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UNITED STATES DISTRICT COURT

FOR THE CENTRAL DISTRICT OF CALIFORNIA

PECHANGA BAND OF INDIANS,

Plaintiff,

v.

ROBERT F. KENNEDY, JR., *et al.*,

Defendants.

No. 5:25-CV-03605-JGB-SP

PECHANGA'S NOTICE OF MOTION AND MOTION FOR SUMMARY JUDGMENT; MEMORANDUM OF POINTS AND AUTHORITIES

Date: June 8, 2026
Time: 9:00 a.m.
Ctrm: Courtroom 1, 2nd Floor
Honorable Jesus G. Bernal

NOTICE OF MOTION AND MOTION

TO ALL PARTIES AND THEIR COUNSEL OF RECORD:

PLEASE TAKE NOTICE that on June 8, 2026, at 9:00 a.m., or as soon thereafter as the matter may be heard, before the Honorable Jesus G. Bernal, United States District Judge, in Courtroom 1, 2nd Floor of the George E. Brown, Jr. Federal Building and United States Courthouse, located at 3470 Twelfth Street, Riverside, CA 92501-3801, Plaintiff Pechanga Band of Indians will and does hereby move for summary judgment declaring that Defendants' Rejection Letter dated July 3, 2025, Compl. Attach. B, Dkt. No. 1-2, of Pechanga's Final Offer dated May 20, 2025, *id*. Attach. A, Dkt. No. 1-1, was unlawful, and issuing an immediate injunction reversing that rejection and compelling Defendants to immediately award and fund the Compact and Funding Agreement attached to the Final Offer as of the effective date stated in the Compact, all as authorized by §§ 5331(a) and 5391(a) of the Indian Self-Determination and Education Assistance Act (ISDA), 25 U.S.C. §§ 5381–5399.

This motion is based upon this Notice of Motion and Motion, the following Memorandum of Points and Authorities, and all other pleadings and papers on file herewith, as well as Pechanga's verified complaint and such other arguments and other materials as may be presented before the Motion is taken under submission.

Dated: May 5, 2026

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MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT OF MOTION FOR SUMMARY JUDGMENT

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INTRODUCTION

The Pechanga Band of Indians (Pechanga or Tribe) moves for summary judgment and an immediate injunction reversing the Indian Health Service's (IHS) unlawful refusal to enter into a compact and funding agreement with the Tribe to operate a desperately needed opioid treatment facility under the Indian Self-Determination and Education Assistance Act (ISDA), 25 U.S.C. §§ 5301–5423.[1]

Title V of the ISDA authorizes IHS to enter into a self-governance compact and associated funding agreement with an Indian tribe, at the tribe's sole option, to assume responsibility for healthcare programs that IHS is authorized by law to operate for the benefit of the tribe. Title V contemplates a negotiation process for the development of such a compact and funding agreement, § 5387(e), but if negotiations falter the ISDA authorizes a tribe to submit a "final offer," § 5387(b). The ISDA then authorizes IHS to "reject" the final offer, but only for four limited reasons and following strict statutory protocols. § 5387(c). Otherwise, the ISDA deems a final offer approved by operation of law. § 5387(b).

Following unsuccessful negotiations, on May 20, 2025, Pechanga conveyed to IHS a Final Offer proposing to assume responsibility for operating IHS's opioid treatment services benefiting Pechanga, and proposing that IHS annually fund the compact and funding agreement with $12,644 of IHS funding already allocated to the Pechanga Band to serve Pechanga citizens (but at the time being paid to an inter-tribal consortium of which Pechanga is a member).[2] Pechanga's Final Offer

[1] All statutory citations in this brief are to Title 25 of the United States Code. Although the Act refers to "the Secretary" of the Department of Health and Human Services, for simplicity this brief refers to IHS since that is the agency which exercised the Secretary's authority in this matter. Unless context demands otherwise, the terms Secretary, IHS, and Defendants are used interchangeably.

[2] The $12,644 was part of a total $20,770 proposed in the funding agreement. Pl.'s Statement of Undisputed Material Facts #23-24 [hereinafter "SUF"]. The

made clear that Pechanga intended to expand services to include non-Indian people, as it is authorized to do under § 1680c(c), and also to add other funds to the $12,644—including tribal funds and program income that Pechanga would collect from Medicare, Medicaid, and private insurers in the course of treating patients—with the result being a multi-million dollar state-of-the-art opioid treatment and primary care facility providing enhanced services to all patients, including Pechanga tribal citizens and other Indians.

IHS rejected Pechanga's Final Offer. IHS's Rejection Letter asserted that the rejection was justified for two of the ISDA's four permitted reasons. In addition, IHS claimed that the proposed compact and funding agreement were "illegal" because (IHS speculated) once the Tribe expanded care, too many non-Indian patients would receive care relative to Indian patients.

IHS's rejection was unlawful. Neither of the asserted statutory rejection reasons applies, and IHS cannot deny a proposed compact and funding agreement simply because a tribe proposes to expand services to non-Indian people. Accordingly, Pechanga respectfully moves the Court to issue an Order granting Pechanga summary judgment and "immediate injunctive relief to reverse" the compact rejection and "compel the Secretary to award and fund" the proposed compact and funding agreement. §§ 5331(a), 5391(a).

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additional funding was to support Pechanga's proposal to assume certain IHS "purchased/referred care" (PRC) program services then under contract to the same inter-tribal consortium. SUF #22. Although IHS did not deny the PRC portion of Pechanga's proposal, to date IHS has not awarded Pechanga a compact or a PRC services funding agreement. Instead IHS has continued to pay all of Pechanga's funds to its inter-tribal consortium. SUF #33.

