used by IHS "exclusively for the purpose of making any improvements in the facilities of such Service ['whether operated by such Service or by an Indian tribe or tribal organization']" as needed to "achieve compliance with the applicable conditions and requirements of [the Social Security Act]"—in other words, to meet the minimum standards applicable to hospitals that serve the general public. Sec. 402(c), 90 Stat. at 1409 (use of Medicaid funds); *see also* sec. 401(b), § 1880(c), 90 Stat. at 1408 (similar provision for use of Medicare funds).

In sum, third party billing originated in 1976 as a critical source of additional federal funding for the "Federal program," and the mechanism for the collection and distribution of these funds confirms this. IHS collected the funds, held the funds, and chose how to distribute the funds among IHS and tribally contracted facilities. *See* S. Rep. No. 106-152, at 2 (1999); H.R. Rep. No. 106-818(I), at 2 (2000). Initially, there was no requirement for IHS to return any of the collected funds to the facility whose services generated the funds that IHS collected, and IHS thus retained full control over all program income.

It is significant that in those early days of the ISDA, only a few Tribes had begun to assume responsibility for operating health programs under the Act, with

implementing regulations only just adopted. *See, e.g.*, Contracts Under the Indian Self-Determination Act, 40 Fed. Reg. 53,122, 53,142 (Nov. 14, 1975). In the following years, as Tribes transitioned to self-determination status, they assumed responsibility for Federal programs that, while operated by IHS, were now heavily reliant on program income. And when the Tribes assumed responsibility for those programs, they continued to receive distributions of program income from IHS. *See infra* at 15-18 (history of tribal authority to collect and receive program income). Thus, from the beginning of the ISDA's implementation, program income has been an integral and inseparable part of the Federal program that Tribes assumed under the Act and under their ISDA contracts with IHS.

B. Congress Acted to End Tribal Subsidies of Federal Programs.

Inadequate funding for medical care was just one problem facing tribal health programs. An equally "serious problem with implementation of the Indian self-determination policy" was the failure of IHS to "provide funding for the indirect costs [later termed "contract support costs"] associated with self-determination contracts." S. Rep. No. 100-274, at 8 (1987). This "practice . . . require[d] tribal contractors to ab[s]orb all or part of such indirect costs within the program level of funding, thus reducing the amount available to provide services to Indians as a direct consequence of contracting." *Id*. at 33; *see also id*. at 8-10 (discussing same). The agencies' failures to pay in full various contract "indirect

costs" also "resulted in a tremendous drain on tribal financial resources," *id*. at 7, because tribal contractors were compelled to "subsidize" the contracted programs, *id*. at 9. Concerned that Tribes would soon "choose . . . to retrocede the contract[s] back to the Federal agency," *id*. at 13, the Select Committee on Indian Affairs declared that IHS "must cease the practice of requiring tribal contractors to take indirect costs from the direct program costs, which results in decreased amounts of funds for services," *id*. at 12. Thus, in 1988, Congress amended the ISDA to require that IHS reimburse the Tribes' contract support costs. Pub. L. No. 100-472, sec. 205, 102 Stat. 2285, 2292 (1988). In doing so, Congress confirmed its intent that "Indian tribes should not be forced to use their own financial resources to subsidize federal programs." S. Rep. No. 100-274, at 9.

The original contract support cost provision simply required that IHS reimburse Tribes for the "reasonable costs for activities which must be carried on by a tribal organization as a contractor to ensure compliance with the terms of the contract and prudent management." Sec. 205, § 106(a)(2), 102 Stat. at 2292. It did not include the 1994 language at issue in this appeal and currently codified at 25 U.S.C. § 5325(a)(3)(A), requiring IHS to reimburse Tribes for the "direct program expenses for the operation of the Federal program" and "any additional administrative or other expense" incurred by the Tribe "in connection with the operation of the Federal program." In 1988, there was no need to include such a

provision because there was no distinction then between funds for the Federal program and funds received under the contract. Just like appropriated dollars, program income was all received by and distributed by IHS under the contract. Tribes had to request program income funds from their regional IHS Area Office, and if the request was approved "the Area Office would modify the tribe's '638' contract to reflect the actual amount received from IHS headquarters and which was to be paid to the tribe." S. Rep. No. 106-152, at 2; H.R. Rep. No. 106-818(I), at 2 . As discussed in greater detail below, when those circumstances changed, Congress added the "Federal program" language.

