UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

SALT RIVER PIMA-MARICOPA INDIAN COMMUNITY,	)	
	)	Case No. 1:18-cv-02360-DLF
PLAINTIFF,	)	
	)	
v.	)	**PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT**
XAVIER BECERRA, et al.,	)	
	)	
DEFENDANTS.	)	ORAL HEARING REQUESTED

PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT

Plaintiff, the Salt River Pima-Maricopa Indian Community (Community), by and through the undersigned counsel, respectfully moves, pursuant to Rule 56 of the Federal Rules of Civil Procedure, for summary judgment in the Community's favor. The essential facts of this case, as set forth in the accompanying Plaintiff's Statement of Material Facts, cannot be genuinely disputed. Therefore, as demonstrated in the accompanying Memorandum of Points and Authorities, the Community is entitled to judgment as a matter of law.

Specifically, the Community asks that this Court enter judgment as follows:

A. Declare that Defendants violated the Indian Self-Determination and Education Assistance Act, 25 U.S.C. §§ 5301–5399, by rejecting the Community's final offer (Final Offer) with respect to the three counts brought forward in the Second Amended Complaint: (1) the Indian Health Service (IHS) refused to transfer that component of the Secretarial amount comprised of third-party revenues generated at facilities other than the Clinic that IHS used to augment the Clinic's funding when IHS operated it;

(2) IHS failed to transfer the Community's full shares of the Phoenix Service Unit and Phoenix Indian Medical Center; and (3) IHS underpaid the contract support costs (CSCs) due to the Community.

B. Grant injunctive and declaratory relief to reverse IHS's partial rejection of the Final Offer on the three issues described in the Second Amended Complaint and to compel Defendants to enter into the FYs 2017-2018 Funding Agreement with respect to those three issues and fully fund them as proposed by the Community or otherwise deemed appropriate by the Court, on a recurring basis, as follows:

Count	Description	Amount ($)	Declaratory and Injunctive Relief
I	Third-Party Funds	$3,697,957	Declare program income from non-Clinic sources used on the Clinic to be part of the Secretarial amount to which the Community was entitled under 25 U.S.C. § 5325(a)(1) and order award of funding accordingly
II	PSU/PIMC Shares	918,390	Declare IHS did not meet its burden under 25 U.S.C. § 5387(c)(1)(A)(i) and award recurring funding as proposed
III	Contract Support Costs	Depends on ruling in II	Declare the Community entitled to CSCs on additional funds awarded for Count II of this action and order the parties to negotiate CSCs consistent with this decision

C. Grant such other relief as the Court deems just.

Respectfully submitted,

s/ Caroline Mayhew

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Attorneys for the Salt River Pima-Maricopa Indian Community

DATED: February 22, 2024.

CERTIFICATE OF SERVICE

I hereby certify that on this February 22, 2024, I caused service of the foregoing document by filing it with the clerk of the Court via the CM/ECF system, which will send a Notice of Electric Filing to all parties with an e-mail address of record who have appeared and consented to electronic service, including John Bardo, Attorney for Defendants. To the best of my knowledge, all parties to this action receive such notices.

By: *s/ Caroline Mayhew*
Caroline P. Mayhew

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

SALT RIVER PIMA-MARICOPA INDIAN COMMUNITY,	)	
	)	Case No. 1:18-cv-02360-DLF
PLAINTIFF,	)	
	)	**MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT OF PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT**
v.	)	
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MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT OF PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT

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INTRODUCTION AND SUMMARY

The Indian Self-Determination and Education Assistance Act (ISDEAA), 25 U.S.C. §§ 5301–5399, authorizes federally recognized Indian tribes, such as the Salt River Pima-Maricopa Indian Community (Community), to assume responsibility for federal programs, and associated funding, that would otherwise be provided to Community members and others by the Indian Health Service (IHS). The Community contends that IHS has failed to transfer the Community's full share of funds associated with the programs, services, functions, and activities (PSFAs) that the Community provides under its ISDEAA agreement. In crafting the ISDEAA, Congress foresaw such agency recalcitrance and built in strong mandatory funding provisions, some of which IHS has violated in this case.

In 2017, the Community elected to participate in the Self-Governance Program authorized by Title V of the ISDEAA, 25 U.S.C. §§ 5381–5399. As a result of negotiations between the Community and IHS, the Community assumed a number of new PSFAs, previously carried out on the Community's behalf by IHS, in a new Title V Compact and funding agreement (FA). *See* Administrative Record, ECF No. 18-1, at 5–69, Apr. 26, 2019 (hereinafter "Record"). The parties agreed to language in the Compact and to most of the terms and funding amounts for a multi-year FA for FYs 2017-2018, but the parties were not able to agree on all of the funding due to the Community.

When the parties are unable to agree on the terms of a compact or funding agreement, the ISDEAA allows the Indian tribe to submit a "final offer" to IHS. 25 U.S.C. § 5387(b). The Community submitted a final offer to IHS by letter dated August 4, 2017 (Final Offer). Record at 75. In a letter dated September 18, 2017, IHS issued a decision rejecting the Community's

position on a number of issues. *Id.* at 142. The Community filed this action, initially challenging IHS's decision on five funding issues. First Am. Compl., ECF No. 14, ¶ 34. The parties subsequently engaged in settlement discussions and were able to narrow the scope of the dispute. The Community now moves for summary judgment on three remaining counts, Second Am. Compl., ECF No. 42, ¶ 36 to ¶ 55:

- Third-Party Revenues: The ISDEAA requires that IHS provide the Community not less than the amount of funds the Secretary of Health and Human Services "would have otherwise provided for the operation" of PSFAs for the Community had the IHS continued to operate those PSFAs itself. 25 U.S.C. § 5325(a)(1). IHS data provided to the Community during the negotiation process demonstrates that when IHS operated the Salt River Clinic Program it drew on funding from three primary sources: IHS appropriations, third-party revenues generated by the Clinic itself, and third-party revenues from sources other than the Clinic. When the Community took over the Clinic, the IHS transferred appropriated funds associated with the Clinic, and the Community began directly collecting third-party revenues generated by the Clinic itself. But the IHS has refused to transfer third-party revenues from non-Clinic sources (which the Community cannot collect directly). Analysis of IHS's own contemporary funding documents shows the agency chose to fund the Clinic with these revenues in lieu of additional appropriated funds. Unless the third-party collections IHS historically used to augment Clinic funding are included in the amount transferred to the Community on a recurring basis, the Community will not receive what the Secretary "would have otherwise provided" to operate the Clinic and will have lost millions of dollars in clinic

funding simply by choosing to exercise its right to self-determination. 25 U.S.C. § 5325(a)(1). That is not what Congress intended, and not what the ISDEAA provides. The Clinic is entitled to the same amount of recurring resources while it is run by the Community as it received when run by IHS—nothing more and nothing less.

- Phoenix Service Unit (PSU)/Phoenix Indian Medical Center (PIMC) Shares: The ISDEAA entitles the Community to "full tribal share funding" for all PSFAs. 25 U.S.C. § 5385(b)(1). This includes functions of the PSU, which is housed in PIMC. The PSU is an administrative entity through which IHS provides direct, non-specialty services to eligible Indians in the Phoenix Area, and is distinct from the PIMC, a regional referral center. IHS refused to provide the full amount of recurring funding that its own analysis identified for these PSU functions, and IHS did not meet its burden to demonstrate, by clear and convincing evidence, that its lower figure was correct. *See* 25 U.S.C. § 5387(d). IHS argued that the PIMC, which functions in part as a regional medical referral center providing specialized health care services to tribes in Arizona and Nevada, is compactible but not divisible into tribal shares at all. But the Community is not seeking to have non-divisible referral functions transferred from PIMC, only the direct, non-specialty health care services and administrative functions carried out by PSU on the Community's behalf, as demonstrated by IHS's own analysis of PSU/PIMC staff time spent on Clinic activities. *See* Record at 277. These PSU functions are not tertiary care or referral PSFAs, but routine primary care and administrative PSFAs such as ambulatory care, family medicine, pharmacy, third-party billing, and health information management—all functions the Community assumed responsibility to carry out at the

Clinic.

- Contract Support Costs: To the extent that the Community recovers additional funding for the two claims above, it will also be entitled to "contract support costs" (CSCs) associated with these funds. The ISDEAA mandates that IHS must add CSCs to the Secretarial amount, 25 U.S.C. § 5325(a)(2)–(3), and that it must pay those costs in full, *Salazar v. Ramah Navajo Chapter*, 567 U.S. 182, 185 (2012) ("[W]e hold that the Government must pay each tribe's contract support costs in full."). CSC funding provides administrative and overhead support for PSFAs carried out under ISDEAA agreements. Any additional funding related to the PSU/PIMC tribal shares would indisputably be part of the Secretarial amount to which CSCs "shall be added."[2]

In rejecting the Community's Final Offer on the three issues above, the Secretary failed to meet his "burden of demonstrating by clear and convincing evidence the validity of the grounds for rejecting the offer." 25 U.S.C. § 5387(d). Therefore, the Community asks this Court for injunctive relief to compel IHS to award and fund the FA as proposed by the Community. *See* 25 U.S.C. § 5331(a); *see also id.* § 5391(a).

LEGAL AND FACTUAL BACKGROUND[3]

A. Self-Governance under Title V of the ISDEAA

The ISDEAA authorizes Indian tribes and tribal organizations to assume responsibility to administer PSFAs the Secretary would otherwise be obligated to provide under federal law to

[2] As part of a partial settlement agreement, the Community withdrew—but expressly reserved—its claim for CSCs on the third-party component of the recurring Secretarial amount. *See* ECF No. 42, Second Am. Compl., ¶ 52 n.3.