QUESTION PRESENTED

Whether the Indian Health Service has carried its burden of proof under § 5387(d) to demonstrate by clear and convincing evidence the validity of the grounds for rejecting Pechanga's Final Offer, on one of the following assertions:

(a) under § 5387(c)(1)(A)(i), Pechanga proposed an amount of IHS funds in excess of the applicable funding level to which Pechanga was entitled for IHS opioid treatment services benefiting the Tribe;

(b) under § 5387(c)(1)(A)(ii), Pechanga's proposed compacting of opioid treatment services benefiting the Tribe involved a program that is an inherent federal function; or

(c) without regard to § 5387(c)(1)(A)(i) or (ii), IHS properly refused to enter into Pechanga's proposed compact based on IHS's assertion that the resulting compact would be "illegal."

LEGAL STANDARDS

In any civil action appealing an agency rejection of a tribe's contracting or compacting proposal under the ISDA, the standard of review is *de novo*. *Saint Regis Mohawk Tribe v. Kennedy*, No. 8:24-CV-01479, 2026 WL 877117, at *5 (N.D.N.Y. Mar. 31, 2026), *citing inter alia Jamestown S'Klallam Tribe v. Azar*, 486 F. Supp. 3d 83, 87 (D.D.C. 2020) .

In civil actions arising out of the ISDA, the agency "shall have the burden of demonstrating by clear and convincing evidence the validity of the grounds for rejecting the offer." § 5387(d).

The ISDA contains its own controlling rule of statutory construction, mandating that every provision of the ISDA "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." § 5392 (f); *see also* § 5321 (g) (similar).

With respect to the Indian Health Care Improvement Act (IHCIA), §§ 1601–

1685, the Indian law canon of statutory construction is to the same effect. *See Cnty. of Yakima v. Confederated Tribes & Bands of Yakima Indian Nation*, 502 U.S. 251, 269 (1992) ("[S]tatutes are to be construed liberally in favor of the Indians . . . ." (quoting *Montana v. Blackfeet Tribe of Indians*, 471 U.S. 759, 766 (1985)) (alteration in original)).

Summary judgment is appropriate "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); *Celotex Corp. v. Catrett*, 477 U.S. 317, 322 (1986).

FACTUAL AND STATUTORY BACKGROUND

A. The 1975 Indian Self-Determination Act

Compacting Overview. The ISDA established a "meaningful Indian self-determination policy" intended to transition away "from the Federal domination of programs" serving Indians "to effective and meaningful participation by the Indian people in the planning, conduct, and administration of those programs and services." § 5302 (b). The ISDA authorizes a tribe to take over programs IHS is authorized to carry out for Indian beneficiaries and to receive the IHS program funds IHS would otherwise spend for those beneficiaries. The ISDA contemplates the transfer of an IHS program to a tribe either through a Title I contract (§§ 5321–5332) or a Title V compact (§§ 5381–5399). This case concerns a proposed Title V compact.

Under Title V, at a tribe's request "[t]he Secretary *shall* negotiate and enter into a written compact [and funding agreement] with each Indian tribe participating in self-governance in a manner consistent with the Federal Government's trust responsibility, treaty obligations, and the government-to-government relationship between Indian tribes and the United States." § 5384 (a) (emphasis added); *see also* § 5385. The funding agreement, in turn, "*shall* . . . authorize the Indian tribe to

plan, conduct, consolidate, administer, and receive 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." § 5385(b)(1) (emphasis added). When a tribe compacts to run a program, the direct program funding provided by IHS must be no less than what the "Secretary would have otherwise provided for the operation of the programs." § 5325(a)(1) (Title I contract funding provision); § 5388(c) (incorporating Title I standard for Title V compacts). Title V calls this sum a tribe's "tribal share."[3]

Title V gives tribes exceptionally broad authority concerning IHS programs that may be included in a tribal funding agreement. *See* § 5385(b)(1)–(2), (c). In brief, the Act authorizes a Tribe to compact to operate any program, service, function, or activity that IHS is *authorized* to operate under any law, even programs IHS may not in fact be operating. *Saint Regis Mohawk*, 2026 WL 877117, at *11–12 (tribe may compact a congressionally authorized IHS operation-and-maintenance program that IHS is not operating).[4] Multiple statutes (including annual appropriations acts) authorize IHS to carry out opioid, alcohol, and other substance abuse programs benefitting Indians.[5] Importantly, Title V mandates that

[3] "The term "tribal share" means an Indian tribe's portion of all funds and resources that support secretarial programs, services, functions, and activities (or portions thereof) that are not required by the Secretary for performance of inherent Federal functions." § 5381(a)(8). It is also commonly called the "Secretarial amount." *See, e.g.*, *Becerra v. San Carlos Apache Tribe*, 602 U.S. 222, 228 (2024).

[4] Of course, if IHS is not spending *any* IHS funds on a program, the compact or funding agreement will issue with no associated funding; in that event, the Tribe must fund the compacted program with non-IHS funding. *Saint Regis Mohawk*, 2026 WL 877117, at *12 (program funded with third-party revenues earned in carrying out the compact); *see also Fort McDermitt Paiute & Shoshone Tribe v. Price*, No. 17-cv-837, 2018 WL 4637009, at *4 (D.D.C. Sep. 27, 2018).

[5] These include numerous provisions in the Indian Health Care Improvement Act. *See* § 1601; § 1603(2) (defining behavioral health as "the blending of substance

IHS "shall interpret all Federal laws . . . in a manner that will facilitate the inclusion of programs" in compacts and funding agreements. § 5392(a).

