[ORAL ARGUMENT NOT YET SCHEDULED]

No. 19-5299

UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

SWINOMISH INDIAN TRIBAL COMMUNITY,
Appellant,

v.

ALEX M. AZAR, II, *et al.*,
Appellees.

On Appeal from the United States District Court for the District of Columbia, No. 1:18-cv-01156-DLF
Before the Honorable Dabney L. Friedrich

BRIEF AMICI CURIAE OF 19 NATIVE AMERICAN TRIBES AND TRIBAL ORGANIZATIONS AND THE NATIONAL CONGRESS OF AMERICAN INDIANS IN SUPPORT OF APPELLANT AND IN SUPPORT OF REVERSAL

Skip Durocher
James Nichols
DORSEY & WHITNEY LLP
50 South Sixth Street, Ste 1500
Minneapolis, MN 55402
612-340-2600

Lloyd B. Miller
Donald J. Simon
SONOSKY, CHAMBERS, SACHSE, ENDRESON & PERRY, LLP
1425 K Street NW, Ste 600
Washington, DC 20005
202-682-0240

Linus Everling
General Counsel
Tom Murphy
Deputy General Counsel
GILA RIVER INDIAN COMMUNITY
P.O. Box 97
Sacaton, Arizona 85247
520-562-9760

Rebecca A. Patterson
Whitney A. Leonard
K. Amanda Saunders
SONOSKY, CHAMBERS, SACHSE, MILLER & MONKMAN, LLP
725 East Fireweed Lane, Ste 420
Anchorage, AK 99503
907-258-6377

CERTIFICATE AS TO PARTIES, RULINGS, AND RELATED CASES

I. PARTIES AND AMICI

Except for the following, all parties and amici appearing before the district court and in this court are listed in the Brief for Appellant. The following amici appear in this appeal but did not appear in the district court:

Alaska Native Tribal Health Consortium
Cherokee Nation
Chickasaw Nation
Confederated Salish and Kootenai Tribes of the Flathead Reservation
Copper River Native Association
Forest County Potawatomi Community
Gila River Indian Community
Little River Band of Ottawa Indians
Muscogee (Creek) Nation
National Congress of American Indians
Navajo Health Foundation – Sage Memorial Hospital
Navajo Nation
Riverside-San Bernardino County Indian Health, Inc.
San Carlos Apache Tribe
Shoshone-Paiute Tribes of the Duck Valley Reservation
Southcentral Foundation
Spirit Lake Tribe
Tanana Chiefs Conference
Yukon-Kuskokwim Health Corporation
Zuni Tribe of the Zuni Reservation

II. RULINGS UNDER REVIEW

All references to the rulings at issue appear in the Brief for Appellant.

III. RELATED CASES

This case has not previously been before this Court or any other court except the District Court below. There are no other cases pending in this Court or in any other court involving substantially the same parties and the same or similar issues, except the following case involving Amicus Gila River Indian Community: *Gila River Indian Community v. Azar,* No. 1:19-03550-CRC (D.D.C.).

CORPORATE DISCLOSURE STATEMENT

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

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

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

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

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

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

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

The Yukon-Kuskokwim Health Corporation is an intertribal consortium that has no parent corporation. No publicly held corporation owns 10% or more of its stock.

All other amici are federally recognized Indian tribes.

TABLE OF CONTENTS

INTEREST OF AMICI 1

INTRODUCTION 1

ARGUMENT 2

I. CONGRESS REQUIRED FULL CSC REIMBURSEMENT IN DIRECT RESPONSE TO AGENCY FAILURES THAT CONTINUE TODAY. 2

A. Congress Intended to Eliminate the Practice of Forcing Tribes to Choose Between Subsidizing Federal Programs with Tribal Funds or Diverting Federal Program Funding to Cover Overhead Costs. 3

B. IHS's Failure to Reimburse CSCs Associated with the Portion of the Federal Program Funded with Third-Party Revenues Compels Reductions in Program Funding, Contrary to Congress's Intent. 7

II. THE "FEDERAL PROGRAMS" TO BE SUPPORTED WITH CSC FUNDING INCLUDE THE PORTIONS OF THOSE PROGRAMS FUNDED WITH THIRD-PARTY REVENUES. 13

A. The Text of the Statute Compels a Broad Interpretation of "Federal Program." 13

B. IHS Collects and Spends Third-Party Revenues in the Same Manner as Tribes, and IHS Treats These Revenues as an Integral Part of its Federal Program. 18

C. The District Court's Interpretation of "Federal Program" Conflicts with the Act and with IHS's Own Practices.......................................21

D. The District Court's Interpretation of "Federal Program" Misunderstood How CSC Amounts Are Determined. 24

III. THE ANTI-DUPLICATION PROVISION DOES NOT NEGATE IHS'S DUTY TO PAY CSC ON THE FULL FEDERAL PROGRAM. 25

CONCLUSION 27

TABLE OF AUTHORITIES

Cases

Bryan v. Itasca Cty., Minn.,
426 U.S. 373 (1976)....................15

Cook Inlet Tribal Council v. Mandregan,
348 F. Supp. 3d 1 (D.D.C. 2018)....................26, 27

Cherokee Nation of Okla. v. Leavitt,
543 U.S. 631 (2005)....................5, 6, 7

King v. St. Vincent's Hosp.,
502 U.S. 215 (1991)....................14

Mittleman v. Postal Regulatory Comm'n,
757 F.3d 300 (D.C. Cir. 2014)....................22

Montana v. Blackfeet Tribe of Indians,
471 U.S. 759 (1985)....................15

Navajo Health Found.—Sage Mem'l Hosp., Inc. v. Burwell,
263 F. Supp. 3d 1083 (D.N.M. 2016)....................26

Ramah Navajo Sch. Bd., Inc. v. Babbitt,
87 F.3d 1338 (D.C. Cir. 1996)....................7

Ramah Navajo Chapter v. Lujan,
112 F.3d 1455 (10th Cir. 1997)....................6

Redding Rancheria v. Hargan,
296 F. Supp. 3d 256 (D.D.C. 2017)....................15

Rumsfeld v. United Techs. Corp.,
315 F.3d 1361 (Fed. Cir. 2003)....................6

Salazar v. Ramah Navajo Chapter,
567 U.S. 182 (2012)....................6, 15

Seminole Tribe of Fla. v. Azar,
376 F. Supp. 3d 100 (D.D.C. 2019)....................27

Swinomish Indian Tribal Cmty. v. Azar,
406 F. Supp. 3d 18 (D.D.C. 2019)....12, 15, 24, 25

Talavera v. Shah,
638 F.3d 303 (D.C. Cir. 2011)....23

United States v. Vecchiarello,
569 F.2d 656 (D.C. Cir. 1977)....23

Federal Statutes

Indian Health Care Improvement Act, 25 U.S.C. §§ 1601-1685

25 U.S.C. § 1621e....7, 18, 19

25 U.S.C. § 1621f....8, 19, 20

25 U.S.C. § 1621u....18

25 U.S.C. § 1623....7, 18, 19

25 U.S.C. § 1641....7, 8, 11, 19, 20, 21

Indian Self-Determination and Education Assistance Act, 25 U.S.C. §§ 5301-5423

25 U.S.C. § 5301....3

25 U.S.C. § 5304....3, 5

25 U.S.C. § 5321....3, 4, 16, 17

25 U.S.C. § 5325....5, 8, 14, 16, 17, 20, 24, 26

25 U.S.C. § 5385....16, 17

25 U.S.C. § 5388....5, 8, 12, 20, 25

25 U.S.C. § 5392....15

Indian Self-Determination and Education Assistance Act Amendments of 1988, Pub. L. No. 100-472, 102 Stat. 2285....4