[3] Pursuant to LCvR 7(h)(1), the Community's numbered Statement of Material Facts accompanies its summary judgment motion and this supporting memorandum.

American Indians and Alaska Natives. 25 U.S.C. § 5321(a)(1). The purpose of the ISDEAA is to reduce federal domination of Indian programs and promote tribal self-determination and self-governance. *Cherokee Nation v. Leavitt*, 543 U.S. 631, 639 (2005); *see* 25 U.S.C. § 5302(b). The ISDEAA reflects the United States' "commitment to supporting and assisting Indian tribes in the development of strong and stable tribal governments, capable of administering quality programs and developing the economies of their respective communities." 25 U.S.C. § 5302(b).

Title V of the ISDEAA, codified at 25 U.S.C. §§ 5381–5399, established the "Tribal Self-Governance Program" and requires the Secretary of Health and Human Services to negotiate and enter into self-governance compacts and funding agreements with tribes and tribal organizations participating in the Self-Governance Program. 25 U.S.C. §§ 5381–5385. Title V requires that each funding agreement "shall, as determined by the Indian tribe," include all PSFAs administered by IHS under certain listed laws, including the Indian Health Care Improvement Act (IHCIA), 25 U.S.C. §§ 1601–1685. 25 U.S.C. § 5385(b). Tribes are entitled to "plan, conduct, consolidate, administer, and receive full tribal share funding" for the PSFAs they elect to include in the agreement. *Id.*

Section 106(a)(1) of the ISDEAA, codified at 25 U.S.C. § 5325(a)(1), establishes that the amount of funds to be provided "shall not be less than the appropriate Secretary would have otherwise provided for the operation of the programs or portions thereof for the period covered by the contract[.]" This amount is commonly referred to as the "Secretarial amount" or the "106(a)(1) amount." This provision is incorporated into Title V at 25 U.S.C. § 5396(a).

Tribal self-governance under the ISDEAA has been, by all accounts, hugely successful as tribes adapt PSFAs to the particular needs of their communities, build administrative capacity,

and improve the health of their people.[4] But the central dynamic of the ISDEAA—federal agencies turning over programs and funding to tribes—makes tension and conflict inevitable. Congress has long recognized that the agencies naturally resist ceding control and resources.[5] While IHS has made progress in recognizing tribes' rights to self-governance, the agency sometimes interprets the statute as narrowly as possible for its own benefit—rather than liberally in favor of tribes, as the ISDEAA requires. *See* 25 U.S.C. § 5392(f). Because of this, the statute includes the interpretive rule just cited, as well as procedures such as the final offer process.

B. The Final Offer Process

Title V of the ISDEAA anticipates that IHS and tribal compactors may sometimes reach a stalemate in negotiations over the terms of a compact or funding agreement. When that occurs, the Title V "final offer" provisions are available at the tribal compactor's option. These statutory provisions limit the Secretary's ability to reject a final offer unless certain criteria apply. The statute provides:

> In the event the Secretary and a participating Indian tribe are unable to agree, in whole or in part, on the terms of a compact or funding agreement (including funding levels), the Indian tribe may submit a final offer to the Secretary. Not more than

[4] *See e.g.*, Billy Cypress, Chairman, Miccosukee Tribe of Indians of Florida, Prepared Statement Before the House Resource Committee (Aug. 3, 1999) (describing self-determination as "the most successful Indian policy [ever] adopted by the United States"); *Tribal Self Governance: Hearing Before the S. Comm. on Indian Affairs*, 109th Cong. 2 (2006) (statement of Sen. Lisa Murkowski) ("There is little dispute within Indian country that the policy of self-determination . . . is probably one of the best, if not the single best thing that this Federal Government has ever done to help our Native people.").

[5] *See, e.g.*, S. REP. NO. 100–274, at 37 (1987), *reprinted in* 1988 U.S.C.C.A.N. 2620, 2656 ("The strong remedies provided in [the 1988] amendments are required because of [the Bureau of Indian Affair's and IHS's] consistent failures over the past decade to administer self-determination contracts in conformity with the law."); H.R. REP. NO. 106–477, at 34–35 (1999), *reprinted in* 2000 U.S.C.C.A.N. 573, 592 ("Because the Act requires the agencies to divest themselves of programs, staff, and funding at tribal request, the courts should not give Administrative Procedure Act-type deference to agency decisionmaking.").

> 45 days after such submission, or within a longer time agreed upon by the Indian tribe, the Secretary shall review and make a determination with respect to such offer. In the absence of a timely rejection of the offer, in whole or in part, made in compliance with subsection (c) of this section, the offer shall be deemed agreed to by the Secretary.

25 U.S.C. § 5387(b). If the Secretary rejects the final offer, the Secretary is required to provide "timely written notification to the Indian tribe that contains a specific finding that clearly demonstrates, or that is supported by a controlling legal authority," that one or more of the following four limited rejection criteria apply:

> (i) the amount of funds proposed in the final offer exceeds the applicable funding level to which the Indian tribe is entitled under [the ISDEAA];
> (ii) the program, function, service, or activity (or portion thereof) that is the subject of the final offer is an inherent Federal function that cannot legally be delegated to an Indian tribe;
> (iii) the Indian tribe cannot carry out the program, function, service, or activity (or portion thereof) in a manner that would not result in significant danger or risk to the public health; or
> (iv) the Indian tribe is not eligible to participate in self-governance under section 5383 of this title.

25 U.S.C. § 5387(c)(1)(A). The statute does not allow the Secretary to reject a final offer for any other reason. *Id.* Moreover, "the Secretary shall have the burden of demonstrating by clear and convincing evidence the validity of the grounds for rejecting the offer (or a provision thereof)[.]" 25 U.S.C. § 5387(d); *Maniilaq Ass'n v. Burwell*, 170 F. Supp. 3d 243, 247 (D.D.C. 2016). These and other Title V provisions restrict the Secretary's ordinary discretion and ensure that tribes are granted a great deal of flexibility in determining how to implement their ISDEAA agreements and PSFAs. *Maniilaq Ass'n v. Burwell*, 72 F. Supp. 3d 227, 233 (D.D.C. 2014).

C. Third-Party Revenues

Given the enormous unmet health care needs in Indian country,[6] third-party collections are critical both when IHS provides services directly and when tribes provide services under ISDEAA agreements. Medicare and Medicaid reimbursement for IHS and tribally operated facilities was provided by special legislation. Title IV of the IHCIA amended the Social Security Act by adding sections 1880 and 1911, 42 U.S.C. §§ 1395qq and 1396j respectively, to make IHS health care facilities, whether operated by IHS or an Indian tribe or tribal organization, eligible for Medicare and Medicaid reimbursement. The legislative history in the House Report emphasizes that these revenues were to expand the federal-tribal programs:

> It is the intent of the Committee that any Medicare and Medicaid funds received by the Indian Health Service program be used to supplement—and not supplant—current IHS appropriations. In other words, the Committee firmly expects that funds from Medicare and Medicaid will be used to expand and improve current IHS health care services and not to substitute for present expenditures.

H.R. Rep. No. 94–1026(I), at 108 (1976) (Committee on Interior and Insular Affairs), *reprinted in* 1976 U.S.C.C.A.N. 2652, 2746.

When IHS provides direct services to eligible beneficiaries, the PSFAs are funded not only by appropriations from Congress, but by third-party revenues billed to and collected from Medicare, Medicaid, the Children's Health Insurance Program, private insurers, and others. *See generally* 42 U.S.C. §§ 1395 *et seq.*, 1396 *et seq.*, 1397aa *et seq*. Each year in its budget request to Congress, IHS estimates how much third-party revenue will be collected and available to

[6] *See generally* U.S. COMM'N ON CIVIL RIGHTS, BROKEN PROMISES: CONTINUING FEDERAL FUNDING SHORTFALL FOR NATIVE AMERICANS 209 (Dec. 2018), www.usccr.gov/pubs/2018/12-20-Broken-Promises.pdf; U.S. COMM'N ON CIVIL RIGHTS, A QUIET CRISIS: FEDERAL FUNDING AND UNMET NEEDS IN INDIAN COUNTRY, at 5 (July 2003), https://archive.org/details/ERIC_ED480450.

spend on services based on past collections. *See, e.g.*, Dep't of Health & Human Servs., *Indian Health Service FY 2018 Justification of Estimates for Appropriations Committees*, at CJ-143 (reporting that, in FY 2016, IHS and tribes collected $1.194 billion from third-party insurers). "Public and private collections represent a significant portion of the IHS and Tribal health care delivery budgets." *Id.* The IHCIA requires IHS to spend third-party revenues on facility improvements or additional services. 25 U.S.C. § 1641(c)(1)(B).

Similarly, the Community's Compact requires it to directly collect third-party reimbursements. Record at 16 (Compact between the Salt River Pima-Maricopa Indian Community and the United States of America (Sept. 24, 2017), Art. III, § 7(a)(1)). All third-party revenues collected by the Community are designated by statute and IHS regulations as "program income" that must be, and is, expended on PSFAs included in the Community's FA with IHS. 25 U.S.C. § 5325(m) (Program income "shall be used by the tribal organization to further the general purposes of the contract; and . . . shall not be a basis for reducing the amount of funds otherwise obligated to the contract."); 42 C.F.R. § 137.110 ("All Medicare, Medicaid, or other program income earned by a Self-Governance Tribe shall be treated as supplemental funding to that negotiated in the funding agreement."). The Community's FA echoes this requirement, stating that the activities described in the agreement will be carried out "using funds provided by the IHS *and any supplemental funds that may be expended* to enhance the delivery of PSFAs under the Compact and this FA." Record at 31 (Fiscal Years (FY) 2017-2018 FA Between the Salt River Pima-Maricopa Indian Community and the Secretary of the Department of Health and Human Services, § 2 ("Obligations of the Community") (emphasis added)).