Once a tribe compacts an IHS program, § 5386(e) guarantees the tribe the absolute right to "redesign" that program "in any manner which the Indian tribe

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(alcohol, drugs, inhalants, and tobacco) abuse and mental health disorders prevention and treatment for the purpose of providing comprehensive services"); § 1621b(a) (directing the "Secretary, acting through the Service, [to] provide health promotion and disease prevention services to Indians," where "health promotion" includes providing "behavioral health" programs, § 1603(11)(G)(xiii), and "substance abuse" programs, § 1603(11)(G)(xxiv)); § 1621h(b) (addressing "coordination of alcohol and substance abuse programs" of the IHS, Bureau of Indian Affairs, and tribes, "particularly with respect to the referral and treatment of dually-diagnosed individuals requiring mental health and substance abuse treatment"); §§ 1665–1667e (subchapter V-A, addressing Behavioral Health Programs); § 1665a(a)(1) (directing "the Secretary, acting through the Service, Indian tribes, and tribal organizations to develop a comprehensive behavioral health prevention and treatment program which emphasizes collaboration among alcohol and substance abuse, social services, and mental health programs"); § 1665c(a)(1) (directing "[t]he Secretary, acting through the Service, [to] provide a program of comprehensive behavioral health, prevention, treatment, and aftercare, which . . . shall include . . . acute detoxification, psychiatric hospitalization, residential, and intensive outpatient treatment [and] community based-rehabilitation and aftercare"); § 1665g (addressing IHS programs for "acute detoxification and treatment for Indian youths"). Other authorizing statutes include IHS annual appropriations acts. *See, e.g.*, Commerce, Justice, Science; Energy and Water Development; and Interior and Environment Appropriations Act, 2026, Pub. L. No. 119-74, 140 Stat. 5, 147 (Jan. 23, 2026) (2026 Appropriations Act) ("amounts made available within this account [for the Indian Health Service] for the Substance Abuse and Suicide Prevention Program, for Opioid Prevention, Treatment and Recovery Services . . . shall be allocated at the discretion of the Director of the Indian Health Service and shall remain available until expended"); *see also* U.S. Senate Comm. on Appropriations, Joint Explanatory Statement, Division C–Dep't of Interior, Env't, and Related Agencies Appropriations Act, 2026 (Jan. 7, 2026) (available at https://www.appropriations.senate.gov/imo/media/doc/fy26_int_jes.pdf) (allotting $267 million to IHS for alcohol and substance abuse programs).

deems to be in the best interest of the health and welfare of the Indian community being served."

A tribe can authorize an inter-tribal consortium to compact on its behalf, § 5381(a)(5), a practice common among smaller tribes that often join together to combine IHS funding in this way. The inter-tribal consortium then receives each tribe's "tribal share" of IHS funding. If a tribe later withdraws from the inter-tribal consortium, or (as relevant here) withdraws only one or two programs from the inter-tribal consortium, the tribe is "entitled to its tribal share of funds supporting those [programs] that the Indian tribe will be carrying out under its own . . . compact and funding agreement." § 5386(g)(2).

Final Offer Process and Judicial Review. The ISDA tightly constrains IHS's discretion in the compacting process. If a tribe and IHS reach an impasse over the terms of a compact or funding agreement, the tribe may submit a "final offer" to the Secretary. § 5387(b). IHS then has 45 days to review the offer. *Id*. If IHS rejects the offer, IHS must provide the tribe with:

> a timely written notification . . . that contains *a specific finding that clearly demonstrates*, or that is supported by a controlling legal authority that—
>
> (i) the amount of funds proposed in the final offer exceeds the applicable funding level to which the Indian tribe is entitled under [Title V];
>
> (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 . . . .

§ 5387(c)(1)(A) (emphasis added). If IHS does not provide a rejection that is both "timely" and "in compliance with" these criteria, "the offer shall be

deemed agreed to by the Secretary." § 5387(b); *see also* Order Denying Plaintiff's Motion for a Preliminary Injunction at 2 (Apr. 27, 2026), Dkt. No. 66 ("Order") (describing final offer and rejection process).

If IHS rejects a tribe's final offer, the tribe may challenge the rejection in federal court. §§ 5331(a), 5391(a) (extending § 5331 to Title V compacts and funding agreements). In that action, "the Secretary shall have the burden of demonstrating by clear and convincing evidence the validity of the grounds for rejecting the offer." § 5387(d); *see also* § 5398 (similar).[6] In addition, Congress has commanded that every provision of the ISDA "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." §§ 5392(f), 5321(g) (similar). As the Supreme Court put it, "[t]he Government, in effect, must demonstrate that its reading is clearly required by the statutory language." *Salazar v. Ramah Navajo Chapter*, 567 U.S. 182, 194 (2012) (discussing similar provision codified at § 5329(c), Model Agreement § 1(a)(2)).

B. Services to Non-Indians Under the Indian Health Care Improvement Act

The IHCIA authorizes both IHS and tribes operating ISDA contracts or compacts to expand care to non-Indians. In the case of IHS, the local tribe must "request" the expansion, and both IHS and the tribe must jointly determine "that the provision of such health services will not result in a denial or diminution of health services to eligible Indians." § 1680c(c)(1).[7] In the case of a compacting

[6] This burden on IHS is in marked contrast to routine Administrative Procedure Act litigation, where the *plaintiff* carries the burden to prove that an agency action is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." *See* 5 U.S.C. § 706(2)(A).

[7] "The Secretary is authorized to provide health services under this subsection through health facilities operated directly by the Service to individuals who reside

tribe, the tribe *itself* "is authorized to determine whether health services should be provided" to non-Indians after "tak[ing] into account" the possible impacts of doing so on services to Indians. § 1680c(c)(2) (cross-referencing § 1680c(c)(1)(B)).[8] The statute gives IHS no role in such a determination by a tribe. Once a tribe makes that determination, the IHCIA commands that services to non-Indian patients are "deemed to be provided under the [ISDA compact]." *Id.* (often referred to as the "deemer" clause).

In the case of "health services provided by [IHS]" to non-Indians, the IHCIA further provides that patients must "reimburse[] [IHS] in an amount not less than the actual cost of providing the health services." § 1680c(c)(3)(A). [9] A recurring appropriations act measure provides that "in accordance with the IHCIA," *tribally*

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within the Service unit and who are not otherwise eligible for such health services if—(A) the Indian tribes served by such Service unit requests such provision of health services to such individuals, and (B) the Secretary and the served Indian tribes have jointly determined that the provision of such health services will not result in a denial or diminution of health services to eligible Indians."