To the extent there is any doubt regarding Congress's intent, it is eliminated by the enactment of another statute that same year, confirming IHS's obligation to fund *tribal* "programs and facilities" on the "same basis" as *IHS* programs and facilities. Under 25 U.S.C. § 1680a, as enacted in 1988 and unchanged to this day:

> The Service shall provide funds for *health care programs and facilities operated by tribes and tribal organizations* under contracts with the Service entered into under the Indian Self-Determination Act—
>
> > (1) for the maintenance and repair of clinics owned or leased by such tribes or tribal organizations,
> >
> > (2) for employee training,
> >
> > (3) for cost-of-living increases for employees, and
> >
> > (4) for *any other expenses relating to the provision of health services, on the same basis as such funds are provided to programs and facilities operated directly by the Service*.

(Emphasis added.); *see* Pub. L. No. 100-713, sec. 705, § 711, 102 Stat. 4784, 4828 (1988).

Section 1680a refutes the notion that IHS's funding obligation is limited by the contract amount. It confirms the over-arching principle that Tribes are entitled to funding on an equal footing with IHS. It refers to "programs and facilities operated . . . under [tribal] contracts" and imposes *additional* funding obligations for expenses related to the operation of those programs and facilities but that may not be covered by the secretarial amount. The only limitation is whether IHS funds those functions for its own programs and facilities; if it does, it must fund tribal contracts on an equal basis.

This measure operates as a critical fail-safe to prevent tribal cutbacks, forced by inadequate funding in previous years, from spiraling out of control. As the 1987 Senate Report reflects, Congress knew that Tribes had both diverted program expenditures and cut back essential administrative and overhead expenses, all because IHS had failed to reimburse contract support costs in full. S. Rep. No. 100-274, at 8-9. Section 1680a complements section 5325(a)(2) and further ensures that these cutbacks are not just stopped, but reversed. IHS cannot refuse to fund an administrative or overhead function simply because a Tribe in the past cannibalized the Federal program or cut its overhead. If IHS and other federal agencies fund all the administrative costs associated with operating Federal

programs under IHS administration—and they do—then IHS is required by the ISDA to fund those same functions for Federal programs under tribal administration.[3]

C. Congress Gradually Shifted Control of Program Income from IHS to Tribes.

Consistent with the underlying principles of the ISDA—to carry out the "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)—in 1988 Congress took the first steps toward authorizing Tribes to bill and collect from Medicare and Medicaid directly, rather than forcing them to rely on IHS to collect the funds and decide how the funds would be spent. That year Congress amended the IHCIA to add a new five-year "demonstration program"

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[3] In addition to relying on other agencies within and outside the U.S. Department of Health and Human Services to support the administration of IHS programs, *see* Appellant's Br. at 22, 35, IHS also relies on a special budget account called Direct Operations for this purpose, *see, e.g.*, Dep't of Health & Human Servs., Indian Health Serv., Fiscal Year 2022 Justification of Estimates for Appropriations Committees, at CJ-197, https://www.ihs.gov/sites/budgetformulation/themes/responsive2017/display_objects/documents/FY_2022.pdf. None of IHS's program income collections are allocated to its Direct Operations overhead, which is funded entirely by funds appropriated to the IHS. *Id*. Conversely, all program income that IHS earns from third-party payers is added to its Federal program operations. *See id*. at 207. Under the ISDA and the IHCIA, Tribes likewise are required to add their program income to their Federal program operations. *See* Aplt. Br. at 30.

under which just four Indian Tribes would be permitted to participate. Sec. 402, 102 Stat. at 4818-20 (adding new § 405 to the IHCIA). However, IHS still retained substantial control over collections by these four Tribes. A Tribe wishing to participate in the demonstration program had to submit an application to the Secretary (not some other non-IHS agency like the Centers for Medicare and Medicaid Services). Sec. 402, § 405(c), 102 Stat. at 4819. In other words, IHS had to approve the Tribe's participation. The Tribes' collections were also "subject to all auditing requirements applicable to programs administered directly by the Service . . . ." *Id*. § 405(b)(2).