Indian Self-Determination and Education Assistance Act Amendments of 1994, Pub. L. No. 103-413, 108 Stat. 4250....4, 5

42 U.S.C. § 1395qq 7, 8, 18, 19, 20

42 U.S.C. § 1396j 7, 18, 19

Regulations

2 C.F.R. pt. 200, Appendix VII....................5, 6

Rules

Fed. R. App. P. 29(a)(2)....................1

Fed. R. Evid. 801(d)(2)(D) 23

D.C. Cir. Rule 29(b)....................1

Other Authorities

Dep't of Health & Human Servs., IHS Indian Health Manual, at 6-3.2 (Aug. 6, 2019), https://www.ihs.gov/ihm/pc/part-6/p6c3/ 25

Dep't of Health & Human Servs., IHS FY 2010 Congressional Justification (2010), https://www.ihs.gov/sites/budgetformulation /themes/responsive2017/documents/FY2010BudgetJustification.pdf 18, 19, 20, 22, 23

Gila River Indian Community, ISDEAA Compact with Indian Health Serv., art. V, § 16 20

Merriam-Webster Dictionary, https://www.merriam-webster.com/dictionary....................16

Geoffrey D. Strommer & Stephen D. Osborne, *The History, Status, and Future of Tribal Self-Governance Under the Indian Self-Determination and Education Assistance Act*, 39 Am. Indian L. Rev. 1 (2015)....................8

S. Rep. No. 100-274 (1987) 3, 4, 6, 11, 12

GLOSSARY OF ACRONYMS

"BIA" means the Bureau of Indian Affairs, an agency of the Department of the Interior.

"CSC" means contract support costs.

"IHCIA" means the Indian Health Care Improvement Act.

"IHS" means the Indian Health Service, an agency of the Department of Health and Human Services.

"ISDEAA" means the Indian Self-Determination and Education Assistance Act.

INTEREST OF AMICI

Amici are 19 federally recognized Tribes and tribal organizations[1] that operate Indian Health Service (IHS) hospitals, clinics, facilities and other Federal programs pursuant to contracts awarded under Titles I or V of the Indian Self-Determination and Education Assistance Act of 1975 (ISDEAA), 25 U.S.C. §§ 5301-5423, and the National Congress of American Indians, a national tribal advocacy organization.[2] As required by Federal law, the tribal Amici all bill and collect third-party revenues from Medicare, Medicaid and private insurers, and, just like IHS, they also spend those revenues to fund the Federal healthcare programs they operate. Amici therefore have a strong interest in the outcome of this appeal.

INTRODUCTION

The ISDEAA is the foundation for most of the essential government services that Tribes provide to their members. It is also critical to the United States' fulfillment of its trust responsibility to Tribes, including IHS's duty to provide healthcare to tribal members. Congress in the ISDEAA mandated that IHS fully

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

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

reimburse tribal contract support costs ("CSCs")—the administrative costs necessarily incurred when Tribes operate IHS healthcare programs—in order to maximize Federal program services, avoid penalizing Tribes for taking on this Federal trust responsibility, and maintain parity between IHS and tribal services.

Contrary to that unmistakable intent, IHS's refusal to reimburse all CSCs forces Tribes either to subsidize this Federal responsibility from tribal funds or to divert Federal program funding to pay those costs. It also destroys the parity Congress intended to achieve between tribal and IHS programs. And when it comes to the expenditure of "program income"—third-party revenue from Medicare, Medicaid, and private insurers—it also violates Congress's intent in the Indian Health Care Improvement Act ("IHCIA"), 25 U.S.C. §§ 1601-1685, that third-party revenues be used to expand healthcare programs.

ARGUMENT

I. CONGRESS REQUIRED FULL CSC REIMBURSEMENT IN DIRECT RESPONSE TO AGENCY FAILURES THAT CONTINUE TODAY.

The district court's consideration of the "context" and "structure" of the ISDEAA did not take into account either the critical role that CSC plays in tribal health programs, or the critical role that program income plays in both IHS and tribal health programs. At the most basic level, the district court failed to understand the context in which Congress added the CSC requirement to the Act—it was precisely

to ensure that Tribes receive full reimbursement for their administrative costs in operating all Federal healthcare programs.

A. Congress Intended to Eliminate the Practice of Forcing Tribes to Choose Between Subsidizing Federal Programs with Tribal Funds or Diverting Federal Program Funding to Cover Overhead Costs.

Congress in the ISDEAA required the Secretary to enter into contracts by which Tribes would receive funding to take over the administration of Federal hospitals, clinics, and other Federal programs that were otherwise being operated by IHS or by the Bureau of Indian Affairs (BIA). 25 U.S.C. §§ 5301(a)(1), 5304(i), 5321(a)(1); *see also* Aplt. Br. 6-8.[3] But in the wake of the ISDEAA's enactment, Congress witnessed the "agencies' consistent failures . . . to administer self-determination contracts in conformity with the law," with the BIA and IHS "systematically violat[ing]" the rights of tribal contractors. S. Rep. No. 100-274, at 37 (1987).

Congress recognized that far and away "*the single most serious problem* with implementation of the Indian self-determination policy ha[d] been the failure of the [BIA] and [IHS] to provide funding for the indirect costs [later termed "contract support costs"] associated with self-determination contracts." *Id*. at 8 (emphasis added). This "practice . . . require[d] tribal contractors to ab[s]orb all or part of such indirect costs within the program level of funding, thus reducing the amount

[3] Unless otherwise noted, all code citations refer to Title 25 of the U.S. Code.

available to provide services to Indians as a direct consequence of contracting." *Id.* at 33; *see also id.* at 9-10 (discussing same). The agencies' failures to pay in full various contract "indirect costs" also "resulted in a tremendous drain on tribal financial resources," *id.* at 7, because tribal contractors were compelled to "subsidize" the contracted programs, *id.* at 9. Concerned that Tribes would soon "choose . . . to retrocede the contract[s] back to the Federal agency," *id.* at 13, the Senate Indian Affairs Committee declared that IHS "must cease the practice of requiring tribal contractors to take indirect costs from the direct program costs, which results in decreased amounts of funds for services." *Id.* at 12.

Congress twice substantially rewrote the Act to constrain as much as possible the Secretary's contracting discretion and to guarantee full funding of all contract costs, including indirect costs. *See* ISDEAA Amendments of 1988, Pub. L. No. 100-472, 102 Stat. 2285 (1988); ISDEAA Amendments of 1994, Pub. L. No. 103-413, 108 Stat. 4250 (1994). The amended Act makes the contracting of Federal programs mandatory for IHS, § 5321(a), and that mandate broadly reaches all agency "programs, functions, services, or activities," "includ[ing] administrative functions . . . that support the delivery of services to Indians, including those administrative activities supportive of, but not included as part of, the service delivery programs . . . [and] without regard to the organizational level within the Department that

carries out such functions." *Id.* The later-enacted Title V adopts the same breadth of contracting rights in the self-governance compacting process. *See* §§ 5381-5399.