D. Contract Support Costs

The ISDEAA mandates that, in addition to the Secretarial or 106(a)(1) amount, IHS must include a second type of funding:

> **(2)** There shall be added to the amount required by paragraph (1) contract support costs which shall consist of an amount 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, but which --
>
> **(A)** normally are not carried on by the respective Secretary in his direct operation of the program; or
>
> **(B)** are provided by the Secretary in support of the contracted program from resources other than those under contract.

25 U.S.C. § 5325(a)(2).

There are three types of CSCs: (1) pre-award and start-up costs, which are one-time costs to plan, prepare for, and assume operation of new or expanded PSFAs, *see* 25 U.S.C. § 5325(a)(5), (6); (2) indirect CSCs, which are costs incurred for a common or joint purpose benefiting more than one PSFA, such as administrative and overhead costs, *see* 25 U.S.C. § 5325(a)(2); and (3) direct CSCs, which are expenses directly attributable to a certain PSFA but not captured in either the indirect cost pool or the Secretarial amount, such as workers' compensation insurance or other expenses the Secretary would not have incurred because, for example, the government is self-insured, *see* 25 U.S.C. § 5325(a)(3)(A).

The U.S. Supreme Court has held—twice—that the ISDEAA requires full payment of CSCs. *Ramah*, 567 U.S. at 185 ("[W]e hold that the Government must pay each tribe's contract support costs in full."); *Cherokee Nation*, 543 U.S. at 634 ("The [ISDEAA] specifies that the Government must pay a tribe's costs, including administrative expenses.").

Congress funds CSCs through a separate, indefinite appropriation—"such sums as may be necessary[.]" Consolidated Appropriations Act of 2018, Pub. L. No. 115–41, 132 Stat. 348,

678. Therefore, increasing the amount of CSCs paid to the Community will not reduce the amount of funding available to IHS or to any other tribe.

For the Community, as for most tribes, the full amount of indirect CSCs is determined by multiplying a negotiated indirect cost rate by the amount of the direct cost base. The Community's FY 2017 indirect cost rate agreement with the Department of the Interior's Interior Business Center, which applies government-wide, called for an indirect cost rate of 14.90% on a direct cost base comprised of "[t]otal direct costs, less capital expenditures and passthrough funds." Record at 287. The Community's FY 2018 indirect cost rate was 17.40%, again using a direct cost base of total direct costs minus capital expenditures and passthrough funds. Record at 246.

E. Procedural History: The Final Offer and the IHS Response

During the negotiation of the Title V Compact and the FYs 2017-2018 FA, the Community and IHS agreed to language for a new Compact and most of the language and funding for the FA. Negotiations between the Community and the IHS stalled, however, with respect to several issues, and the Community invoked the ISDEAA's dispute resolution process. By letter dated August 4, 2017, the Community submitted its Final Offer to IHS under 25 U.S.C. § 5387(b) regarding the unresolved language and funding issues. Record at 75-141. By letter dated September 18, 2017, IHS partially or fully rejected the Community's Final Offer on each of the unresolved issues. *Id.* at 142–65.

Because the ISDEAA at 25 U.S.C. § 5387(c)(1)(D) gives a tribe the option of entering into a severable portion of a final proposed funding agreement, the parties entered into the Compact and multi-year FA for FYs 2017-2018, effective September 24, 2017. Record at 5–69.

The FA excluded the disputed language and funding that were the subject of the Final Offer rejected by IHS.

The Community filed an action challenging portions of IHS's September 18, 2017 rejection of the Community's Final Offer per 25 U.S.C. § 5387(c)(1)(C). Compl., ECF No. 1 (Oct. 11, 2018). The Complaint sought relief under Section 110 of the ISDEAA, codified at 25 U.S.C. § 5331(a), which authorizes actions against the Defendants for money damages or injunctive relief against any action by an officer of the United States contrary to the ISDEAA, including injunctive relief to reverse IHS's decision and compel IHS to fund the FYs 2017-2018 FA as proposed. *See also id.* § 5391(a) (stating the word "contract" for purposes of 25 U.S.C. § 5331 includes compacts and funding agreements, such as the Community's, under Title V of the ISDEAA). The Community filed its First Amended Complaint, adding an additional count, on March 7, 2019. ECF No. 14.

As a result of settlement discussions, the parties were able to narrow the scope of the litigation and resolve two of the five counts in the First Amended Complaint. *See* ECF No. 40, Partial Settlement Agreement (Oct. 18, 2021). On October 18, 2021, the Community filed its Second Amended Complaint reflecting the settlement agreement and focusing on the three remaining counts described above. ECF No. 42. The parties subsequently described the remaining issues in their Joint Meet and Confer Report (Nov. 17, 2021) as follows:

> (1) whether the recurring Secretarial amount for the programs assumed by the Community include funding from Medicare, Medicaid, and other third parties that IHS historically used to carry out the programs on the Community's behalf; (2) whether IHS has failed to pay the Community's full tribal shares of the Phoenix Service Unit and the Phoenix Indian Medical Center; and (3) the appropriate contract support costs to be paid in connection with the Phoenix Service Unit and Phoenix Indian Medical Center tribal shares.

ECF No. 44 at 2. On July 29, 2022 the Community filed a motion for summary judgment on

these remaining three claims. ECF No. 53.

Thereafter, the Defendants requested a stay for purposes of further settlement negotiations. ECF No. 55. The Court granted that request in part, but made clear that no further extensions would be granted while the Community's motion remained pending. Minute Order of November 3, 2022. Based on that order, and because the parties had reached an agreement in principle to settle Counts II and III, the Community filed a consent motion to withdraw its motion for summary judgment without prejudice to refiling at a later date. ECF No. 57. The parties continued to work toward settlement but ultimately were not successful. On November 21, 2023, at the Community's request, the Court ordered the Parties to submit a schedule for further briefing and stayed discovery pending resolution of the parties' dispositive motions. The Community now files this renewed Motion, seeking summary judgment in its favor on all remaining counts.

STANDARD OF REVIEW

A. Review of Agency Action Under the ISDEAA

This Court has joined others in determining that a *de novo* standard of review applies to an appeal of an agency rejection decision under the ISDEAA. *Pyramid Lake Paiute Tribe v. Burwell*, 70 F. Supp. 3d 534, 541–42 (D.D.C. 2014); *Seneca Nation of Indians v. U.S. Dep't of Health and Human Servs.*, 945 F. Supp. 2d 135, 141–42 (D.D.C. 2013). *See also Cheyenne River Sioux Tribe v. Kempthorne*, 496 F. Supp. 2d 1059, 1066–67 (D.S.D. 2007); *Cherokee Nation of Okla. v. United States*, 190 F. Supp. 2d 1248, 1258 (E.D. Okla. 2001), *rev'd on other grounds by Cherokee Nation*, 543 U.S. 631; *Shoshone-Bannock Tribes of the Fort Hall Reservation v. Shalala*, 988 F. Supp. 1306, 1318 (D. Or. 1997). Thus, the more deferential

standard that often applies to review of agency action under the Administrative Procedure Act (APA), 5 U.S.C. § 706, is not appropriate where, as here, a tribe or tribal organizations brings claims solely under the ISDEAA. *Compare Citizen Potawatomi Nation v. Salazar*, 624 F. Supp. 2d 103, 107–08 (D.D.C. 2009) (applying the APA "arbitrary and capricious" standard of review where an Indian tribe sought relief primarily under the APA, with a secondary claim based on the ISDEAA) *with Seneca Nation*, 945 F. Supp. 2d at 142 n.5 (applying *de novo* review and distinguishing *Citizen Potawatomi* in part on the grounds that *Seneca Nation* involved only ISDEAA claims). This *de novo* standard of review comports with Congress's intent to reign in the agencies' "bureaucratic recalcitrance," and "consistent failures over the past decade to administer self-determination contracts in conformity with the law." *Shoshone-Bannock Tribes*, 988 F. Supp. at 1315–16 (citing S. Rep. No. 100–274, at 37 (1987), *reprinted in* 1988 U.S.C.C.A.N. 2619).

At the same time, "the Court's review of a decision under ISDEAA is somewhat similar to review under the APA," in that "a 'reviewing court may not supply a reasoned basis for an agency action that the agency itself did not give in the record under review.'" *Fort McDermitt Paiute & Shoshone Tribe v. Price*, No. CV 17-837 (TJK), 2018 WL 4637009, at *4 (D.D.C. Sept. 27, 2018) (quoting *Pierce v. SEC*, 786 F.3d 1027, 1034 (D.C. Cir. 2015)). "This is true even though the ISDEAA's standard of review is otherwise incompatible with the APA standard, as noted above." *Id.* In other words, under the ISDEAA as with review of agency actions in other contexts, "the court must look to the agency's reasoning in making its decision ..., and not to other reasons for its decision that the agency might marshal before the court[,]" and "The court 'may not accept appellate counsel's post hoc rationalizations for agency action.'"

Susanville Indian Rancheria v. Leavitt, No. 2:07-CV-259-GEB-DAD, 2008 WL 58951, at *6 (E.D. Cal. Jan. 3, 2008) (citing § 5387(c)(1), then codified at 25 U.S.C. § 458aaa-6(c)(1), and quoting *N.W. Envt'al Def. Ctr. v. Bonneville Power Admin.*, 477 F.3d 668, 688 (9th Cir. 2007)) (cleaned up). *See also, Burlington Truck Lines, Inc. v. United States*, 371 U.S. 156, 168 (1962) (it is a "simple but fundamental rule of administrative law" that "courts may not accept appellate counsel's *post hoc* rationalizations for agency action[.]").