[8] "In the case of health facilities operated under a contract or compact entered into under the [ISDA], the governing body of the Indian tribe . . . providing health services under such contract or compact is authorized to determine whether health services should be provided under such contract or compact to individuals who are not eligible for such health services under any other subsection of this section or under any other provision of law. In making such determinations, the governing body of the Indian tribe or tribal organization shall take into account the consideration described in paragraph (1)(B). Any services provided by the Indian tribe . . . pursuant to a determination made under this subparagraph *shall be deemed to be provided under the agreement entered into by the Indian tribe or tribal organization under the [ISDA]*." (Emphasis added.)

[9] "Persons receiving health services provided by the Service under this subsection shall be liable for payment of such health services under a schedule of charges prescribed by the Secretary which, in the judgment of the Secretary, results in reimbursement in an amount not less than the actual cost of providing the health services."

administered facilities must similarly "charge[]" non-Indian patients for their health care.[10] Finally, the IHCIA requires that all direct reimbursements a tribe receives must be devoted to various health care purposes. §§ 1621f (itemizing various reimbursements subject to § 1641), 1641(d)(2)(A) (addressing permitted uses of reimbursements).

C. Pechanga's Proposed Compact[11]

The need for opioid treatment in Native communities is well-documented, *see* Compl. ¶¶ 38–41, Dkt. No. 1,[12] and IHS itself acknowledges "[t]he impact of the opioid crisis on American Indian and Alaska Native (AI/AN) populations is immense," Indian Health Serv., *Community Opioid Intervention Pilot Projects*, 85 Fed. Reg. 65,845 (Oct. 16, 2020). After experiencing multiple tribal member deaths due to opioid addiction and overdose, Pechanga decided to establish its own opioid treatment program to provide desperately needed services for its members and other Indians in the area. Compl. ¶ 46; Yoder Decl., Ex. 2, at 1–2, Dkt. No. 58-4 (providing data on tribal member need, including 14 members who received treatment for substance abuse in a six-month span, and at least eight opioid-related tribal member deaths in the past five years); SUF #5-7, 13; *see also* Order at 8.

Pechanga is a member of Riverside San-Bernardino County Indian Health,

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[10] *See, e.g.*, 2026 Appropriations Act, 140 Stat. at 149 ("*Provided*, That in accordance with the provisions of the Indian Health Care Improvement Act, non-Indian patients may be extended health care at all tribally administered or Indian Health Service facilities, *subject to charges* . . . .").

[11] Some of the facts set forth in this section are included only for helpful context. Facts that are *material* to the precise legal question presented—whether IHS's rejection of Pechanga's final offer was lawful—are restated in Plaintiff's Statement of Undisputed Material Facts.

[12] "[A] verified complaint may serve as an affidavit for purposes of summary judgment if it is based on personal knowledge and if it sets forth the requisite facts with specificity." *Moran v. Selig*, 447 F.3d 748, 759 n.16 (9th Cir. 2006).

Inc. (Riverside), SUF #2, an inter-tribal consortium of nine federally recognized tribes that provides health care services to the tribes' members and to unaffiliated IHS Indian beneficiaries, SUF #3. Riverside operates federal IHS programs pursuant to a Title V compact, and as an inter-trial consortium its compact is funded with each of its constituent tribes' "tribal shares" of IHS funding. *Supra* note 3; SUF #4.

Riverside does not provide comprehensive opioid addiction treatment, and it supports the transfer of funds for Pechanga's opioid program. Compl. ¶ 47; Yoder Decl., Attach. 1, at 6–7 Dkt. No. 58-4 (Riverside letter); SUF #26. In order to expand the services available to its members, Pechanga proposed to enter into its own compact with IHS under which it would transfer 2.5% of Pechanga's existing tribal share of IHS funds from Riverside to the Tribe, and of which Pechanga would then devote $12,644 annually to provide opioid treatment services to its tribal citizens.[13] Compl. ¶ 46; SUF #9, 16, 24.

The proposal only addressed Pechanga's tribal share of its own IHS program funds already managed by Riverside; that is, it demanded *no* additional IHS program funding. Pechanga explained its intent to then stand up and operate an opioid treatment program for its citizens that would also be expanded to insured or paying non-Indian patients as permitted under § 1680c(c)(2), using a combination of the $12,644 in IHS funds designated to serve Pechanga's own members, several million dollars of Pechanga's own funds (for initial investment in developing the

[13] The remaining $8,126 would fund Pechanga's PRC program, *see supra* note 2. IHS *agreed* to these sums in the negotiations, Compl. ¶¶ 60–61, 78–79, 83, and so did Riverside, *id.* ¶ 47; SUF #26. That said, the proposed amount for the opioid treatment program is but a tiny portion of the several million dollars Pechanga anticipates actually spending each year to operate the clinic (funded principally with anticipated third-party revenues from Medicaid, but not any additional IHS funding). SUF #17.

facility), and anticipated third-party collections from Medicaid and other insurers. Compl. ¶¶ 47–49, 62; SUF # 10-11, 17, 22.

Pechanga initiated the compacting process with IHS in August 2023. Compl. ¶ 52; SUF #8. Pechanga and IHS, through IHS Area Lead Negotiator Wesley Simmons, met multiple times over the following year to negotiate the terms of the compact and funding agreement. Compl. ¶¶ 54–83; SUF #12.

IHS assisted Pechanga with drafting a resolution authorizing Pechanga to serve non-Indian patients pursuant to section 813 of the IHCIA, § 1680c(c)(2). Compl. ¶¶ 64–65, 72–74. Similarly, the parties reached agreement on the amount of its tribal share funding that Pechanga would withdraw from Riverside to form the base IHS funding for the Pechanga compact; Mr. Simmons agreed to Pechanga's tribal resolution authorizing the withdrawal of 2.5% of its existing tribal share funding from Riverside to fund the new compact (including the $12,644 for the opioid treatment clinic). *Id.* ¶¶ 76–79.