For the administrative costs necessary to operate contracted programs, the amended Act mandates that contract support costs "shall be added" to the contract "to ensure compliance with the terms of the contract and prudent management," § 5325(a)(2), with another subsection emphasizing that "[n]othing in this subsection shall be construed to authorize the Secretary to fund less than the full amount of need for indirect costs associated with a self-determination contract." § 5325(d)(2). The CSCs addressed in these sections cover both:

(1) "indirect" CSC, which are the relevant agency's proportionate share of a Tribe's total indirect costs required to administer and support all of the Tribe's operations, including the Federal programs under contract (§§ 5304(f), 5325(a)(3)(A)(ii)); and

(2) "direct" CSC, such as workers' compensation insurance, that specifically support only those Federal programs under contract with that agency (§ 5325(a)(3)(A)(i)).

This mandate is incorporated by reference into compacts awarded under Title V. § 5388(c).

"Most contract support costs are indirect costs 'generally calculated by applying an "indirect cost rate" to the amount of funds otherwise payable to the Tribe.'" *Cherokee Nation of Okla. v. Leavitt*, 543 U.S. 631, 635 (2005) (citation omitted). An "[i]ndirect cost rate . . . is the ratio (expressed as a percentage) of the indirect costs to a direct cost base." 2 C.F.R. Pt. 200, App. VII, at ¶ B.7. "Indirect

costs" (also called the "indirect cost pool") are pooled overhead costs "that jointly benefit two or more programs," *id*. at ¶ B.6, such as centralized accounting costs. The direct cost "base" is the total program spending of all programs served by the indirect cost pool. *Id*. at ¶ B.1. Such cost allocation systems are a common feature of government contracts. *E.g.*, *Rumsfeld v. United Techs. Corp*., 315 F.3d 1361, 1365 (Fed. Cir. 2003).

Direct and indirect CSCs under the Act cover the overhead costs that tribal contractors must incur to carry out these contracted Federal programs. S. Rep. No. 100-274, at 8-9; *Ramah Navajo Chapter v. Lujan*, 112 F.3d 1455, 1461 (10th Cir. 1997). Because these overhead costs are necessarily incurred when the Tribe spends program funds to provide services, a Tribe is forced to find a way to cover these costs if IHS does not fully reimburse them, either by using other sources of *tribal* funds (to the extent available), or (more commonly) by diverting program funds under the contract to make up the shortfall—funds IHS would have used to deliver healthcare but which the Tribe must use to pay for overhead costs. Rejecting precisely the need to put Tribes to that "onerous choice," Congress mandated that Tribes receive full CSC funding to enable them to deliver "at least the same amount of services as the Secretary would have otherwise provided" had the Secretary continued operating the contracted Federal program. S. Rep. No. 100-274, at 9, 13, 16; *see also Salazar v. Ramah Navajo Chapter*, 567 U.S. 182, 186 (2012); *Cherokee*,

543 U.S. at 639. The new duty requiring agencies to fully reimburse CSC requirements was intended to eliminate the practice of forcing Tribes into making the Hobson's choice of either subsidizing or reducing the essential Federal services provided through their ISDEAA contracts. As this Circuit has noted, Congress "clearly expressed . . . its intent to circumscribe as tightly as possible the discretion of the Secretary" in contract funding matters. *Ramah Navajo Sch. Bd., Inc. v. Babbitt*, 87 F.3d 1338, 1344 (D.C. Cir. 1996). Indeed, "[p]recisely *because* the Secretary had consistently failed to behave in a reasonable manner . . . Congress elected specifically to cabin the Secretary's discretion under the Act." *Id.* at 1345 n.9.

B. IHS's Failure to Reimburse CSCs Associated with the Portion of the Federal Program Funded with Third-Party Revenues Compels Reductions in Program Funding, Contrary to Congress's Intent.

IHS's ongoing failure to pay full CSCs—and the narrow interpretation of the ISDEAA it asserts in this case—forces Tribes into the precise situation Congress sought to avoid when it amended the ISDEAA.

As described in Appellant's brief, when Tribes contract or compact to operate an IHS program, they are authorized—indeed, required—to bill Medicare, Medicaid, and other third-party payers for the services provided. Aplt. Br. 4-5, 25-26; *see* 42 U.S.C. §§ 1395qq (Medicare), 1396j (Medicaid); 25 U.S.C. §§ 1621e(a) (private insurance), 1623(b) (payer-of-last-resort provision), 1641(d)(1) (tribal

direct billing). Under the ISDEAA and the IHCIA, Tribes are then *required to spend* these third-party revenues (known as "program income") to augment the contracted or compacted healthcare programs. 25 U.S.C. §§ 1621f(a)(1), 1641(c)(1)(B), 1641(d)(2)(A), 5325(m)(1), 5388(j); 42 U.S.C. § 1395qq(c). Necessarily, that spending to provide additional services generates additional overhead costs.[4]

This is the key point the district court failed to understand. In essence, by requiring Tribes to collect and use program income for ISDEAA health programs, Congress required Tribes to incur additional CSC need. When IHS refuses to fund that additional CSC need, it puts Tribes squarely back in the bind that Congress sought to avoid by mandating full payment of CSCs.

A practical illustration demonstrates the flaws in IHS's approach. As noted, *supra* p. 5-6, most CSCs are comprised of indirect costs, which are calculated by multiplying a Tribe's indirect cost rate by the direct cost base associated with its IHS contract. When IHS applies that indirect cost rate only to part of the Tribe's direct cost base (the portion funded with appropriated dollars), the Tribe receives no funding for the indirect costs associated with the portion of the contracted program funded with third-party revenues. The Tribe is forced to fill this gap by subsidizing

[4] CSCs, by definition, are *necessary* expenditures for carrying out tribal health programs. *See generally* Geoffrey D. Strommer & Stephen D. Osborne, *The History, Status, and Future of Tribal Self-Governance Under the Indian Self-Determination and Education Assistance Act*, 39 Am. Indian L. Rev. 1, 50-51 (2015).

the Federal program with tribal resources, or—for the vast majority of Tribes that have limited tribal resources, including many of the Amici—by pulling resources out of program funding to pay for overhead costs. The following simplified illustration shows how Federal programs are reduced to cover unreimbursed CSCs. (The actual amounts at issue are orders of magnitude larger than the illustrated amounts, leading to funding shortfalls that impose heavy burdens on Tribes.)

Assume a Tribe spends $250 on "pooled" overhead costs, supporting $1,000 in program expenditures, composed of $600 in IHS programs (funded with appropriated dollars and third-party revenues) and $400 in non-IHS programs:

EXAMPLE A

<table>
<tr><td colspan="2">Indirect cost pool:
$250 in overhead=25%</td></tr>
<tr><td colspan="2">Direct cost base:</td></tr>
<tr><td>Non-IHS programs: $400</td><td>Contracted IHS Federal program: $600 ($400 appropriated + $200 third-party revenues)</td></tr>
</table>

Example A illustrates Amici's position. An indirect cost pool of $250 produces a 25% indirect cost rate because it supports a direct cost base totaling $1,000. That base includes $600 in total IHS Federal program spending, funded with both appropriated funds and third-party revenues. IHS reimburses the Tribe 25% of that $600 ($150) to fund the associated portion of the $250 indirect cost pool. The remaining $100 needed to fund the pool is paid by other agencies in proportion to

their share of the $400 in non-IHS programs included in the direct cost base. In Example A, all pooled administrative costs are fully reimbursed.