Except for the four Tribes in the limited demonstration program, the collection and distribution of program income remained under the control of IHS after 1988. IHS continued to collect Medicare and Medicaid for the hundreds of Tribes not in the demonstration program. IHS then transferred those payments to the contracting Tribe *under each Tribe's ISDA contract*, by "modify[ing] the Tribe's '638' contract to reflect" the amount of program income earned by the Tribe (but billed and collected by IHS on the Tribe's behalf). S. Rep. No. 106–152, at 2.

Congress did take one step in 1988 to enhance tribal receipt of funds IHS collected for services at tribal facilities, by mandating that 50% of the Secretary's collections had to now be returned to the tribal facility where the services being

billed were performed. Sec. 401(a)(3), 102 Stat. at 4818. In 1992, Congress increased the minimum amount to 80%. *See* Pub. L. No. 102-573, sec. 401, § 402(a), 106 Stat. 4526, 4565 (1992) (rewriting § 402 of the IHCIA).[4]

D. In 1994 Congress Amended the ISDA to Apply the Contract Support Cost Requirement to the Entire Federal Program.

This was the state of affairs when in 1994 Congress updated the ISDA's contract support cost provisions once again, this time to require that these costs be reimbursed with respect to "the operation of the Federal program that is the subject of the contract." 25 U.S.C. § 5325(a)(3)(A)(i) (added by Pub. L. No. 103-413, sec. 102, § 14(C), 108 Stat. 4250, 4257-58 (1994)). Congress spoke of costs supporting the operation of the "Federal program" under the ISDA contract at a time when that contract included the program income funding that the Secretary was annually adding to each contract. This context and history confirm that Congress in 1994 must have intended contract support costs to cover the entire Federal program

[4] The program income amounts were so much a part of the Federal program that IHS had a practice of decreasing appropriated funds that supported programs with substantial collections. Until 1992, the "amounts collected from Medicare and Medicaid [were] considered in determining the amount of appropriated funds the facility should receive." H.R. Rep. No. 102-643(I), at 50-51 (1992); S. Rep. No. 102-392, at 28 (1992). In 1992, Congress sought to "clarif[y] that any payments received from Medicare shall not be considered in determining appropriations for health care and services to Indians." S. Rep. No. 102-392, at 29. The ISDA currently provides that earning program income "shall not be a basis for reducing the amount of funds otherwise obligated to the contract." 25 U.S.C. § 5325(m)(2).

under contract, and not just the portion funded with dollars appropriated to the IHS.

In 1994 Congress also reaffirmed its intent that "program" resources should be used for healthcare services, not contract management:

> Throughout this section the Committee's objective has been to assure that there is no diminution in *program resources* when programs, services, functions or activities are transferred to tribal operation. In the absence of section 106(a)(2) as amended, a tribe would be compelled to divert *program funds* to prudently manage the contract, a result Congress has consistently sought to avoid.

S. Rep. No. 103-374, at 9 (1994) (emphasis added) (Committee on Indian Affairs). Congress was seeking to protect not just the secretarial amount, but *all* "program resources" (which includes the program income funding IHS was adding to each contract)—an intentionally broad term that defies any attempt by IHS to impose a limitation. Here too, IHS has defied the congressional mandate.

E. Congress Expanded Tribal Control of Program Income.

Having confirmed under multiple statutory provisions that IHS must provide diverse funding to Tribes under the specific terms of their ISDA contracts—ensuring that all aspects of tribal health programs are funded on the same basis as IHS programs, 25 U.SC. §§ 5325, 1680a—Congress accelerated the transition to greater tribal control over program income.

In 2000, Congress made its direct billing demonstration project permanent. Pub. L. No. 106-417, 114 Stat. 1812 (2000) (rewriting IHCIA § 405), though tribal

billing remained subject to substantial IHS oversight, Sec. 3, § 405(b)(3), 114 Stat. at 1814, and in order to participate Tribes had "to submit an application to the Secretary," *id*. § 405(c)(1).