In late 2024, IHS began to express concerns about Pechanga's proposed services to non-Indians, and also raised concerns about a contractor the Tribe had engaged to assist with standing up the clinic. *Id.* ¶¶ 85–112. On April 25, 2025, IHS declared an impasse. *Id.* ¶¶ 113–19; SUF #14. On May 20, 2025, the Tribe sent IHS its Final Offer seeking approval of its proposed Title V compact and funding agreement. Compl. ¶ 121; SUF #15; *see also* Final Offer, Compl., Attach. A, Dkt. No. 1-1.

On July 3, 2025, IHS issued the Rejection Letter rejecting the Tribe's Final Offer. Compl. ¶ 136; SUF #28. IHS listed three reasons for its rejection: (1) the opioid treatment program would not sufficiently benefit Native patients; (2) Pechanga requested too much federal program funding; and (3) the determination of what programs may be operated under the ISDA by tribes is an inherent Federal function. Rejection Letter at 11, Compl., Attach. B, Dkt. No. 1-2; SUF #29–32.

In an effort to avoid litigation, Pechanga requested technical assistance from IHS to overcome IHS's objections. Compl. ¶ 143; *see* § 5387(c)(1)(B). In September 2025, Pechanga also secured a meeting with IHS Acting Director Smith, Compl. ¶¶ 147–49, and followed up with a detailed letter urging IHS to reverse the rejection, *id.* ¶¶ 150–152. When IHS did not respond, this lawsuit followed.

ARGUMENT

I. IHS HAS NOT CLEARLY DEMONSTRATED THAT ANY OF THE STATUTORY REJECTION GROUNDS APPLY.

We first address the portion of IHS's rejection that invoked two of the ISDA's four rejection criteria: that "the amount of [federal] funds proposed in the final offer exceeds the applicable funding level to which the Indian tribe is entitled," § 5387(c)(1)(A)(i), and that Pechanga proposed to operate "an inherent Federal function that cannot legally be delegated to an Indian tribe," § 5387(c)(1)(A)(ii). Both contentions fail.

A. Rejection Criterion (i) Does Not Apply.

IHS asserts that Pechanga proposed too much IHS funding, triggering § 5387(c)(1)(A)(i). But IHS's rejection never explained why it believed this was the case, and what the 'right' funding amount would be. In any event, under the facts it was an impossibility for the Tribe to have requested too much funding.

Pechanga never proposed receiving *any* new or increased funding from IHS. Instead, Pechanga's tribal share of IHS's annual funding had long before been identified and transferred by IHS to Pechanga's inter-tribal organization Riverside. Pechanga's final offer then only proposed shifting a *de minimus* $12,644 of *its own tribal share* funding to its compact, to be used for its Indian opioid treatment program. SUF #9, 16. It requested no additional IHS funds to serve unaffiliated

Indians (or non-Indians).[14]

Since Pechanga's total "tribal share" represents Pechanga's *own* "portion of all [IHS] funds and resources that support secretarial programs" to serve its own tribal citizens—in other words, "money [that] already belongs to Pechanga," Order at 10—it is impossible for Pechanga's Final Offer to "exceed[] the applicable funding level to which [Pechanga] is entitled" under § 5387(c)(1)(A)(i). To the contrary, the ISDA expressly *protects* a tribe's right to withdraw its own share of funds from an intertribal organization, § 5386(g)(2)(A), along with its right to "reallocate or redirect funds . . . in any manner which the Indian tribe deems to be in the best interest of the health and welfare of the Indian community being served," § 5386(e). Importantly, IHS never contended that the $12,644 in IHS funding at issue here will not be used exclusively for the benefit of Pechanga tribal citizens.[15]

The "applicable funding level" for all of Pechanga's IHS-funded operations was long ago agreed to. Since Pechanga never requested any additional funding from IHS, it was unlawful for IHS to reject the proposed compact and funding

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[14] The fact that Pechanga did *not* seek an additional allocation of funds to serve any other Indians, including "unaffiliated Indians," is a complete answer to IHS's misstatement to the contrary. *See* Rejection Letter at 6 (first citing *Shingle Springs Rancheria v. Indian Health Serv.*, DAB CR 318 (1994) and then citing *Pit River Health Serv. v. Indian Health Serv.*, DAB CR 333 (1994)).

Pechanga also did not propose any alteration to the IHS eligibility requirements for serving Indian patients who present for care, *cf. Susanville Indian Rancheria v. Leavitt*, No. 2:07-CV-259-GEB-DAD, 2008 WL 58951 (E.D. Cal. Jan. 3, 2008), so no Indian patient will be denied care.

[15] As the Court noted, the Tribe's Final Offer "sufficiently ensure[s] that compact funds will be used for eligible Indian patients." Order at 9.

agreement based upon § 5387(c)(1)(A)(i).[16]

B. Rejection Criterion (ii) Does Not Apply.

IHS's one paragraph invocation of subsection 5387(c)(1)(A)(ii) equally lacks any basis in law or fact.

IHS asserts that Pechanga's proposal somehow represents a noncontractible "inherent federal function" because, as IHS frames it, Pechanga would be exercising IHS's judgment about whether the program would be carried out for the benefit of Indians and therefore whether the program is contractible. Rejection Letter at 11.

The Court has aptly characterized this argument as "ridiculous." Order at 11.

First, IHS misstates § 5387(c)(1)(A)(ii). Under the only "reasonable, logical reading" of the statute, § 5387(c)(1)(A)(ii) asks simply whether the *targeted IHS program*—the program "that is the subject of the final offer"—is inherently federal. *See* Order at 11. "It does not authorize IHS to sweep into [this provision] the *decision* whether a program complies with another part of the statute." *Id.* (emphasis in original). Here, the program "that is the subject of the final offer" is simply an IHS opioid treatment program, SUF #22; it is not "the determination of whether the program will be carried out for the benefit of Indians because of their status as Indians."