EXAMPLE B

Indirect cost pool: $250 in overhead=25%		
Direct cost base:		
Non-IHS programs: $400	Contracted IHS Federal program: **$400** appropriated	Contracted IHS program: **$200** third-party revenues

Example B illustrates IHS's position. IHS separates third-party revenues funding the Federal program ($200) from the appropriated dollars funding the program ($400), and only pays the indirect costs that support the appropriated dollars. Thus, IHS only reimburses $100 to the indirect cost pool (25% of $400). After the other agencies add $100 to the pool in connection with operating the non-IHS programs, *the pool has only $200 and is now $50 short of what it needs*. This $50 must come out of the money that would otherwise be spent for the healthcare program (assuming it cannot be subsidized by the Tribe). Example C shows the result.

EXAMPLE C

Indirect cost pool: $250 in overhead=25%		
Direct cost base:		
Non-IHS programs: $400	Contracted IHS Federal program: **$400** appropriated	Contracted IHS program: **$150** third-party revenues

In Example C, $50 in third-party revenues has been pulled out of the program base to cover the shortfall in the indirect cost pool. This leaves the contracted Federal healthcare program with only $550, instead of the $600 that should be available for program spending.[5] For most Tribes, this is precisely what happens when IHS fails to reimburse the costs of overhead for running the entire Federal program under contract.[6]

Using program income for this purpose puts the Tribe at a significant disadvantage as compared to an IHS-operated program, because IHS does not, and cannot, use third-party revenue for indirect costs. § 1641(c)(1)(B). Thus, in Example C, IHS would spend $600 to provide healthcare, but the Tribe can only spend $550. Congress's express goal was to *stop* this "practice which require[d] tribal contractors to ab[s]orb all or part of such indirect costs within the program level of funding, thus reducing the amount available to provide services." S. Rep. No. 100-274, at 33. Congress barred the very practice IHS is perpetuating here,

---

[5] Another result is that, because overhead costs remain at $250 but the direct base has been reduced to $950, the indirect cost rate will end up being recalculated to 26.3%. The non-IHS programs therefore have to pay a higher rate that effectively subsidizes the contracted IHS Federal program.

[6] In the case of the Swinomish Tribe, the Tribe had tribal funds to subsidize the CSC gap in its Federal program. *See* Aplt. Br. 17. Yet Congress warned "that Indian tribes should *not* be forced to use their own financial resources to subsidize federal programs" because the contracted programs "are a *federal* responsibility." S. Rep. No. 100-274, at 9 (emphasis added).

finding that IHS "must cease the practice of requiring tribal contractors to take indirect costs from the direct program costs, which results in decreased amounts of funds for services." *Id*. at 12.

The district court erroneously assumed the situation illustrated by Example C is the way the system is designed to work, rather than being a necessity adopted by Tribes in the face of incomplete CSC funding. *See Swinomish Indian Tribal Cmty. v. Azar*, 406 F. Supp. 3d 18, 30 n.10 (D.D.C. 2019) (noting the Tribe uses program income "to fund both the direct and indirect costs associated with future health care services"). The district court also appeared to assume that Tribes would continue to divert program funding for administrative costs even if they received CSC for the expenditure of program income. *Id.* at 30 & n.10. But the IHS policy that forces Tribes to divert program funding in this manner is precisely what the Swinomish Tribe is challenging. If the Tribe prevails, it would use its program income *solely* for healthcare services—as Congress intended—with IHS funds reimbursing the associated CSCs as required by the Act. It is not the case, as the district court assumed, that the Tribe sought to use program income to pay for future services *and* CSC, and then seek funding for the same CSC from IHS. *Id*.

The district court also misunderstood the ISDEAA section providing that Tribes are not obligated to perform a contract in excess of federal funding. *See id.* at 29 (citing § 5388(k)). This provision is a safety valve to protect Tribes from being

forced to use their own funds to make up shortfalls in federal funding—it is not a justification for IHS to underfund tribal health programs. The district court's interpretation is based on the idea—contrary to Congress's intent—that it is permissible to force Tribes to reduce the services they provide as a result of IHS's failure to pay full CSCs.

II. THE "FEDERAL PROGRAMS" TO BE SUPPORTED WITH CSC FUNDING INCLUDE THE PORTIONS OF THOSE PROGRAMS FUNDED WITH THIRD-PARTY REVENUES.

A proper understanding of the ISDEAA requires IHS to pay CSCs on the *entire* Federal program—including the portion funded with third-party revenues—thereby avoiding the pitfalls Congress warned against. This interpretation accords with the language of the Act and implements Congress's expressed desire to avoid forcing Tribes to fund administrative costs through reductions in program funding. It also faithfully mirrors the way IHS treats its own funding for the Federal programs it operates.

A. The Text of the Statute Compels a Broad Interpretation of "Federal Program."

This case is a dispute about the definition of CSC. For all its claimed reliance on the "statutory context" and "overall structure" of the ISDEAA to resolve this dispute, the district court ignored the language of the statute itself. The statute defines "contract support costs" by express reference to the "Federal program" the Tribe is operating: direct CSCs are "(i) direct program expenses *for the operation of*

the Federal program that is the subject of the contract," § 5325(a)(3)(A), and indirect CSCs are "(ii) any additional administrative or other expense related to the overhead incurred by the tribal contractor *in connection with the operation of the Federal program, function, service, or activity* pursuant to the contract," *id*. (emphases added). The district court did not acknowledge *any* significance in Congress's choice of words. But as the statutory language makes clear, it is the *Federal program*—not just the portion of the program funded by appropriated dollars, or even the Secretarial amount—that is the baseline for calculating CSCs.[7]

These provisions necessarily pose the question: what is the "Federal program?"

"Federal program" is not a defined term, so it must be interpreted within the context of the Act in which it appears. *See King v. St. Vincent's Hosp.*, 502 U.S. 215, 221 (1991) (statute must be read as a whole because "the meaning of statutory language, plain or not, depends on context"). Here, the ISDEAA contains a specific provision mandating that "[e]ach provision" of Title V and the compacts and funding agreements thereunder "shall be liberally construed for the benefit of the Indian tribe." § 5392(f); *see also* § 5392(a); Aplt. Br. 22-23. This mandatory rule of construction is an overlay on longstanding precedent holding that the United States'

[7] Program income is part of the Federal program regardless of whether program income is considered part of the Secretarial amount. Aplt. Br. 25, 31-33.

trust relationship with Indian tribes compels that when interpreting Indian-related statutes, courts must "be guided by that 'eminently sound and vital canon' that 'statutes passed for the benefit of dependent Indian tribes . . . are to be liberally construed'" for the tribes' benefit. *Bryan v. Itasca Cty., Minn.*, 426 U.S. 373, 392 (1976) (alteration in original) (citations omitted). Thus, "the standard principles of statutory construction do not have their usual force in cases involving Indian law." *Montana v. Blackfeet Tribe of Indians*, 471 U.S. 759, 766 (1985).

The district court apparently believed it did not need to consider § 5392(a) or (f) because it did not find the ISDEAA provisions at issue to be ambiguous. *Swinomish*, 406 F. Supp. 3d at 32. But § 5392(a) and (f) and the related Indian canon establish rules of construction that apply even if the law in question is not facially ambiguous: "if legislation 'can reasonably be construed as the Tribe would have it construed, it *must* be construed that way.'" *Redding Rancheria v. Hargan*, 296 F. Supp. 3d 256, 266 (D.D.C. 2017) (citing *Muscogee (Creek) Nation v. Hodel*, 851 F.2d 1439, 1444-45 (D.C. Cir. 1988)). And in an ISDEAA case, "[t]he Government . . . must demonstrate that its reading is clearly required by the statutory language." *Salazar*, 567 U.S. at 194.