Finally, in 2010, Congress removed these last barriers. Tribes may now elect (without the need for IHS approval) "to directly bill for, and receive payment for, health care items and services" covered by third party payers, including Medicare and Medicaid. 25 U.S.C. § 1641(d)(1). Thus, it was only recently in the ISDA's 46-year history (and the inter-related IHCIA history) that program income was separated from IHS control, and it is improper now for IHS to impose a penalty on Tribes for this development.[5]

F. Congress Consistently Implements Measures to Preserve Tribal Health Resources, Not to Diminish Them

Congress did not implement the program income or CSC measures in a vacuum. A consistent theme of federal Indian health law is the preservation and enhancement of tribal health care resources and the treatment of tribally-operated

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[5] The ISDA and the IHCIA address the same subject matter, cross-reference each other, and are *in pari materia*. *Navajo Health Fdn. – Sage Mem. Hosp., Inc. v. Burwell*, 263 F. Supp. 3d 1083, 1165 (D.N.M. 2016), *app. dism'd*, No. 18-2043, 2018 WL 4520349 (10th Cir. July 11, 2018). Thus, the two statutes should be read as "one law." *United States v. Stewart*, 311 U.S. 60, 64 (1940); *see also United States v. Botefuhr*, 309 F.3d 1263, 1281, n.9 (10th Cir. 2002) (discussing how statutes that are *in pari materia* "must be construed together").

programs on a par with those directly operated by IHS.[6] In many cases, these measures preserve tribal resources by obligating additional funds from other federal programs.

- Medicare-Like Rates ("MLR"): Under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 ("the Medicare Modernization Act") and 42 C.F.R. § 136.30-.32, Tribes carrying out certain programs under an ISDA agreement can purchase care from Medicare-participating hospitals at the MLR—much lower than the undiscounted rates, and often lower than the rates available to group health insurance plans. This MLR entitlement was later extended to care purchased from health professionals outside hospital settings too. 42 C.F.R. § 136.201-.204.
- Payer of Last Resort Status: Under 25 U.S.C. § 1623(b), health programs operated by Indian Tribes are the payer of last resort for services provided through such programs, notwithstanding any Federal, State, or local law to the contrary.

[6] *See, e.g.,* 25 U.S.C. § 1602(7) ("confirming that Tribes must receive funding for programs and facilities that they operate "in amounts that are not less than the amounts provided to programs and facilities operated directly by the [Indian Health] Service").

- Access to Federal Supply Schedule: Under 25 U.S.C. § 5324(k), employees of a tribal organization carrying out a contract with IHS "shall be eligible to have access to [federal] sources of supply on the same basis as employees of an executive agency." Under this authority, Tribes may purchase pharmaceuticals under the Federal Supply Schedule through IHS and the Department of Veterans Affairs' programs—a substantial discount as compared to usual wholesale prices and one that places Tribes on an equal footing with IHS.
- Protection of Tribal Self-Insurance: Under 25 U.S.C. § 1621e(f), the right of IHS to recover the cost of services provided in its facilities from any other payer that would otherwise be liable does not apply when such health services are "covered under a self-insurance plan funded by an Indian tribe, tribal organization, or urban Indian organization."
- Relief from Insurance Costs through Extension of the Federal Tort Claims Act: Under 25 U.S.C. § 5321(d), Tribes are placed on an identical footing with IHS by being deemed a part of the Federal government for purposes of liability protection under the Federal Tort Claims Act, 28 U.S.C. §§ 1346(b), 2671-2680.

- Reimbursement from Veterans' Affairs: The Department of Veterans Affairs or Department of Defense must reimburse Tribes for healthcare services provided to beneficiaries who would be eligible for such services from the VA or the Department, notwithstanding any other provision of law. 25 U.S.C. § 1645(c).

All of these measures are intended to conserve tribal resources. It defies common sense to find that the ISDA's contract support cost provisions—also enacted to conserve tribal resources—only apply to a subset of tribal health funding and thereby force Tribes either to cut health care services to Indians or to subsidize the administrative and overhead costs of the Federal program.