IHS conceded in open court that Indian opioid treatment programs *are* compactible and can therefore be delegated to a tribe, Tr. of Mot. Hr'g at 22:4–24 (Apr. 27, 2026), Dkt. No. 64, a concession compelled by the mountain of statutes

[16] Stated less technically, Pechanga's tribal share of IHS healthcare funding cannot be the right amount when compacted by Riverside, yet the wrong amount when compacted by Pechanga. (Moreover, were IHS's assertion true, IHS would have been required to award the lesser funding amount it believed was compliant with the Act, § 5387(c)(1)(A); but instead, IHS rejected the compact altogether.)

which authorize IHS to operate Indian substance abuse programs generally and Indian opioid programs in particular. *Supra* p. 5 and note 5. If a program is compactible, by definition it is *not* an "inherent federal function" that only IHS can operate. That concession defeats IHS's reliance on subsection 5387(c)(1)(A)(ii).

Concessions aside, IHS is simply wrong when it asserts (somewhat incoherently) that "the determination of whether the program [under tribal operation] will be carried out for the benefit of Indians because of their status as Indians is an 'inherent Federal function.'" Rejection Letter at 11. Not only is providing healthcare services *not* an inherently federal function, deciding to expand services to non-Indians is *also* not an inherently federal function. To the contrary, it is precisely what Congress authorized a tribe to do in § 1680c(c). *Supra* pp. 8–9. A *tribal* decision under that section therefore cannot possibly implicate any inherently *federal* function.[17]

C. IHS Cannot Prevail By Claiming Pechanga's Proposed Compact and Funding Agreement are "Illegal."

As this Court has noted, "Section 5387(c) is clear that there are only four possible bases for rejecting a final offer." Order at 7; *see supra* p. 7. Frustrated by this limitation, IHS spends most of the decisional portion of its Rejection Letter arguing that it has additional power to refuse to award a compact if it determines the proposed compact and funding agreement are "illegal." Rejection Letter at 6–9.

Even if IHS could reach beyond the four statutory rejection grounds, its refusal to approve Pechanga's compact on this score is plainly wrong. Obviously, there is nothing unlawful in a tribe compacting an IHS program with IHS funds appropriated to serve tribal members. Nor is there anything unlawful in a tribe

[17] The best on-the-ground evidence supporting the Tribe is the fact that at least two other tribes in California (Pinoleville and Viejas) contracting with IHS under the ISDA are carrying out identical IHS Indian opioid treatment programs expanded to also treat non-Indian patients.

expanding that program on a pay-as-you-go basis to non-Indians by using *non*-IHS funds such as Medicaid collections. To the contrary, this is *expressly* what Congress authorized in § 1680c(c).

IHS argues that Congress limited a tribe's authority to expand care in two ways: by requiring the tribe to consider the impact that doing so would have on health care for Indians, § 1680c(c)(2), and by requiring non-Indian patients to pay for their care in full (either directly or through insurance, including Medicare and Medicaid), § 1680c(c)(3). IHS then jumps from those two limitations to assert that other limitations exist too—limitations IHS invents with no statutory support—namely that some unspoken threshold percentage of non-Indian patients renders a given program no longer an Indian program. Rejection Letter at 8–9.

But basic rules of statutory construction foreclose that conclusion. For one thing, when Congress specifies precise limitations without leaving the door open to others, it means no other limitations can be implied. *Cf. United States v. Johnson*, 529 U.S. 53, 58 (2000). For another, to read an ambiguity into § 1680c(c)(2) and resolve it against the Tribe would violate the controlling rules of statutory construction, *supra* pp. 3–4, all the more so given that § 1680c(c)(2) is interlocked with the ISDA's rule of construction through § 1680c(c)(2)'s "deemer" clause, *supra* p. 9.

More fundamentally, reading § 1680c(c)(2) to grant IHS power to determine either when or the extent to which a tribe can expand services to non-Indian people is contrary to the express terms of that section and diametrically opposed to everything Congress sought to achieve in the ISDA and the IHCIA: to maximize tribal self-determination and self-governance over all tribal health care operations. IHS's contorted view of what is "illegal" contradicts the ISDA's primary goal of allowing tribes to make their own decisions about how best to serve their members, including whether to serve non-Indians with non-IHS funds to create more robust

programs for all patients including the tribe's own citizens.[18]

IHS insists that it "lacks the contracting authority to allow" the Tribe to compact for this program, Rejection Letter at 9, because the program "would overwhelmingly benefit non-Indians, rather than provide health services for the benefit of Indians because of their status as Indians as mandated by the [ISDA]," *id.* at 6. But the ISDA does not "impose any requirement that the tribe must promise a certain number of tribal members will certainly use the program once it exists." Order at 9. Rather, the statute makes clear "that eligible Indians need not be the *only* beneficiaries of a program" a tribe chooses to operate. *Id.* at 8 (citing § 5383(b)(2)).[19] Moreover, as just noted, it is § 1680c(c)(2) that expressly authorizes a tribe to take an Indian services program and to expand it to non-Indian patients too, so long as those non-Indian patients are charged for their services. If more were needed, it bears adding that a tribe can even operate a program in a manner that IHS is *prohibited by law* from doing. *See Susanville Indian Rancheria*, 2008 WL 58951, at *6–10 (affirming right of Tribe to charge certain Indian patients for services, even though IHS is prohibited from doing so). If a Tribe can operate a program in a manner IHS never could, *a fortiori* a tribe can operate a program in a manner that IHS could do too (as is the case under § 1680c(c)(1)). Again, nothing in the ISDA establishes a test or limitation on the extent to which a

[18] Because § 1641(d)(2)(A) requires that all Medicaid and Medicare revenues be spent on the contracted program or other healthcare purposes, the Tribe's expansion of services to non-beneficiaries will ultimately allow it to provide *more* services to its members and other IHS beneficiaries.