Here, the Tribe's construction of the term "Federal program" is not only a reasonable construction; it is also the most straightforward interpretation and the one that aligns most closely with the plain meaning of the text and Congress's clearly

expressed intent. Beginning with the dictionary, the word "Federal" is broad and encompasses everything of a Federal character, including anything a Federal agency does: "of, relating to, or loyal to the federal government." *Federal*, Merriam-Webster Dictionary, https://www.merriam-webster.com/dictionary/federal. The word "program" is also broad, meaning "a plan or system under which action may be taken toward a goal." *Program*, Merriam-Webster Dictionary, https://www.merriam-webster.com/dictionary/program. In the context of the ISDEAA, a contractible "program" means anything the Secretary of Health and Human Services does "for the benefit of Indians," §§ 5321(a)(1)(E), 5385(b)(1), which of course means all of the *Indian* Health Service. Going further, Congress provided that these terms include IHS's "administrative functions" at any organizational level of the agency.[8] Plainly it was Congress's intent to mandate the broadest possible scope of contracting and compacting across IHS.

Congress's decision to use the broad terms "Federal program" and "Federal program, function, service, or activity" in § 5325(a)(3)(A)(i) and (ii), and to use these

[8] *See* §§ 5321(a)(1) ("The programs, functions, services, or activities that are contracted under this paragraph shall include administrative functions of . . . the Department of Health and Human Services . . . that support the delivery of services to Indians, including those administrative activities supportive of, but not included as part of, the service delivery programs described in this paragraph that are otherwise contractable. The administrative functions referred to in the preceding sentence shall be contractable without regard to the organizational level within the Department that carries out such functions."); 5385(b)(1) (similar provision).

and like terms throughout the ISDEAA,[9] necessarily means that the term "Federal program" encompasses the entirety of IHS's Federal program serving Indians. Services provided by IHS, whether paid for by appropriated funds or third-party revenues, cannot plausibly be considered anything but part of a "Federal program"—and these are the same services and facilities that are transferred to Tribes under ISDEAA agreements. To limit the "Federal program" to only the portions funded with "appropriations," as IHS urges, does violence to Congress's intent that the term "Federal program" have broad application.

Moreover, if Congress intended that limit, it knew how to say so. *See, e.g.*, § 5325(b) ("Notwithstanding any other provision in this chapter, the provision of funds under this chapter is subject to the availability of appropriations . . . ."). The fact that it could have restricted CSCs to programs paid for only with appropriated funds, yet chose not to do so, further argues against a construction that would import any such limitation into § 5325(a)(3). In sum, the term "Federal program" in § 5325(a)(3)(A)(i) and (ii) for which CSCs are to be reimbursed includes all IHS programs operated by Tribes regardless of funding source, including third-party revenues.

---

[9] *See* §§ 5321(a)(2), (4); 5324(j); 5325(a)(1), (a)(3)(ii), (a)(3)(B), (a)(4), (a)(5)(A), (g), (n); 5329(c); 5330; 5385(b)(1), (b)(2); 5387(a)(2)(A)-(D) (all referring to "program, function, service, or activity" or variations thereof).

B. IHS Collects and Spends Third-Party Revenues in the Same Manner as Tribes, and IHS Treats These Revenues as an Integral Part of its Federal Program.

Appellant's and Amici's interpretation of the "Federal program" is borne out in practice, as demonstrated by IHS's annual reports to Congress describing the agency's activities—reports which demonstrate beyond debate that the "Federal programs" IHS operates are paid for with both appropriated funds and third-party revenues (or "collections"). *See, e.g.*, Dep't of Health & Human Servs., IHS FY 2010 Congressional Justification, at CJ-1 (2010) ("2010 CJ"), https://www.ihs.gov/sites/budgetformulation/themes/responsive2017/documents/FY2010BudgetJustification.pdf.[10]

Third-party billing—and the reinvestment of third-party revenue, as required by law—is a routine part of IHS's Federal program. 2010 CJ at CJ-169. At IHS direct-service facilities, IHS provides healthcare free of charge to all eligible American Indians and Alaska Natives. § 1621u(a). Since IHS, by statute, is a payer of last resort, § 1623(b), IHS must bill and collect the cost of care from third-party payers covering patients enrolled in Medicare, Medicaid, or private insurance. 2010 CJ at CJ-169-70. IHS is authorized to do so under various authorities, including 25 U.S.C. § 1621e(a) (private insurance), 42 U.S.C. §§ 1395qq (Medicare), and 1396j

[10] While this appeal concerns FY 2010, similar statements appear in all IHS congressional budget justifications.

(Medicaid). IHS is required to use these funds for its health programs. 25 U.S.C. §§ 1621f, 1641(c)(1)(B). Such third-party collections "are a significant part of the IHS and Tribal budgets, and support increased access to quality healthcare services for American Indian[s] and Alaska Native[s]." 2010 CJ at CJ-169; *see also id.* at CJ-5 (IHS's "Program Level" budget reported to Congress includes Medicare, Medicaid, and private insurance collections).

In FY 2010, third-party revenues contributed nearly $800 million to IHS's budget, *id.* at CJ-5, which was then spent directly on the programs and facilities that generated those revenues, *see id.* at CJ-9 (all third-party collections allocated to "clinical services" budget). Indeed, "[t]hird party revenue represents up to 50 percent of operating budgets at many facilities." *Id.* at CJ-169 (showing these collections supporting 4,204 full-time equivalent (FTE) IHS personnel and noting that "[t]he collection of third party revenue is essential to maintaining facility accreditation and standards of health care . . . .").

When Tribes take over operating these "Federal programs" under the ISDEAA, they, too, bill and collect from third-party payers in the same manner and under the same authorities. *See* 25 U.S.C. § 1621e(a), 42 U.S.C. §§ 1395qq, 1396j); *see also* 25 U.S.C. § 1641(d)(1) (tribal direct billing to Medicare and Medicaid). Indeed, Tribes (just like IHS) are *required* to bill third-party payers because, like IHS, tribal programs are a "payer of last resort." 25 U.S.C. § 1623(b). And—again,

just like IHS—Tribes are *required* to spend these revenues to augment the contracted programs.[11] 25 U.S.C. §§ 1621f(a)(1), 1641(c)(1)(B), 1641(d)(2)(A), 5325(m)(1), 5388(j); 42 U.S.C. § 1395qq(c). Consistent with Congress' mandate that third-party revenues be used to advance tribal health programs, these revenues have become an essential source of funding for IHS and tribal programs alike.

In sum, IHS's own programs and services indisputably include healthcare services funded by third-party revenues. IHS's reports to Congress make plain these revenues are an integral part of the agency's "total, program level" budget, *see* 2010 CJ at CJ-5, and "a significant part of the IHS . . . budget[]," *id.* at CJ-169. Given that third-party revenues infuse program operations at virtually every IHS program and facility, *supra* p. 18-19, one cannot reasonably conclude that a Tribe's contracting right under the ISDEAA somehow does not reach the portion of an IHS program that IHS funds with third-party revenue.[12] The very structure of IHS program operations, together with the ISDEAA's broad contracting mandate,

---

[11] IHS funding through appropriated dollars remains woefully inadequate. *See* Aplt. Br. 5-6. For instance, Amicus Gila River Indian Community's ISDEAA Compact states "the IHS budget is inadequate to fully meet the special responsibilities and legal obligations of the United States to assure the highest possible health status for American Indians and Alaska Natives and that, accordingly, the funds provided to the Community are inadequate to permit the Community to achieve this goal." GRIC Compact art. V, § 16. Other compacts have similar provisions.