G. Congress's Recent Actions Demonstrate It Still Understands the Federal Program Includes Program Income

Congress's understanding that the expenditure of program income to enlarge services is part of the contracted Federal program is reinforced by recent instances where Congress has directly appropriated funds to support certain programs that did not recover as much third-party revenue as anticipated, and therefore had less to spend on services.

For instance, in 2017, Congress appropriated $29 million for "accreditation emergencies," mostly arising from incidents in the IHS Great Plains Area where certain federally-operated hospitals lost accreditation (or were in jeopardy of losing accreditation) due to the failure to efficiently collect and spend program income.

Consolidated Appropriations Act, 2017, Pub. L. No. 115-31, div. H, title II, 131 Stat. 135, 484; *see* Kevin Abourezk, *Another Indian Health Service hospital placed in "immediate jeopardy" status*, INDIANZ (Nov. 6, 2017), https://www.indianz.com/News/2017/11/06/another-indian-health-service-hospital-p.asp (describing multiple hospitals in the Great Plains Area with accreditation issues, due in part to backlogs in third-party billing and collections); Reexamining the Substandard Quality of Indian Health Care in the Great Plains, S. Hrg. 114-375 (Feb. 3, 2016) (prepared statement of Victoria Kitcheyan, Treasurer, Winnebago Tribal Council) ("We recommend that the IHS be directed to insure that no tribe suffers the loss of services or resources because of IHS mismanagement. The third party billing from Medicare and Medicaid represented a sizable percentage of the Winnebago IHS Hospital's operating budget.") That Congress makes available appropriations to shore up services due to an emergent drop in program income only underscores that when Congress uses the term "Federal program," that includes both appropriated funds *and* program income.

Similarly, when the COVID-19 pandemic caused health facilities to postpone or cancel elective surgeries and procedures, Congress directly appropriated to IHS nearly $2 billion to make up for IHS *and tribal* program income shortfalls experienced by these programs. *See* American Rescue Plan Act, § 11001(a)(1)(A) (direct appropriation for "lost reimbursements"); *see also*

Evaluating the Response and Mitigation to the Covid-19 Pandemic in Native Communities and S.3650, S. Hrg. 116-269 (Jul. 1, 2020) (statement of Lisa Elgin, Secretary, National Indian Health Board) ("In a hearing before House Interior Appropriations on June 11, 2020, IHS Director Rear Admiral (RADM) Weahkee stated that third party collections have plummeted 30–80% below last year's collections levels, and that it would likely take *years* to recoup these losses." (emphasis in original)).

Program income "is essential to maintaining facility accreditation and standards of health care." DHHS, Indian Health Service FY 2012 Justification of Estimates for Appropriations Committee at CJ-137. It is beyond reasonable debate that the Federal program under contract includes services funded both by appropriated dollars and program income. This Court should reject IHS's arguments to the contrary.

CONCLUSION

The district court failed to appreciate that the federal program under contract has always included and continues to include program income-funded services. IHS's contrary position deprives Tribes of the contract support costs they are due, undermining the purposes of the ISDA, the IHCIA, and the goals of the overall policy of Tribal Self-Determination. The decision below should be reversed.

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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), this brief contains 4,901 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.

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CERTIFICATE OF SERVICE

I hereby certify that on September 21, 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.

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ADDENDUM

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LIST OF TRIBAL AMICI CURIAE

This brief is filed on behalf of the National Congress of American Indians, the Alaska Native Health Board, the Northwest Portland Area Indian Health Board, and the following Tribal Amici:

Alaska Native Tribal Health Consortium

Arctic Slope Native Association

Bois Forte Band of Chippewa Indians

Cherokee Nation

Chickasaw Nation

Citizen Potawatomi Nation

Confederated Salish and Kootenai Tribes of the Flathead Reservation

Copper River Native Association

Gila River Indian Community

Kodiak Area Native Association

Little River Band of Ottawa Indians

Navajo Health Foundation – Sage Memorial Hospital

Navajo Nation

Quileute Tribe of the Quileute Reservation

Riverside-San Bernardino County Indian Health, Inc.

San Carlos Apache Tribe

Southeast Alaska Regional Health Consortium

Tanana Chiefs Conference

Zuni Tribe of the Zuni Reservation