B. Summary Judgment

Here, the Court must apply this standard of review in the context of a motion for summary judgment. Summary judgment is warranted "if the movant shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(a); *Arrington v. United States*, 473 F.3d 329, 333 (D.C. Cir. 2006) (citing *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 247 (1986)). The movant bears the initial burden of identifying those portions of the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, which it believes demonstrate the absence of a genuine issue of material fact. Fed. R. Civ. P. 56(c); *Roth v. U.S. Dep't of Justice,* 642 F.3d 1161, 1179 (D.C. Cir. 2011) (*citing Celotex Corp. v. Catrett*, 477 U.S. 317, 323 (1986)).

In ruling on a motion for summary judgment, the court ordinarily must draw all justifiable inferences in the nonmoving party's favor and accept the nonmoving party's evidence as true. *Anderson*, 477 U.S. at 255. A nonmoving party, however, must establish more than "[t]he mere existence of a scintilla of evidence" in support of its position. *Id.* at 252. Rather, the nonmoving party must present specific facts that would enable a reasonable jury to find in its favor. Importantly, "'[t]he mere existence of *some* alleged factual dispute between the parties

will not defeat an otherwise properly supported motion for summary judgment; the requirement is that there be no *genuine* issue of *material* fact.'" *Theodus v. McLaughlin*, 852 F.2d 1380, 1382 (D.C. Cir. 1988) (citing *Anderson*, 477 U.S. at 247–248) (emphasis in original). A material fact is one that "might affect the outcome of the suit under governing law." *Hendricks v. Geithner*, 568 F.3d 1008, 1012 (D.C. Cir. 2009) (citing *Anderson*, 477 U.S. at 248–251).

In cases governed by the APA, the ordinary summary judgment standard does not apply because in such cases summary judgment becomes a "mechanism for deciding, as a matter of law, whether an agency action is supported by the administrative record and consistent with the [APA] standard of review." *Stewart v. Azar*, 313 F. Supp. 3d 237, 249 (D.D.C. 2018) (quotation marks and citations omitted). The standard of review under the ISDEAA is far less deferential than the standard of review under the APA, and the court is not necessarily limited to the administrative record in ISDEAA cases. *Fort McDermitt Paiute & Shoshone Tribe*, 2018 WL 4637009, at *2 (D.D.C. Sept. 27, 2018) (citing *Shoshone-Bannock Tribes of the Fort Hall Reservation*, 988 F. Supp. at 1317). At the same time, however, the ISDEAA expressly and intentionally places the burden on the IHS when rejecting a final offer to make "a specific finding that clearly demonstrates" one of the enumerated grounds for rejection. 25 U.S.C. § 5387(c); *Cook Inlet Tribal Council v. Mandregan*, No. 14-CV-1835 (EGS), 2019 WL 3816573, at *10 (D.D.C. Aug. 14, 2019) (citing parallel provision for declination of contract proposals under Title I and noting that it is the agency's burden to "develop the record" within the statutory time period for declination). Accordingly, the IHS should not be permitted to create a material issue of fact that finds no support in the administrative record, because "Congress specifically assigned *to IHS*, and not to [the Tribe] or to the Court, the role of making defensible … funding

determinations when assessing contract proposals. IHS' failure to do so must result in the approval of the proposal." *Id.* (emphasis in original; citation omitted). *See also Gen. Elec. Co. v. Dep't of Air Force*, 648 F. Supp. 2d 95, 100 (D.D.C. 2009) ("Any *post hoc* rationales an agency provides for its decision are not to be considered" in the context of a motion for summary judgment on review of agency action.)

C. Statutory Interpretation Under the ISDEAA

Finally, an agency's interpretation of statutory provisions of the ISDEAA is not entitled to deference under *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984). *Pyramid Lake Paiute Tribe*, 70 F. Supp. 3d at 542. In this Circuit, *Chevron*-type deference is not applied where "[t]he governing canon of construction requires that 'statutes are to be construed liberally in favor of Indians, with ambiguous provisions interpreted to their benefit.'" *Cobell v. Norton*, 240 F.3d 1081, 1101 (D.C. Cir. 2001) (quoting *Montana v. Blackfeet Tribe of Indians*, 471 U.S. 759, 766 (1985)). *See also S. Ute Indian Tribe v. Sebelius*, 657 F.3d 1071, 1078 (10th Cir. 2011) ("If the [ISDEAA] can reasonably be construed as the Tribe would have it construed, it must be construed that way. This canon of construction controls over more general rules of deference to an agency's interpretation of an ambiguous statute.") (quotation and citation omitted); *Tunica-Biloxi Tribe of La. v. United States*, 577 F. Supp. 2d 382, 421 (D.D.C. 2008) (same) (quoting *Muscogee (Creek) Nation v. Hodel*, 851 F.2d 1439, 1444–45 (D.C. Cir. 1988)); *Maniilaq Ass'n*, 170 F. Supp. 3d at 247–48.

Congress incorporated this canon of statutory construction into Title V of the ISDEAA, which provides the statutory basis for the Community's self-governance Compact

and FA with IHS:

> Each provision of [Title V] and each provision of a compact or funding agreement shall be liberally construed for the benefit of the Indian tribe participating in self-governance and any ambiguity shall be resolved in favor of the Indian tribe.

25 U.S.C. § 5392(f). As the U.S. Supreme Court wrote of a very similar rule of construction in Title I, when interpreting the ISDEAA, "[t]he Government, in effect, must demonstrate that its reading is clearly required by the statutory language." *Ramah*, 567 U.S. at 194.

ARGUMENT

I. The ISDEAA requires IHS to transfer, as part of the "Secretarial amount," non-Clinic third-party revenues that IHS historically used to provide services to the Community.

The ISDEAA mandates that, when a tribe takes over IHS programs, the tribe receives at least as much funding for those programs as IHS would have used to provide services directly. "The amount of funds provided under the terms of self-determination contracts entered into pursuant to this chapter shall not be less than the appropriate Secretary would have otherwise provided for the operation of the programs or portions thereof for the period covered by the contract. . . ." 25 U.S.C. § 5325(a)(1). Contemporary financial documents show that when IHS operated the Salt River Clinic Program it drew on funding from three primary sources: IHS appropriations, third-party revenues generated from the Clinic itself, and third-party revenues from other sources. There is no dispute that the Secretarial amount includes the appropriated funding IHS would otherwise have available. And the Community acknowledges that, under controlling precedent, third-party revenues deriving from Clinic operations are *not* part of the Secretarial amount that IHS must transfer, because the Community now bills and collects those revenues itself and IHS no longer has access to them. *Fort McDermitt Paiute and Shoshone*

Tribe v. Becerra, 6 F.4th 6, 13–14 (D.C. Cir. 2021). But the third-party revenues from non-Clinic sources historically used by IHS to augment the Salt River Clinic Program are not being collected by the Community in its operation of the Clinic program. IHS still has access to those revenues. The agency's refusal to transfer these amounts means they simply have been lost to the Community as a result of the Community's choice to exercise its right to self-determination. That is not what Congress intended. These non-Clinic third-party revenues are a part of the Secretarial amount and must be transferred to the Tribe. *Pyramid Lake Paiute Tribe*, 70 F. Supp. 3d at 544.

A. The Administrative Record and contemporary documentation show that IHS historically used third-party revenues from non-Clinic sources to augment Clinic funding.

When IHS provides direct services to a tribe, the PSFAs are funded not only by funds appropriated by Congress, but also by third-party revenues, such as collections from Medicare, Medicaid, and private insurers. *See supra* pages 8-9. For example, in FY 2016, PIMC alone received $104,063,869 in third-party collections. Record at 314 (IHS PIMC profile). IHS is legally required to spend these revenues on additional services or on facilities serving tribal beneficiaries. *See* 25 U.S.C. § 1641(c)(1)(B) (Medicare and Medicaid payments received by an IHS facility must be used to improve programs "operated by or through such facility" or on additional services to tribes within the service unit).

The IHS produces Cost Center Reports to display revenues, expenditures, and balances associated with the IHS operation of a given facility for a given period of time, usually a single fiscal year. Record at 402-411. During compact negotiations, IHS provided the Community with Cost Center Reports for fiscal years 2008 through 2017. Brown Decl. ¶ 9; Record at 402–11. Each of these Cost Center Reports includes a footnote indicating that the source of the data

is from the IHS "Discoverer Reports." *Id.*

The IHS "Budget Activity Program" or BAP shown on the Cost Center Reports identifies the sources of funding for the Clinic in that fiscal year. These include various categories of appropriated funding as well as third-party or generated revenue, primarily from Medicaid, Medicare, Private Insurance and the Veterans Administration. Deveau Decl. at ¶ 6; Record at 402–11. The Community reviewed and analyzed the IHS Cost Center Reports for fiscal years 2012-2016 to identify the sources of revenue for each year (allowances) and the obligations associated with each revenue source to determine total annual obligations by funding source. Brown Decl. at ¶ 9.