[12] *See also* Aplt. Br. 31-33, 36-37 (discussing court decisions including program income within the scope of a Tribe's ISDEAA contract).

compel the conclusion that contractible "Federal programs" cover the entirety of an IHS program, including the portion funded with third-party revenues.

C. The District Court's Interpretation of "Federal Program" Conflicts with the Act and with IHS's Own Practices.

By defining the "Federal program" to exclude activities funded by third-party revenues, IHS's formulation (accepted by the district court) would require Tribes to divert a portion of third-party revenues to pay for overhead instead of direct program costs. This result contradicts Congress's intent that third-party revenues provide *additional program* resources to the Tribes, in parity with the additional program resources these collections provide to IHS. Nothing suggests that Congress intended Tribes (or IHS, for that matter) to divert those revenues to overhead.

Indeed, the opposite is true: Congress specified in the IHCIA that tribal expenditures of program income should be used for healthcare facilities and services, not for indirect costs. § 1641(d)(2)(A) (tribal health programs must use program income for healthcare facility improvements, providing additional healthcare services, other healthcare purposes, or to otherwise achieve the objectives of the IHCIA). While CSCs are essential to support the "Federal program," they are not healthcare services or facilities. The interpretation adopted by the district court therefore creates impermissible tension between the ISDEAA (which, under the district court's reading, requires the diversion of third-party revenue to pay for overhead) and the IHCIA (which directs that all third-party revenue be used to pay

for services and programs). The district court's creation of this conflict between the two statutes violates elementary principles of statutory construction. *See Mittleman v. Postal Regulatory Comm'n*, 757 F.3d 300, 306 (D.C. Cir. 2014) (courts "must attempt 'to harmonize and give meaningful effect to'" related statutory provisions (citation omitted)).

Here again, the district court's approach treats Tribes differently from IHS, contrary to the ISDEAA's core principle. When IHS collects and spends third-party revenues, they are not spent by IHS on overhead. Instead, IHS overhead for its Federal programs is paid from a separate budget component known as "Direct Operations." 2010 CJ at CJ-158-60. "Direct Operations" supports the "overall management of the IHS" including "oversight of financial, human, facilities, information and support resources and systems." *Id.* at CJ-159.

IHS uses this single administrative cost structure to support the overhead associated with program expenditures paid for with both appropriated dollars and third-party revenues. IHS does not have separate accounting or human resources staff associated with the portion of its programs funded through third-party revenues. As an IHS representative testified in the *Sage Hospital* case discussed by Appellant, *see* Aplt. Br. 33-35, the administrative functions associated with the portion of the program funded by third-party revenues are "not separate" from the overall IHS administrative system that supports all of IHS's program expenditures regardless of

funding source, *see* Decl. of Lloyd B. Miller, Ex. A (Dep. of Duff Pfanner).[13] Congressional Budget Justifications illustrate the same point, showing that the centralized administrative function classified as "Direct Operations" covers all IHS programs, with no separate allocation for programs funded with third-party revenues. 2010 CJ at CJ-9.

At the same time, these centralized administrative costs are funded exclusively with appropriated dollars, and *no portion of IHS third-party revenue goes to IHS's "Direct Operations" for administrative costs*. On this point too, IHS's Budget Justifications are clear. IHS commits 100% of third-party revenues to enhance IHS programs, services, and facilities. *Id.* (showing all third-party collections going into "Hospitals & Health Clinics" and none into "Direct Operations").

Yet when Tribes collect and spend third-party revenues in exactly the same manner and under the same authorities, IHS would have Tribes divert third-party revenues from programs to pay for administrative costs, thus decreasing the services Tribes can provide. This directly contravenes Congress's goal of ensuring that tribal

[13] *See Talavera v. Shah*, 638 F.3d 303, 310 (D.C. Cir. 2011) (statements admissible under Fed. R. Evid. 801(d)(2)(D) if "within the scope of [declarant's] employment or [if declarant] was given authority to speak on behalf of the [employer] on the subject"); *United States v. Vecchiarello*, 569 F.2d 656, 663-65 (D.C. Cir. 1977) (admitting depositions from prior civil trial in later criminal trial).

contractors be funded to provide at least the same level of services as IHS provides, and it cannot be squared with Congress's inclusion of the CSC provisions in the Act.

D. The District Court's Interpretation of "Federal Program" Misunderstood How CSC Amounts Are Determined.

The district court's belief that program income could not be part of the "Federal program"—and thus, that program income falls outside the scope of the CSC requirement—relied on the incorrect assumption that CSC must be calculated definitively before the contract year begins, and that IHS and the Tribe must determine the final CSC amount in the funding agreement. *Swinomish*, 406 F. Supp. 3d at 26. Based on this faulty assumption, the district court concluded that program income expenditures must fall outside the Federal program because they cannot be known ahead of time, and thus cannot be included in the funding agreement. *Id.*

But the district court failed to recognize that IHS's obligation to pay CSC is an obligation to "*reimburs[e]* each tribal contractor" for those costs, § 5325(a)(3)(A) (emphasis added), not to pay those costs in advance; that is, despite the setting of an initial estimated CSC amount in the funding agreement, by law the CSC amount must be reconciled to actual expenditures, *see also* § 5325(a)(3)(A)(ii) ("the overhead incurred"), (a)(5)-(6) (referring to "incurred" costs). The district court's assumption is therefore contrary to the plain text of the ISDEAA.

It is also contrary to established practice. Under the IHS Manual, funding agreements generally provide for an estimated CSC amount to be paid when the

contract year begins, subject to a process for calculating the actual final amount due after the contract year ends and an audit is completed. Dep't of Health & Human Servs., IHS Indian Health Manual, at 6-3.2(E)(1)(b)(vi) (Aug. 6, 2019), https://www.ihs.gov/ihm/pc/part-6/p6c3/. The funding agreement is then amended *after* the contract year closes, reconciling estimated funding with the actual costs incurred. *Id.* The district court overlooked both the text of the statute and its actual implementation.

In short, nothing in the Title V funding provision the district court relied upon, § 5388(c), precludes a calculation of CSC that accounts for the overhead costs of programs paid for with program income.

III. THE ANTI-DUPLICATION PROVISION DOES NOT NEGATE IHS'S DUTY TO PAY CSC ON THE FULL FEDERAL PROGRAM.

The district court was concerned that the Tribe's request for payment of full CSCs might duplicate an amount IHS had already paid: "providing CSC for additional future services would duplicate reimbursements for past services." *Swinomish*, 406 F. Supp. 3d at 30. But this makes no sense. If a Tribe provides additional services, and incurs additional CSC in doing so, then providing funding for the additional CSC would only compensate the Tribe for those additional costs. A single payment cannot compensate a Tribe for past *and* future costs. Because the district court failed to understand that CSCs on program revenues are incurred only

when those revenues are *spent* for additional program services (not when they are collected), the district court's duplication analysis was fatally flawed.