[19] As the Court has explained, "Section 5385 does not require that some threshold percentage of individuals living in the vicinity of the proposed clinic be tribal members in order to permit IHS funding." Order at 9.

tribe can expand a compacted program using non-IHS funds under § 1680c(c)(2).[20]

IHS is also wrong in asserting that the contractibility of IHS programs under § 5385(b)(1) and (2) is limited. To the contrary, the plain meaning of the statutory text (particularly the expansive word "include" in subsection (2)) is that Congress intended to *expand* tribal program eligibility to every last program IHS is authorized to carry out under any federal law and at any level of IHS, even including inside IHS headquarters.[21] *See, e.g.*, S. Rep. No. 106-221, at 9 (1999) ("The Committee is concerned with the reluctance of the [IHS] to include all available federal health funding in self governance funding agreements. . . . This section is intended to directly remedy this situation."); H.R. Rep. No. 106-477, at 21 (1999) (same).

Subsections 5385(b)(1) and (2) emphasize that IHS must allow a tribe to compact for "all" programs IHS is authorized to operate for Indian beneficiaries, and an Indian opioid treatment program is surely that. *Supra* p. 5 and note 5. And to drive home this point, Congress directed IHS to *facilitate the inclusion of programs* in tribal compacts, § 5392(a), never mind that Congress also directed IHS to liberally interpret the Act for the benefit of the compacting tribe. § 5392(f).

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[20] *Susanville* completely demolishes IHS's assertion the "[t]he IHS may only contract for that which it may do." *Compare* 2008 WL 58951, at *10 *with* Rejection Letter at 11.

[21] The word "include" is equivalent to "include but is not limited to." *See* House Office of Legislative Counsel Guide to Legislative Drafting (available at https://legcounsel.house.gov/holc-guide-legislative-drafting) ("The basic distinction between ["means" and "includes"] is that "means" is exclusive while "includes" is not. If a definition says that "the term 'X' means A, B, and C", then X means *only* A, B, and C and cannot also mean D or E. If a definition says that "the term 'X' includes A, B, and C", then X must include A, B, and C, but it may also include D or E, or both. Thus, the phrase 'includes, but is not limited to' is redundant.").

IHS's narrow reading of § 5385(b)(1) and (2) is contrary to the Act.[22]

IHS caps its argument with two additional cases, Rejection Letter at 7–8, but both are inapposite. *Navajo Nation v. Department of Health and Human Services*, 325 F.3d 1133 (9th Cir. 2003), did not involve an IHS program at all, but the general public assistance program Temporary Assistance for Needy Families (TANF). Since the TANF program only "collaterally benefit[s] Indians as part of the general population," the court concluded that TANF programs are not contractible. *Id.* at 1138.[23] Here, by contrast, it is undisputed that an IHS-funded opioid treatment program "is *precisely* the kind of federal program IHS offers specifically for Indians and is subject to compacting under the ISDA." Order at 9; *see supra* p. 5 and note 5.

IHS's reliance on *Jamestown S'Klallam Tribe v. Azar* is even more peculiar, because in that case IHS never disputed that the ISDA agreement with the tribe was perfectly lawful even though *97% of the patient load was non-Indian*. 486 F. Supp. 3d 83 (D.D.C. 2020). (IHS only contested the reasonableness of reimbursing certain leasing costs associated with serving those non-Indians. *Id.* at 85–86.)

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[22] In *Susanville*, IHS argued that a tribe's proposed compact went beyond the scope of IHS's authority because it was "not a program provided to eligible beneficiaries under Federal law," nor "a program that IHS is authorized to administer." 2008 WL 58951, at *6 (citing § 5385(b)(1)–(2), then codified at § 458aaa-4(b)(1)–(2)). The court rejected this argument, emphasizing that when a tribe enters an ISDA compact, IHS "turns over the provision of federal [programs] to that tribe" and the tribe is free to operate the program in the manner it deems best; it "is not required to operate a [program] in the same manner as the IHS." *Id.* at *10. The court reversed IHS's rejection because IHS "ha[d] not shown, by clear and convincing evidence," the validity of its "decision to reject Plaintiff's final offer on the ground that the ISDEAA prohibited the IHS from accepting the final offer." *Id.* The same is true here.

[23] As this Court explained, the key in *Navajo Nation* was "the fundamental nature of the program[]," not the percentage of tribal members served. Order at 10.

Nothing in *Jamestown* supports IHS's assertion that it is unlawful for IHS to award ISDA compacts that replicate the *Jamestown* situation.[24]

II. THE PROPER REMEDY IS THE AWARD AND FUNDING OF PECHANGA'S PROPOSED COMPACT AND FUNDING AGREEMENT.

Given the foregoing, IHS has failed to carry its burden of proof to demonstrate "by clear and convincing evidence the validity of [any of] the grounds for rejecting [Pechanga's] offer." § 5387(d). Summary judgment should therefore be entered against IHS declaring IHS's rejection to be unlawful, deeming the compact and funding agreement approved by operation of law (because it was never lawfully rejected, *see* § 5387(b)(final sentence)), and issuing "immediate injunctive relief to reverse [the] rejection finding[s]" and "compel [IHS] to award and fund" the approved compact and funding agreement, § 5331(a), *see* § 5391(a).

This relief is standard practice in ISDA litigation overturning unlawful rejections or declinations.[25] But here, the facts are particularly compelling. First,

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[24] IHS spills a considerable amount of ink trying to malign Pechanga's decision to work with consultant OneTogether Solutions to help Pechanga stand up its opioid treatment clinic (Rejection Letter at 10–11 & n.4). But none of IHS's three reasons for rejecting Pechanga's proposal relies upon this arrangement. The role OneTogether Solutions may ultimately play in Pechanga's clinic is thus irrelevant to the issue presented here. (That said, it bears noting that the ISDA affords IHS *no* role in second-guessing a sovereign tribe's decision how best to serve its tribal citizenry, including whether to engage consultants, award grants, or operate programs entirely on its own.)