Analysis of the Cost Center Reports showed that, when IHS ran the Clinic, the third-party revenues expended far exceeded the amounts that would reasonably or customarily be generated in an IHS program using only the amounts of appropriated funding allocated to the Clinic. Brown Decl. at ¶¶ 9-10; Deveau Decl. at ¶ 9. In the five years leading up to the compact negotiations—fiscal years 2012-2016—the Cost Center Reports showed a total of $18,270,947 in third-party revenue Allowances for use in the Salt River Clinic, compared with Appropriation allowances of $7,435,306. Deveau Decl. at ¶ 9.a (citing Record at 406-410). If 100% of those third-party revenue Allowances were generated at the Salt River Clinic, that would translate to a ratio of $2.46 in third-party collections for every $1 of Appropriations revenue. In FY 2016, the year before the Community assumed operation of the Clinic, the ratio was even higher: The Cost Center Report for that year shows a total of $5,665,795 in third-party revenue Allowances for use in the Salt River Clinic, and Appropriation allowances of $1,482,059. Deveau Decl. at ¶ 9.a; Record at 410. Unless IHS augmented Clinic funding with third-party revenues from non-Clinic

sources, IHS generated $3.82 for every dollar of appropriated funds—an entirely unrealistic proposition.

These ratios are far higher than those of other IHS and tribal facilities around the country. According to IHS, in FY 2016, IHS and Tribes collected an estimated total of $1,193,577,000 from third-party payers, *see* IHS FY 2018 Budget Justification at CJ-143, based on total appropriated funding of $3,566,387,000, Appropriations Act 2016, Pub. L. No. 114–113, 129 Stat. 2242, 2564 (2015). This translates to a nation-wide ratio of 33.5 **cents** in third-party collections for every appropriated dollar spent. The Salt River Clinic's ratio that year was over ten times the national average, indicating that much (and likely the majority) of the third-party funding supporting the Clinic in FY 2016 came not from Clinic operations but from other sources. *See also,* Deveau Decl. at ¶ 9.

The Community therefore sought to determine how much of the third-party revenue supporting the Clinic was generated by Clinic operations and how much came from other sources. To determine this, the Community requested that IHS provide historical billed and collected data for all providers at the Salt River Clinic. Brown Decl. at ¶ 10. This information would allow the Community to identify the amount of third-party revenues attributable to the Clinic itself, and to compare those amounts with the total third-party revenue amounts reflected in the Cost Center Reports. The difference would reveal the amount of third-party revenues from other sources being used by IHS to support clinic operations. In response, the IHS provided a report labeled "Salt River Federal/IHS Providers, Collected FY02-FY15, Updated 1/17/16." Brown Decl. at ¶ 11 & Exh. D (stating that it was prepared by Doreen Pond).

A comparison of the Cost Center Reports with the collections data provided by the IHS confirms that, in the years before the Community assumed Clinic operations at the end of FY 2017, IHS did fund the Clinic with a mix of appropriated funds, third-party revenues generated at the Clinic, and third-party revenues generated elsewhere and used to augment the other two sources. Deveau Decl. ¶ 8 and table included therein. Specifically, the Community compared total Allowances from third-party revenue sources identified in the Cost Center Reports against the total collections by Salt River Clinic providers for each fiscal year to calculate the difference. *Id.* The difference represents the amount of third-party revenue that IHS allocated to the Salt River Clinic program but that were not generated from Salt River Clinic providers—i.e., third-party revenues that must have been provided from sources other than the Salt River Clinic to augment funding for the Salt River Clinic program. *Id.*

In fiscal year 2016, for example—the year immediately preceding compact negotiations and the Community's final offer—the IHS's Salt River Clinic Provider Revenue Reports show the total amounts of third-party revenue collected from Salt River Clinic providers were $1,712,082. Brown Decl. Exh. D at 1; Deveau Decl. at ¶ 8.c.v & Exh. B. However, the IHS's Cost Center Reports show that IHS's Allowances from third party-revenues for FY 2016 were $5,665,795. Record at 410 (sum of Medicare, Medicaid, Private Insurance, Buybacks and VA IHS Reimbursement columns); Deveau Decl. at ¶ 8.c.v. Therefore, in FY 2016 IHS had to augment its Salt River Clinic Program with an additional $3,953,713 of third-party collections from sources other than the Salt River Clinic.

The exact amount of supplemental third-party revenues varies somewhat by year, but in total, for the five years preceding the Compact (2012-2016), the IHS's Salt River Clinic Provider

Revenue Reports show that IHS collected $6,898,379 in third party revenues attributable to providers stationed in the Salt River Clinic. Deveau Decl. at ¶ 8.d & Exh. B. Allowances from third party revenues for the Salt River Clinic for that same period, shown in the IHS's Cost Center Reports, total $18,270,947. Deveau Decl. at ¶ 8.d; Record at 406-410 (sum of Allowances from Medicare, Medicaid, Private Insurance, Buybacks and VA IHS Reimbursement columns). The difference of $11,372,568 represents allowances of third-party revenues, allocated by the IHS to support operations of the Salt River Clinic, that were not attributable to Clinic providers; an average of $2,274,514 annually. Over the same 2012-2016 time period, IHS's Cost Center Reports also show IHS actually expended $18,035,829 of the $18,270,947 third-party revenue Allowances it allocated for the Clinic, Deveau Decl. at ¶ 8.e; Record at 406-410 (sum of Obligations from Medicare, Medicaid, Private Insurance, Buybacks and VA IHS Reimbursement columns), a total difference of $11,137,450 as compared with collections from Clinic providers and an average difference of $2,227,490.00 per year.

This analysis confirms that when IHS ran the Clinic, it used appropriations, third-party revenues generated at the Clinic, and third-party revenues generated at other facilities—averaging approximately $2.2 million per year in the years leading up to the Compact. Indeed, the IHS's Salt River Clinic Cost Center Reports from earlier years expressly state that deficits were "applied against PIMC funds," indicating that IHS has historically looked to PIMC to cover gaps in Salt River Clinic funding. Record at 402-403; Deveau Decl. at ¶ 7.b. When IHS turned over Clinic operations to the Community in late FY 2017, it lost access to third-party revenues generated at the Clinic, which the Community would begin collecting. But the rest of the

funding historically used to fund Clinic remained available for transfer to the Community. This was the Secretarial amount IHS was required to transfer, but it failed to do so.

B. IHS's refusal to transfer non-Clinic third-party revenues violated the ISDEAA.

When the Community took over the Clinic at the end of FY 2017, the Community proposed that IHS award roughly the same amount of non-Clinic third-party revenue as IHS expended on the Clinic in FY 2016. Record at 114 (Final Offer, FA Funding Table, lines 20-23, proposing that the funding agreement include a total of $3,697,957 in third-party revenues). The Community reasoned that the best estimate for FY 2017 would be actual expenditures in FY 2016. *See Pyramid Lake*, 70 F. Supp. 3d at 544–45 (quoting IHS acknowledgment that the agency "generally determines the applicable funding level for an ISDEAA contract 'based on the amount the Agency previously spent to operate the program'").

IHS rejected the Community's proposal to assume the third-party funding on the ground that the proposed amount "exceeds the applicable funding level to which the tribe is entitled" per 25 U.S.C. § 5387(c)(1)(A)(i). Record at 148. IHS rewrites the statute by describing the Secretarial amount as "funds that the Secretary would have otherwise provided *out of the IHS's annual appropriations from Congress*." *Id*. (emphasis added). But IHS's interpretation of 25 U.S.C. § 5325(a)(1) is not reasonable—let alone compelled by the statute, as required for IHS to prevail, *Ramah*, 567 U.S. at 194—and IHS's argument has been rejected by this Court.

Section 106(a)(1) of the ISDEAA says that "[t]he amount of funds provided" must not be less than what the Secretary "would have otherwise provided" to operate the PSFAs. 25 U.S.C. § 5325(a)(1). Congress could have easily said what IHS wishes it did—that the amount of funds provided must not be less than the amount the Secretary would have provided *from*

Congressional appropriations—but it did not. As this Court explained in *Pyramid Lake*, "the applicable funding level for a contract proposal under [the ISDEAA] is determined based on what the Secretary otherwise would have spent, not on the source of the funds the Secretary uses." 70 F. Supp. 3d at 544. The Court therefore ordered IHS to transfer the third-party revenues that the agency had been using to fund the program. *Id*.

The *Fort McDermitt* decision is not to the contrary. The question in that case was "whether the secretarial amount must include the value of Medicare and Medicaid reimbursements that IHS previously had collected on behalf of the Fort McDermitt, *even though the tribe now collects the reimbursements directly*." 6 F.4th at 13 (emphasis added). In other words, the Tribe sought the third-party revenues IHS would otherwise have collected from the Tribe's clinic, even while the Tribe was billing and collecting its own third-party revenues for the same services. The court declined to adopt the Tribe's "strained interpretation of the [ISDEAA] that would allow precisely that double-dipping." *Id.* at 14.

Here the Community is not seeking to double-dip, acknowledging that IHS owes nothing for third-party revenues associated with Clinic operations now undertaken by the Community itself. The Community instead seeks recurring third-party revenues from sources other than the Clinic, to which the IHS presumably still has access but which the Community cannot collect for itself. This puts the Community's claim on all fours with *Pyramid Lake*. There, IHS had been using third-party revenues generated by the local clinic to fund an Emergency Medical Services (EMS) program the Tribe sought to assume under the ISDEAA. *Pyramid Lake*, 70 F. Supp. 3d at 538–39. The Tribe proposed to assume only the EMS program, whereas the IHS would continue to operate the clinic and to collect the clinic revenues it had historically used to support

the EMS program. *Id.* at 539. In that situation, the Court held, IHS must include those revenues in the Secretarial amount transferred to the Tribe to operate the EMS program. "If the Secretary chooses to augment its spending on a program with other funds available to her, nothing in the Act permits her to deduct those amounts from the tribe's funding under an otherwise acceptable ISDEAA contract." *Id.* at 544. Under a contrary interpretation, the Tribe would have had fewer resources than the IHS to operate the same EMS program—while the IHS would have increased its own resources to operate the clinic.