Further, IHS has not shown that it has paid *any* administrative costs associated with the Tribe's expenditure of third-party revenues, let alone that it has already paid *all* of them. IHS has made similar arguments elsewhere—asserting that tribal CSC requirements of one kind or another are broadly prohibited as duplicate payments—but these arguments have been universally rejected. The *Sage* court concluded that a duplication offset could only be claimed "for [an] individual [CSC] activity [if] IHS already paid for that specific, individuated activity under the Secretarial amount." *Navajo Health Found.—Sage Mem'l Hosp., Inc. v. Burwell*, 263 F. Supp. 3d 1083, 1178 (D.N.M. 2016). It rejected the notion that IHS could disqualify entire classes of CSC requirements and bypass its burden to prove precise duplicated costs simply by invoking § 5325: "The United States' repeated admission . . . that it does not know what costs fall into the Secretarial amount fortifies the Court's conclusion on this point, because this lack of knowledge would leave no check on IHS'[s] ability to claim without proof that any specific CSC claim duplicates a cost within the Secretarial amount's black box." *Id.*

Similarly, in *Cook Inlet Tribal Council v. Mandregan* the court rejected IHS's effort to categorically disqualify all CSCs required for facility costs simply based on an assertion that *some* facility costs in *some* amount had already been paid in the

Secretarial amount. 348 F. Supp. 3d 1, 14 (D.D.C. 2018) ("IHS posits that it is 'irrelevant' that it cannot show how much facility funding has been provided [in the Secretarial amount]. The Court disagrees." (citation omitted)), *vacated in part on other grounds on reconsideration*, No. 14-CV-1835 (EGS), 2019 WL 3816573 (D.D.C. Aug. 14, 2019).

It is plausible—but IHS has not proven—that program income expenditures would not generate CSC need at the same rate as expenditures from the appropriated amount. But any question regarding the precise amount of CSCs attributable to program income expenditures does not justify a categorical rule that CSCs on program income expenditures are automatically duplicative. To the extent IHS contends there is some aspect of the Tribe's budgeting decisions that warrant adjustment to the conventional indirect CSC formula, "it is IHS's burden to show by 'clear and convincing evidence'" that such circumstances exist. *Seminole Tribe of Fla. v. Azar*, 376 F. Supp. 3d 100, 111 (D.D.C. 2019). But as these other courts have correctly concluded, IHS may not simply wave the "duplicated cost" card and thereby avoid its duty to pay the full contract support costs mandated by the Act.

CONCLUSION

The district court failed to properly apply the ISDEAA, producing an outcome that undermines both the ISDEAA and the IHCIA while depriving Tribes of their right to full CSC funding—a result that undermines federal policies that encourage

tribal self-governance and support Tribes in achieving national health goals. The decision below should be reversed.

Respectfully submitted this 18th day of March 2020.

Skip Durocher
James Nichols
DORSEY & WHITNEY LLP
50 South Sixth Street, Ste 1500
Minneapolis, MN 55402
612-340-2600

Counsel for:
National Congress of American Indians
Gila River Indian Community

Linus Everling
General Counsel
Tom Murphy
Deputy General Counsel
GILA RIVER INDIAN COMMUNITY
P.O. Box 97
Sacaton, Arizona 85247
520-562-9760

Counsel for:
Gila River Indian Community

Lloyd B. Miller
Donald J. Simon
SONOSKY, CHAMBERS, SACHSE, ENDRESON & PERRY, LLP
1425 K Street NW, Ste 600
Washington, DC 20005
202-682-0240

Rebecca A. Patterson
Whitney A. Leonard
K. Amanda Saunders
SONOSKY, CHAMBERS, SACHSE, MILLER & MONKMAN, LLP
725 East Fireweed Lane, Ste 420
Anchorage, AK 99503
907-258-6377

Counsel for:
Alaska Native Tribal Health Consortium
Cherokee Nation
Chickasaw Nation
Confederated Salish and Kootenai Tribes of the Flathead Reservation
Copper River Native Association
Forest County Potawatomi Community
Little River Band of Ottawa Indians
Muscogee (Creek) Nation
Navajo Health Foundation – Sage Memorial Hospital
Navajo Nation
Riverside-San Bernardino County Indian Health, Inc.
San Carlos Apache Tribe

Shoshone-Paiute Tribes of the Duck Valley Reservation
Southcentral Foundation
Spirit Lake Tribe
Tanana Chiefs Conference
Yukon-Kuskokwim Health Corporation
Zuni Tribe of the Zuni Reservation

CERTIFICATE OF COMPLIANCE

I certify that this brief complies with the type-volume limitations of Fed. R. App. P. 29(a)(5) and 32(a)(7)(B) because, excluding the items permitted by Fed. R. App. P. 32(f) and Circuit Rule 32(d), this brief contains 6,482 words, including footnotes.

This Brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) because it has been prepared in a proportionally spaced typeface in Microsoft Word using Times New Roman, 14-point font.

Dated: March 18, 2020

Respectfully submitted,

/s/ Lloyd B. Miller

Lloyd B. Miller

CERTIFICATE OF SERVICE

I hereby certify that on March 18, 2020, I electronically filed the foregoing brief with the Clerk of the Court using the CM/ECF system.

I certify that the participants of this case are registered CM/ECF users and that service will be accomplished by the appellate CM/ECF system.

/s/ Lloyd B. Miller
Lloyd B. Miller

ADDENDUM

Addendum

LIST OF TRIBAL AMICI CURIAE

This brief is filed on behalf of the National Congress of American Indians and the following tribal amici curiae, all of which are federally recognized Indian tribes or tribal organizations that have entered into contracts or compacts with the Indian Health Service pursuant to the Indian Self-Determination and Education Assistance Act, 25 U.S.C. §§ 5301-5423:

Alaska Native Tribal Health Consortium
Cherokee Nation
Chickasaw Nation
Confederated Salish and Kootenai Tribes of the Flathead Reservation
Copper River Native Association
Forest County Potawatomi Community
Gila River Indian Community
Little River Band of Ottawa Indians
Muscogee (Creek) Nation
Navajo Health Foundation – Sage Memorial Hospital
Navajo Nation
Riverside-San Bernardino County Indian Health, Inc.
San Carlos Apache Tribe
Shoshone-Pauite Tribes of the Duck Valley Reservation
Southcentral Foundation
Spirit Lake Tribe
Tanana Chiefs Conference
Yukon-Kuskokwim Health Corporation
Zuni Tribe of the Zuni Reservation

DECLARATION OF LLOYD B. MILLER

UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

Swinomish Indian Tribal Community, Plaintiff - Appellant, v. Alex M. Azar, II, in his official capacity as Secretary, U.S. Department of Health & Human Services; Michael D. Weahkee, Rear Admiral, in his official capacity as Acting Director, Indian Health Service; United States of America, Defendants - Appellees.	)	Case No. 19-5299

DECLARATION OF LLOYD B. MILLER

I, Lloyd B. Miller, hereby declare as follows:

1. I am counsel for the amici curiae 19 Native American Tribes and Tribal Organizations and the National Congress of American Indians in the above-captioned matter.

2. This Declaration is offered in further support of the Brief Amici Curiae of 19 Native American Tribes and Tribal Organizations and the National Congress of American Indians In Support of Appellant and In Support of Reversal.

3. I certify that the following Exhibit attached to this Declaration is a true and correct excerpt of the original document:

Exhibit A: Excerpt of Transcript of Deposition of Duff Pfanner

Navajo Health Found.—Sage Mem'l Hosp., Inc. v. Burwell, No. 1:14-cv-958-JB-GBW, Tr. of Dep. of Duff Pfanner at 1-2, 5-8, 11-18, 48-50, 97 (June 9, 2016).

I declare under penalty of perjury this 18th day of March 2020 that the statements in this Declaration are true and correct.