[25] "Because the [ISDA] specifically provides for both injunctive and mandamus relief to remedy violations of the Act, . . . the Tribe need not demonstrate the traditional equitable grounds for obtaining the relief it seeks," and a court may award immediate injunctive relief without considering the ordinary test for a preliminary injunction. *Pyramid Lake Paiute Tribe v. Burwell*, 70 F. Supp. 3d 534, 545 (D.D.C. 2014) (first citing § 5331(a), then codified at 450m–1(a); then citing *Susanville*, 2008 WL 58951, at *10–11; and then citing *Red Lake Band of Chippewa Indians v. Dep't of the Interior*, 624 F. Supp. 2d 1, 25 (D.D.C. 2009)).

despite nothing even arguably objectionable in the four corners of the compact, to this day IHS has never awarded the compact. Second, despite technically approving the portion of the proposed funding agreement addressing PRC services (*supra* note 2), IHS not only failed promptly to effectuate that award; it marched forward as if nothing had changed. Today, IHS reports that it awarded *all* of Pechanga's FY 2026 funds to Riverside. SUF #33. It then has the audacity to complain that, having done so, any relief today would require IHS to prospectively deobligate funds from Riverside and only then to reobligate those funds to Pechanga, all of which will take an indeterminate amount of time, or else IHS could find itself having doubly obligated its appropriation. Defs.' Opp'n to Pl.'s Mot. Prelim. Inj. at 22, Dkt. No. 59.

All this is a mess of IHS's own making, starting with its illegal refusal to award the compact and funding agreement in the first place, compounded by IHS's unilateral decision to continue transferring Pechanga's funds at issue here to Riverside. Fortunately, IHS is a multi-billion-dollar agency funded in the main with large lump-sum appropriations. In other similar situations, judges have ordered IHS to award the compacts, contracts, and funding agreements at issue as originally proposed, including with respect to funding as of the effective date, forcing IHS to draw funds from its lump sum appropriations or otherwise as

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This is because "it is not the role of the courts to balance the equities between the parties [where] Congress has already balanced the equities and has determined that, as a matter of public policy, an injunction should issue where the defendant is engaged in . . . any activity which the statute prohibits." *Star Fuel Marts, LLC v. Sam's E., Inc.*, 362 F.3d 639, 652 (10th Cir. 2004) (alterations in original) (citation omitted). Courts have routinely issued injunctions pursuant to § 5331 after concluding that IHS violated a provision of the ISDA. *E.g.*, *Susanville*, 2008 WL 58951, *10–11; *Red Lake Band*, 624 F. Supp. 2d at 25–26; *Pyramid Lake Paiute Tribe*, 70 F. Supp. 3d at 545–46.

necessary to comply with the Court's order. *See, e.g.*, *Navajo Health Found.-Sage Mem'l Hosp., Inc v. Burwell*, 220 F. Supp. 3d 1190, 1266 (D.N.M. 2016).

The proper remedy under the ISDA is the award of the proposed compact and funding agreement as of the effective date of July 4, 2025. *See Saint Regis Mohawk*, 2026 WL 877117 at *13 ("Because the Proposed Amendment to the Funding Agreement would have been effective in full on August 8, 2024 had IHS not partially rejected it, the Court deems those portions of the Proposed Amendment that IHS rejected . . . effective as of August 8, 2024."). The Compact was submitted May 20, 2025, and became effective at the end of the 45-day review period. Compl. Attach. A, Proposed Compact at 15, Dkt. No. 1-1 ("Section 2 — Effective Date. (a) This Compact and the Funding Agreement, attached hereto as Attachment 2, are effective as of the earlier of the date of approval by the Secretary or deemed approval per 25 U.S.C. § 5387(b)."); SUF #15, 18. The effective date is thus July 4, 2025. SUF #19.

Of course, if IHS refuses to award and fund the contract as of that date, Congress in § 5331(a) has also empowered this Court to award Pechanga "money damages." In this instance, those damages would be no less than the face value of the proposed funding agreement, from the effective date of the funding agreement through 2026. The total annualized funding amount for the opioid treatment program set forth in the proposed funding agreement was $12,644 for calendar year 2025.[26] Final Offer at 49; SUF #24. On July 4 there remained 180 days in 2025, or 49.32% of the fiscal year. Thus, for calendar year (CY) 2025, Pechanga is

[26] Pechanga's compact (like Riverside's) operates on a calendar year basis. Final Offer at 40.

due $6,236.02, and for CY 2026 Pechanga is owed no less than $12,644, for a total of $18,880.02.[27]

CONCLUSION

For the foregoing reasons, Pechanga is entitled to summary judgment reversing as unlawful IHS's refusal to approve, award and fund the compact and funding agreement attached to Pechanga's final offer, ordering injunctive relief as specified in the preceding section, and awarding specific performance or money damages totaling no less than $18,880.02.[28]

Respectfully submitted this 5th day of May 2026.

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[27] We say "no less" because by the terms of the compact each year Pechanga has a right to a proportionate increase reflecting any increase in new appropriations enacted over the preceding year. Final Offer at 38. If the Court enters the requested Judgment, IHS will automatically compute that additional sum as required by the Compact.

[28] Upon entry of judgment, Pechanga reserves the right to seek attorneys' fees to the extent authorized in the Equal Access to Justice Act, 28 U.S.C. § 2412.

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LOCAL RULE 11-6.2 CERTIFICATE OF COMPLIANCE

The undersigned, counsel of record for Plaintiff Pechanga Band of Indians, certifies that this memorandum complies with the limit set out in section 9.b. of this Court's Standing Order, Dkt. No. 36, because it does not exceed 25 pages. The memorandum has been prepared in a proportionally-spaced typeface using Microsoft Word for Office 365 Times New Roman 14-point font.

DATED this 5th day of May 2026 at Anchorage, Alaska.

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