IHS could have allocated additional appropriated funds to fully support the Salt River Clinic, but chose to reallocate third-party revenues instead. The Community acknowledges that, prior to an ISDEAA contract or compact, the IHS retains broad budgeting authority to allocate funding as it sees fit in the operation of its own programs. *Lincoln v. Vigil*, 508 U.S. 182 (1993). But that fact supports the Community's argument that funds from sources other than agency appropriations must be considered part of the Secretarial amount. Here, IHS has attempted to avoid having to transfer the full amount of recurring funds it historically used to operate the Clinic by using other revenues and then asserting that they are not a part of the Secretarial amount. If the court rules that only appropriated funds—and not third-party revenues from non-contract sources—are part of the Secretarial amount, IHS would be able to make certain programs unattractive, or even financially unviable, for contracting—completely undermining Congress's intent in the ISDEAA. The ISDEAA should not be read to enable IHS to manipulate funding blends to discourage or effectively deny the transfer of PSFAs under the Act.

IHS's rejection of the Community's proposal to assume recurring third-party funding that the agency would have used to carry out PSFAs on the Community's behalf was contrary to the

ISDEAA and to this Court's decision in *Pyramid Lake*. In its final offer, the Community estimated the amount of such recurring funding at $3,697,957 based on FY 2016 expenditures. The FY 2016 Cost Center Report Allowances from third-party revenues, compared with the Salt River Clinic Provider Revenue Reports, puts the figure slightly higher, at $3,953,713.[7] Deveau Decl. at ¶ 8.c.v. Regardless, this is not a material factual dispute that precludes summary judgment on the legal issue. The Court should rule that, as a matter of law, IHS was required to transfer all non-Clinic third-party revenues to the Community in the FYs 2017-2018 FA. The Secretary did not meet his burden of proof to establish that IHS was excused from doing so.

II. The Community was entitled to full tribal shares of PSU/PIMC that IHS formerly used to provide direct, non-specialty services to the Community.

The ISDEAA entitles the Community to "***full tribal share funding***" for "all programs, services, functions, and activities (or portions thereof), that are carried out for the benefit of Indians because of their status as Indians without regard to the agency or office of the Indian Health Service within which the program, service, function, or activity (or portion thereof) is performed." 25 U.S.C. § 5385(b)(1) (emphasis added). This includes funding associated with activities carried out by PSU/PIMC that directly benefit the Clinic.

In its Final Offer, the Community requested that IHS include in the FYs 2017-2018 FA the Community's shares of PSU/PIMC. The PIMC is in part a regional medical referral center that provides specialized health care services to members of tribes in Arizona, Utah, and Nevada, including the Community. Record at 314 (PIMC Profile). IHS takes the position that "[t]he referral portion of the PIMC is compactible in its entirety (so long as resolutions of support are

[7] As discussed above, a five-year average comes to approximately $2.2 million.

submitted by all Tribes served . . .), but it is not divisible into tribal shares," as dividing it up would "render it financially unsustainable as a referral center." Record at 149 (IHS rejection of Final Offer). But the Community does not seek to take over referral functions.

The PIMC also operates in part as IHS's PSU, providing direct (non-specialty) health care services to members of six tribes in Arizona, including the Community. *See* Record at 314 (PIMC profile). These PSFAs that the PSU has historically conducted from the PIMC campus *are* divisible into tribal shares. Record at 149–50 (recounting, in letter rejecting Final Offer, tribal consultation meetings on methodology for determining PSU tribal shares).

During negotiations, the Community's consultant, Michel Lincoln, asked IHS to identify for the Community the "Level of effort time PSU/PIMC staff spent on Salt River Clinic activities." Brown Decl. ¶ 12. In response, IHS provided a detailed Excel spreadsheet identifying the number of days per annum that these individuals provided services and support to the Salt River Clinic Program which was the subject of the compact proposal by the community. A summary version of this spreadsheet is included in the Record at 277. Time recorded on the PIMC spreadsheet represents "Time Spent on Salt River Clinic Activities (Days – Annualized)" —that is, activities specifically directed to the Clinic by these PSU/PIMC staff. The spreadsheet recorded 2,941 days' worth of effort, or some 23,528 hours of work, specifically identified by PSU/PIMC directly in support of the Salt River Clinic Program. Record at 277.

The total cost associated with the Level of Effort identified in the Excel spreadsheet, including administrative costs, was $1,348,696. *Id.* Roughly 40% of the "Total Tribal Shares" ($434,348) were reported to have been funded with appropriated resources, and the IHS elected to fund the remaining 60% of Total Tribal Shares ($644,609) with Medicaid, Medicare, Private

Insurance and other collections. *Id.* Rather than transfer this full amount, however, IHS transferred only $430,306 during the 2017 Compact negotiations.[8]

The Community included in its Final Offer the identified amount totaling $1,348,696, which represents the recurring shares of PSU/PIMC that could be attributed specifically to the Community, plus administrative costs, as determined by the IHS Level of Effort analysis. Record at 114 (FA funding table, lines 18–19); *id.* at 277.

IHS partially rejected this proposal on the ground that "the amount of funds proposed in the final offer exceeds the applicable funding level to which the tribe is entitled." Record at 149. IHS calculated the Community's share of the PSU to be only $430,306, and the Community's share of the PIMC referral services to be $0. Record at 149–50. IHS argued that the $1,348,696 the Community sought was "based largely on costs associated with referral-level functions, rather than functions carried out at the Service Unit level." *Id.* at 149. But the Level of Effort analysis belies this assertion, detailing the "Department and Position" associated with all of the PSU/PIMC hours devoted to the Clinic. The vast majority of these PSFAs provided by PIMC personnel, according to IHS's analysis, are routine primary care and administrative PSFAs—such as ambulatory care, family medicine, pharmacy, third-party billing, and health information management, among others. These are not referral PSFAs administered at PIMC, but direct, non-specialty health care services and administrative functions performed for the benefit of the

[8] IHS argues that the administrative costs identified in the Level of Effort analysis "should be funded as [contract support costs] and not as part of the Tribe's 'Secretarial amount.'" Record at 149. But the Secretarial amount includes the amount the Secretary would otherwise have provided, "including supportive administrative functions that are otherwise contractible." 25 U.S.C. § 5325(a)(1). Under the statute IHS was correct to include reasonable "Administrative Support Costs" in its Level of Effort analysis in the Record.

Salt River Clinic. These are PSFAs that the Community assumed responsibility for providing when it took over the Clinic at the end of FY 2017. *Compare* Record at 32–34 (listing, in Funding Agreement, PSFAs to be performed by the Community) *with id.* at 277 (listing PSU/PIMC-provided PSFAs in Level of Effort analysis).

The documentary evidence shows that IHS devoted significantly more PSU/PIMC time and resources to the Clinic when the agency was running it than it provided once the Community took over Clinic operations. This violates the ISDEAA mandates that the Community is entitled to the Secretarial amount and its full tribal share of agency resources. 25 U.S.C. § 5325(a)(1); *Fort McDermitt*, 6 F.4th 6, 9 (D.C. Cir. 2021) (noting that "the secretarial amount is keyed to what IHS would have contributed, in dollars and cents, to program operations"); 25 U.S.C. § 5385(b)(1). Because IHS did not "clearly demonstrate" that the statutory rejection criterion on which it relied—25 U.S.C. § 5387(c)(1)(A)(i)—applies, the Secretary has not met his burden of proof under 25 U.S.C. § 5398, and the Community's Final Offer on funding associated with PSU/PIMC tribal shares must be deemed approved and awarded as proposed. 25 U.S.C. § 5387(b).

III. IHS must pay additional contract support costs to support the additional PSU/PIMC funding.

The parties dispute the amount of CSCs due in both FY 2017 and FY 2018 (and succeeding years), primarily due to their disagreement on the funding issues described in Section II above: PSU/PIMC shares. The ISDEAA dictates that CSCs "shall be added" to the Secretarial amount, 25 U.S.C. § 5325(a)(2), so the general rule is that the bigger the Secretarial amount, the bigger the CSC entitlement. To the extent the Community prevails on the PSU/PIMC claim

above, it will increase the size of the direct cost base, creating a greater indirect cost need. *See supra* page 11 (describing rate-times-base calculation).[9]

In its Final Offer, the Community requested for FY 2017 a total CSC award of $1,840,656, while IHS agreed to pay $1,527,507. Compl., ¶ 73; Answer, ¶ 73. This left a shortfall of $313,149. For FY 2018, the Community requested in its Final Offer a total CSC award of $5,973,751, while IHS agreed to pay $2,526,437. Compl., ¶ 74; Answer, ¶ 74. This left a shortfall of $3,447,314. These figures are estimates based on projected increases in the direct cost base resulting from this Court's rulings on the two issues above, and can be adjusted by the parties based on those rulings. Regardless of the exact final figures, however, this Court should hold that the ISDEAA requires IHS to pay full CSCs on any additional funding the Community is awarded as a result of the PSU/PIMC claim. *Ramah*, 567 U.S. at 185 ("[W]e hold that the Government must pay each tribe's contract support costs in full."); *Cherokee Nation*, 543 U.S. at 634 ("The [ISDEAA] specifies that the Government must pay a tribe's costs, including administrative expenses.").

CONCLUSION

Because IHS's Final Decision failed to demonstrate, by clear and convincing evidence, that its partial rejection of the Community's Final Offer was justified by the statutory criteria in 25 U.S.C. § 5387(c)(1)(A), the Community is entitled to an Order declaring that IHS failed to

[9] In the original complaint the Community asserted that third-party revenues claimed as part of the Secretarial amount in Section I above generate CSC needs. As part of the settlement agreement, the Community agreed to withdraw this part of the CSC claim without prejudice, and so does not pursue it here. ECF No. 40, ¶ 34 (Settlement Agreement); ECF No. 42, ¶ 52 and n.3 (Second Amended Complaint). The Community continues to believe, however, that, if the Court rules it is entitled to be paid recurring third-party revenues as part of the Secretarial amount in Section I, under the *Pyramid Lake* decision it is also entitled to be paid CSC on those amounts.

fully fund the Community's FA and compelling IHS to award and fund the Final Offer as proposed, or in an amount otherwise deemed appropriate by the Court. Specifically, the Community asks for declaratory and injunctive relief on its three counts as follows:

Count	Description	Amount ($)	Declaratory and Injunctive Relief
I	Third-Party Funds	$3,697,957	Declare program income from non-Clinic sources used on the Clinic to be part of the Secretarial amount to which the Community was entitled under 25 U.S.C. § 5325(a)(1) and order award of funding accordingly
II	PSU/PIMC Shares	$918,390	Declare IHS did not meet its burden under 25 U.S.C. § 5387(c)(1)(A)(i) and award recurring funding as proposed
III	Contract Support Costs	Depends on ruling in II	Declare the Community entitled to CSCs on additional funds for Count II of this action awarded and order the parties to negotiate CSCs consistent with this decision

Respectfully submitted,

s/ Caroline P. Mayhew

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Attorneys for the Salt River Pima-Maricopa Indian Community

DATED: February 22, 2024.

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

SALT RIVER PIMA-MARICOPA INDIAN COMMUNITY,	)	Case No. 1:18-cv-02360-DLF
PLAINTIFF,	)	
v.	)	**STATEMENT OF MATERIAL FACTS**
XAVIER BECERRA, et al.,	)	
DEFENDANTS.	)	

STATEMENT OF MATERIAL FACTS

Pursuant to LCvR 7(h), Plaintiff Salt River Pima-Maricopa Indian Community submits this Statement of Material Facts as to which Plaintiff contends there is no genuine dispute:

1. Plaintiff Salt River Pima-Maricopa Indian Community (Community) is a federally recognized tribe. Dep't of the Interior, *Indian Entities Recognized and Eligible to Receive Services from the United States Bureau of Indian Affairs*, 89 FED. REG. 944, 946 (Jan. 8, 2024).

2. The Community operates a health services delivery program to carry out health care programs, services, functions, and activities (PSFAs) for the Community's members and other eligible Indians in the Community's service area. The Community currently does so under Title V of the Indian Self-Determination and Education Assistance Act (ISDEAA), 25 U.S.C. §§ 5381–5399, through its Title V Compact and Funding Agreement (FA) with the Indian Health Service (IHS). Administrative Record, ECF No. 18-1 (Record), at 5–69 (page numbers reflect Doc. 18-1 as filed with the Court). The FA includes funding amounts negotiated for each fiscal year (FY) between IHS and the Community to fund the PSFAs the Community performs on the federal government's behalf. Record at 43–57 (FA funding tables).

3. Prior to entering into the Title V Compact and FA with IHS on September 24, 2017, the Community had in place a contract and annual funding agreement with IHS under Title I of the ISDEAA. Second Am. Compl., ECF No. 42 (Compl.), ¶ 28; Answer to Second Am. Compl., ECF No. 43 (Answer), ¶ 28. The Title I agreement between the parties for FY 2017 funded and authorized the Community to perform and administer the following PSFAs: health education; community health care representatives; pharmacy; alcohol and substance abuse services; physician services; public health nursing; mental health; and social services. Compl., ¶ 28; Answer, ¶ 28.

4. In the new Title V Compact and FA, the Community assumed PSFAs that IHS had, until that time, been carrying out for the Community's members. For example, the FA added a broader range of patient health care services like family practice, pediatrics, optometry, dental, emergency and non-emergency services, and health promotion and disease prevention. Compl., ¶ 29; Answer, ¶ 29.

5. During the negotiation of the Title V Compact and the FYs 2017-2018 FA, the Community and IHS agreed to language for a new Compact and most of the language and funding for the FA, but the parties were not able to come to agreement on several issues. Compl., ¶ 30; Answer, ¶ 30. On August 4, 2017, the Community submitted its final offer (Final Offer) on these unresolved issues, including five that formed the basis of the initial complaint. Record at 75-141 (Final Offer); ECF No. 1, Counts I-V.

6. On September 18, 2017, IHS issued a decision letter partially or fully rejecting the Community's proposal as to each of the Final Offer issues. Record at 142–165 (IHS Response).

7. In a letter dated September 21, 2017, the Community agreed to the severable portion of the Final Offer that IHS did not reject. Compl., ¶ 32; Answer, ¶ 32.

8. On October 11, 2018, the Community filed this action challenging IHS's partial rejection of the Final Offer. ECF No. 1.

9. On March 7, 2019, the Community filed its First Amended Complaint. ECF No. 14. Defendants answered the First Amended Complaint on April 5, 2019. ECF No. 14.

10. On October 18, 2021, the Community filed its Second Amended Complaint. ECF No. 42. Defendants answered the Second Amended Complaint on November 2, 2021. ECF No. 43.

Third-Party Revenues

11. When IHS provides direct services to a tribe, the PSFAs are funded not only by funds appropriated by Congress, but also by third-party revenues—collections from Medicare, Medicaid, and private insurers, for example. Compl., ¶ 37; Answer ¶ 37. Each year in its budget to Congress, IHS estimates how much third-party revenue will be collected and available to spend on services based on past collections. *See, e.g.*, Dep't of Health & Human Servs., *Indian Health Service FY 2018 Justification of Estimates for Appropriations Committees*, at CJ-143 (reporting that in FY 2016, IHS and tribes collected $1.194 billion from third-party payers). The Department has acknowledged that "[p]ublic and private collections represent a significant portion of the IHS and Tribal health care delivery budgets." *Id.*

12. During the negotiation of the Title V Compact and the FYs 2017-2018 FA, the IHS provided the Community with information and documents needed to identify the PSFAs and the related funds to which the Community would be entitled should it choose to enter the

compact. Some of these documents were provided initially by IHS, while others were provided in response to requests from the Community and its consultants. Brown Decl. ¶¶ 3, 5-6. Some, but not all, of these documents are included in the Administrative Record. ECF No. 18-1.

13. Among the documents provided by the IHS to the Community during Compact negotiations were IHS Cost Center Reports for the Salt River Clinic. Record at 278, 402–411. The Cost Center Reports are the reports the IHS generates to display revenues, expenditures and balances associated with the IHS operation of a given program for a given period of time, usually a single fiscal year. The IHS "Budget Activity Program" or BAP on the Cost Center Reports identifies the source of funding, including appropriated funds (for example, "Hospitals and Clinics" and "Dental"), and third-party revenues (e.g., Medicare, Medicaid, Private Insurance, and, in some years, VA IHS Reimbursement). The Cost Center Reports provided include a footnote indicating that the source of the data is from the IHS "Discoverer Reports." Record at 402–411.

14. The Cost Center Reports in the Administrative Record show amounts down to the penny across multiple line items and expense categories for the fiscal years ending September 30, 2008 through September 30, 2017. They show the balance of available revenues both at the beginning and at the end of each year. Record at 402–411.

15. The Fiscal Year End Balance (Surplus/Deficit) reported at the end of each year on the Cost Center Reports for Fiscal Years 2008-2015 is the same as the starting Balance for the next fiscal year. Record at 402-409. For example, the Cost Center Report for Fiscal Year 2015 (Record at 409) begins with the "Final Fiscal Year End 2014 Balance" of $4,031,873.85, which

is the same as the "Fiscal Year End Balance (Surplus/Deficit)" shown in the Cost Center Report for the Fiscal Year 2014 (Record at 408).

16. There are minor differences between the "Fiscal Year End Balance (Surplus/Deficit)" shown on the Cost Center Report for Fiscal Year 2015 ($2,518,505.80) (Record at 409) and the "Final Fiscal Year End 2015 Balance" shown at the top of the Cost Center Report for Fiscal Year 2016 ($2,410,379.29) (Record at 410).

17. There are minor differences between the "Fiscal Year End Balance (Surplus/Deficit)" shown on the Cost Center Report for Fiscal Year 2016 ($2,458,972.53) (Record at 410) and the "Final Fiscal Year End 2016 Balance" shown at the top of the Cost Center Report for Fiscal Year 2017 ($2,454,178.94) (Record at 411).

18. According to IHS, in FY 2016, IHS and Tribes nationwide collected an estimated total of $1,193,577,000 from third-party payers. IHS FY 2018 Budget Justification at CJ-143. The IHS appropriated funding amount for FY 2016 (exclusive of appropriations for facilities and contract support costs) was $3,566,387,000. Appropriations Act 2016, Pub. L. No. 114–113, 129 Stat. 2242, 2564 (2015). This translates to a nationwide ratio of 33.5 cents in third-party collections for every appropriated dollar spent.

19. The IHS's Salt River Clinic Cost Center Report for FY 2016 shows a total of $5,665,795 in third-party revenue Allowances for use in the Salt River Clinic, Record at 410 (sum of Medicare, Medicaid, Private Insurance, Buybacks, and VA IHS Reimbursement columns), and Appropriation allowances of $1,482,059 in Appropriations revenue, *id.* (sum of Hospital and Clinics, Dental, and Equipment columns). If 100% of those third-party revenue Allowances were generated at the Salt River Clinic, that would translate to a ratio of $3.82 in

third-party collections for every appropriated dollar spent. This is more than ten times the FY 2016 nation-wide ratio of 33.5 cents.

20. For the 2012-2016 fiscal years combined, IHS Cost Center Reports in the Administrative Record show a total of $18,270,947 in Third Party Revenue allowances for use in the Salt River Clinic, and Appropriation allowances of $7,435,307. Record at 406-410. If 100% of those third-party revenue allowances were generated at the Salt River Clinic, that would translate to a ratio of $2.46 in third-party collections for every $1 of Appropriations revenue.

21. During Compact negotiations, the Community and its consultants requested third-party collections amounts by provider for all providers associated with the Clinic, in order to determine whether the third-party revenue amounts shown as available in the Cost Center Reports were generated by the program itself (i.e., Salt River Clinic providers) or from other sources. Brown Decl. ¶¶ 10-11 & Exh. C.

22. One of the documents provided by IHS was "Salt River Federal/IHS Providers, Collected FY02-FY15, Updated 01/17/16," prepared by Doreen Pond. Brown Decl. at ¶ 11 & Exh. D. The first page of this document summarizes amounts collected by each individual Salt River Clinic provider by fiscal year, for FYS 2002-2016, as of the date of the report (January 17, 2016).

23. The total third-party revenue amounts identified in the IHS Cost Center Reports as Allowances for the Salt River Clinic in each fiscal year, Record at 402–410, are significantly larger than the total collections by Salt River Clinic providers for each fiscal year as reflected in the provider collections data provided by IHS during negotiations. Brown Decl. Exh. D; Deveau Decl. ¶ 8.

24. In FY 2012, the IHS's Cost Center Reports show that IHS's FY 2012 Allowances from Third Party Revenues were $2,908,811. Record at 406 (sum of Medicare, Medicaid, Private Insurance, and Buyback columns). The IHS's SRC Provider Revenue Reports show the total third-party revenue collected from Salt River Clinic providers were $1,445,195 for the same period. Brown Decl. Exh. D at 1. The difference is $1,463,616.

25. In FY 2013, the IHS's Cost Center Reports show that IHS's Allowances from Third Party Revenues were $4,988,798. Record at 407 (sum of Medicare, Medicaid, Private Insurance, and Buyback columns). The IHS's SRC Provider Revenue Reports show the total third-party revenue collected from Salt River Clinic providers were $955,794 for the same period. Brown Decl. Exh. D at 1. The difference is $4,033,004.

26. In FY 2014, the IHS's Cost Center Reports show that IHS's Allowances from Third Party Revenues were $3,661,527. Record at 408 (sum of Medicare, Medicaid, Private Insurance, Buybacks, and VA IHS Reimbursement columns). The IHS's SRC Provider Revenue Reports show the total third-party revenue collected from Salt River Clinic providers were $1,151,631 for the same period. Brown Decl. Exh. D at 1. The difference is $2,509,896.

27. In FY 2015, the IHS's Cost Center Reports show that IHS's Allowances from Third Party Revenues were $1,046,016. Record at 409 (sum of Medicare, Medicaid, Private Insurance, Buybacks, and VA IHS Reimbursement columns). The IHS's SRC Provider Revenue Reports show the total third-party revenue collected from Salt River Clinic providers were $1,633,677 for the same period. Brown Decl. Exh. D at 1. The difference is ($587,661).

28. In FY 2016, the IHS's Cost Center Reports show that IHS's Allowances from Third Party Revenues were $5,665,795. Record at 410 (sum of Medicare, Medicaid, Private

Insurance, Buybacks and VA IHS Reimbursement columns). The IHS's SRC Provider Revenue Reports show the total third-party revenue collected from Salt River Clinic providers were $1,712,082 for the same period. Brown Decl. Exh. D at 1. The difference is $3,953,713.

29. In total, the IHS's Cost Center Reports (Record at 406-410) show that IHS's Allowances from Third Party Revenues were $18,270,947 for FYs 2012-2016 (the five years leading up to the Compact), while the IHS's SRC Provider Revenue Reports (Brown Decl. Exh. D at 1) show the total third-party revenue collected from Salt River Clinic providers were $6,898,379 for the same 2012-2016 period. The difference is $11,372,568. This averages to a difference of $2,274,514 between annual allowances from third-party revenues for the Salt River Clinic and third-party revenues actually collected by Salt River Clinic providers.

30. Over the same 2012-2016 time period, the IHS Cost Center Reports (Record at 406-410) also show Obligations (expenditures) from third-party revenue in the amount of $18,035,829. Record at 406-410 (sum of Obligations from Medicare, Medicaid, Private Insurance, Buybacks and VA IHS Reimbursement columns). The difference between these total obligations and the total third-party revenue collected from Salt River Clinic providers ($6,898,379, Brown Decl. Exh. D at 1) is $11,137,450. This averages to a difference of $2,227,490 per year.

31. When the Community took over the Clinic at the end of FY 2017, the Community proposed that IHS award $3,697,957 in third-party revenues from sources other than the Salt River Clinic—revenues that would have otherwise been used by IHS to carry out PSFAs serving the Community's members and other eligible individuals in the Community's service area. Record at 114 (Final Offer, FA Funding Table, column (1), sum of lines 20–23).

32. IHS rejected the Community's proposal to assume the third-party funding on the ground that the proposed funding "exceeds the applicable funding level to which the tribe is entitled" per 25 U.S.C § 5387(c)(1)(A)(i). Record at 148. IHS contended that these third-party collections were not appropriations and thus were not within the scope of the "Secretarial" funding required by 25 U.S.C § 5325(a)(1). *Id.*

Shares of Phoenix Service Unit/Phoenix Indian Medical Center

33. In its Final Offer, the Community requested that IHS include in the FY 2017-2018 FA the Community's shares of the IHS Phoenix Service Unit (PSU) and the IHS Phoenix Indian Medical Center (PIMC). Record at 78; *id*. at 114 (FA funding table, lines 18–19).

34. The PIMC is in part a regional medical referral center that provides specialized health care services to members of tribes in Arizona, Utah, and Nevada, including the Community. Record at 314 (PIMC profile). The PIMC also operates in part as IHS's PSU, providing direct (non-specialty) health care services to members of six tribes in Arizona, including the Community. Compl., ¶ 44; Answer, ¶ 44.

35. The Community explained in its Final Offer that it was reserving the right to separately negotiate with IHS the amount of the PSU/PIMC shares to be added to the FA, as IHS during negotiations promised it would provide additional information to identify the amount of tribal shares available to the Community. Record at 78.

36. During negotiations, the Community's consultant, Michel Lincoln, asked IHS to identify for the Community the "Level of effort time PSU/PIMC staff spent on Salt River Clinic activities." Brown Decl. ¶ 12. In response, IHS provided a detailed Excel spreadsheet identifying the number of days per annum that these individuals provided services and support to

the Salt River Clinic Program which was the subject of a compact proposal by the community. *Id*.; Record at 277.

37. Time recorded on the PIMC spreadsheet represented a level of effort specific to the Salt River Clinic by these PSU/PIMC staff. The spreadsheet recorded 2,941 days' worth of effort, or some 23,528 hours of work, specifically identified by PIMC directly in support of the Salt River Clinic Program. Record at 277.

38. The PSFAs provided by PSU/PIMC personnel, according to IHS's analysis, are mostly routine primary care and administrative PSFAs—such as ambulatory care, family medicine, pharmacy, third-party billing, and health information management—that the Community began providing when it took over the Clinic at the end of FY 2017. *Compare* Record at 32–34 (listing, in Funding Agreement, PSFAs to be performed by the Community) *with id*. at 277 (listing PSU/PIMC-provided PSFAs in Level of Effort analysis). These are not referral PSFAs but direct, non-specialty health care services and administrative functions performed for the benefit of the Salt River Clinic.

39. Based on IHS's calculation of the PSU/PIMC Level of Effort spent in support of the Salt River Clinic Program, which included personnel costs, time and benefits, and administrative support costs, the full amount of tribal shares plus the associated administrative costs was $1,348,696. *Id*.

40. IHS transferred only $430,306 for PSU shares awarded during the 2017 Compact negotiations—and nothing for PIMC tribal shares. Record at 149–50 (IHS rejection letter).

41. The Community included in its Final Offer the amount, $1,348,696, identified in IHS's Level of Effort analysis as the Community's tribal shares of PSU/PIMC. Record at 114 (FA funding table, column (1), sum of lines 18 and 19).

42. IHS partially rejected this proposal on the ground that "the amount of funds proposed in the final offer exceeds the applicable funding level to which the tribe is entitled." Record at 149. IHS calculated the Community's share of the PSU/PIMC to be only $430,306. Record at 149–50.

Contract Support Costs

43. The parties dispute the amount of CSCs due in both FY 2017 and FY 2018, primarily due to their disagreement on the funding required for PSU/PIMC shares. Compl., ¶ 52; Answer ¶ 52.

44. The Community's FY 2018 indirect cost rate agreement with the Department of the Interior's Interior Business Center, which applies government-wide, calls for an indirect cost rate of 17.40% on a direct cost base comprised of "[t]otal direct costs, less capital expenditures and passthrough funds." Record at 246.

45. The Community's FY 2017 indirect cost rate was 14.90%, again using a direct cost base of total direct costs minus capital expenditures and passthrough funds. Record at 287.

46. In its Final Offer, the Community requested for FY 2017 a total CSC award of $1,840,656, while IHS agreed to pay $1,527,507, a difference of $313,149. Compl., ¶ 73; Answer, ¶ 73. This figure includes $251,460 in pre-award costs requested by the Community but not yet reimbursed by the IHS. *See* 25 U.S.C. § 5325(a)(5), (6).

47. For FY 2018, the Community requested in its Final Offer a total CSC award of $5,973,751, while IHS agreed to pay $2,526,437, a difference of $3,447,314. Compl., ¶ 74; Answer, ¶ 74.

DATED: February 22, 2024

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