/s/ Lloyd B. Miller

Lloyd B. Miller
DC Bar No. 317131
SONOSKY, CHAMBERS, SACHSE,
MILLER & MONKMAN, LLP
725 E Fireweed Lane, Suite 420
Anchorage, AK 99503
Telephone: (907) 258-6377
lloyd@sonosky.net

Counsel for Amici Curiae

EXHIBIT A

THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF NEW MEXICO

NAVAJO HEALTH FOUNDATION-SAGE MEMORIAL HOSPITAL, INC.

Plaintiff,

-vs- NO: 1:14-cv-958-JB-GBW

SYLVIA MATHEWS BURWELL, SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; MARY SMITH, ACTING DIRECTOR OF INDIAN HEALTH SERVICE; DOUGLAS GENE PETER, M.D., ACTING AREA DIRECTOR, NAVAJO AREA INDIAN HEALTH SERVICE; and MARGARET SHIRLEY-DAMON, CONTRACTING OFFICER, NAVAJO AREA INDIAN HEALTH SERVICE,

Defendants.

VIDEO DEPOSITION OF DUFF PFANNER

June 9, 2016
9:03 a.m.
Suite 310
10400 Academy Road, Northeast
Albuquerque, New Mexico

PURSUANT TO THE FEDERAL RULES OF CIVIL PROCEDURE, this deposition was:

TAKEN BY: REBECCA A. PATTERSON, ESQ.
ATTORNEY FOR PLAINTIFF

REPORTED BY: KENDRA D. TELLEZ

CCR-RMR-CRR

Kendra Tellez Court Reporting, Inc.

302 Silver, Southeast

Albuquerque, New Mexico 87102

1 APPEARANCES

2 For the Plaintiff:

3 FRYE LAW FIRM, P.C.
Suite 310
4 10400 Academy Road, Northeast
Albuquerque, New Mexico 87111
5 tea@freylaw.us
BY: THOMAS E. ALBRIGHT, ESQ.
6 and
SONOSKY, CHAMBERS, SACHSE, MILLER & MUNSON, LLP
7 Suite 700
900 West Fifth Avenue
8 Anchorage, Alaska, 99501
rebecca@sonosky.net
9 BY: REBECCA A. PATTERSON, ESQ.

10 For the Defendants:

11 U.S. DEPARTMENT OF JUSTICE
Civil Division
12 P.O. Box 480
1100l Street, Northwest
13 Washington, DC 20044
Wolak.Devin@usdoj.gov
14 Jana.Moses@usdoj.gov
BY: DEVIN WOLAK, ESQ.
15 JANA MOSES, ESQ.

16
For the Defendant U.S. Department of Health and
17 Human Services:

18 U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Suite 4-500
19 90 7th Street
San Francisco, California 94103
20 Paula.Lee@hhs.gov
BY: PAULA R. LEE, ESQ.
21

22 Also Present: Joseph Casalnuovo (Videographer)

23

24

25

1 Interrogatories, I have no knowledge of that.
2 Q. Can you specify what cases?
3 A. You know, I don't specifically recall.
4 They all had to do with contract support cost
5 claims. I'm -- I'm just drawing a blank on which
6 cases.
7 Q. Okay. I'm going to hand the court
8 reporter what will be marked as Exhibit 3.
9 (Exhibit 3 Marked for Identification.)
10 Q. Mr. Pfanner, does this look like a copy of
11 your current contract with the Navajo Area?
12 A. Yes, it does.
13 Q. Are there any modifications to this
14 contract or amendments that are not here?
15 A. Not that I'm aware of.
16 Q. Okay. How much have you been paid under
17 this contract per year, approximately?
18 A. I'd say the approximate range is 12- to
19 15,000, and that includes the travel expenses.
20 Q. Okay. And how much have you been paid
21 approximately per year from all of your contracts
22 with the Indian Health Service?
23 A. Oh, I think an average would be maybe
24 80,000, and -- including travel expenses.
25 Q. Okay. How does your contract work in

1 terms of the number of hours? Do they add more
2 hours as they're needed or is it a fixed amount?
3 A. The Alaska Area Navajo Area estimated the
4 number of hours, and on occasion if -- if they ask
5 me to work more hours than they estimated, then
6 they'd -- they'd add money to the contract.
7 Q. Do you receive additional amounts if cases
8 go into liti- -- litigation?
9 A. Well, if it requires extra hours, I -- I
10 believe the answer would be yes.
11 Q. Did you receive a separate contract for
12 this case?
13 A. No, I did not.
14 Q. Will you be paid by IHS for your time here
15 today?
16 A. Yes, I will.
17 Q. Is that at your hourly rate stated in this
18 contract?
19 A. Yes.
20 Q. Have you been paid any other consulting
21 fee or other payment arrangements?
22 A. Could you rephrase that question?
23 Q. Sure. Have you received any other
24 consulting fee or other payments outside of this
25 contract?

1 the local service unit or at the actual program the
2 tribe was assuming; is that correct?
3 A. Yes.
4 Q. Would -- would that rate reflect the
5 expenditures of the agency for those items I
6 discussed earlier, FICA, health, disability, life
7 insurance?
8 A. Yes, um-hmm.
9 MS. PATTERSON: Do we want to take a
10 five-minute break?
11 MR. WOLAK: Sure.
12 MS. PATTERSON: I know I would like
13 to take one.
14 VIDEOGRAPHER: The time is 10:23. We
15 are now off the record.
16 (Recess was taken from 10:23 a.m. until 10:33 a.m.)
17 VIDEOGRAPHER: The time is 10:33. We
18 are now on the record.
19 Q. Mr. Pfanner, when IHS runs a service unit,
20 does it bill for third-party revenues?
21 A. Yes.
22 Q. Does it use those revenues to provide
23 additional healthcare services?
24 A. Medicare and Medicaid have requirements
25 with regards to the use of the collections, and I

1 think the first requirement is meeting accreditation
2 requirements. If the entity then had funds over and
3 above that, I think they would be used for providing
4 additional services. Private insurance doesn't come
5 with any limitations on its use, that I am aware of.
6 Q. When IHS runs a service unit and collects
7 third-party revenues, does it maintain a separate
8 administrative structure to operate just the
9 third-party revenue share of funding? Or to manage
10 that funding, might be a better word?
11 A. Could I have that question again, please.
12 Q. Sure. When IHS runs a service unit and
13 collects third-party revenue, does it maintain a
14 separate administrative structure to manage the
15 third-party revenue funds? Does it have a second,
16 for example, financial officer or accountant or
17 human resources personnel to deal directly with
18 those aspects of the program funded with third-party
19 revenues?
20 A. No. I'm going to say it's not separate.
21 And IHS service units are not standalone with
22 regards to billing. There's a -- the billing system
23 for the IHS, it's -- I think -- I don't know all the
24 details, but there's a fiscal intermediary that's
25 used. It doesn't all happen at the service unit,

1 the building.

2 Q. Okay. I'm going to change topics again

3 and talk about the process for negotiating an ISD

4 Request. Are you familiar with the term "ISD

5 Request"?

6 A. Yes.

7 Q. Can you describe what that is?

8 A. From -- ISD stands for Indian

9 Self-Determination Fund, there's no "F" there, but

10 the ISD Fund. It -- it's described in the Contract

11 Support Cost Policy. It's for new and expanded

12 contracts or -- or -- agreements under the Act. It

13 could be Title V agreements, self -- self-governance

14 agreements. But they're -- they're new or expanded

15 and the policy defines how -- how that's defined.

16 But something new that they're taking on or some

17 major expansion of a program.

18 Opens up the possibility of having

19 pre-award startup costs for that new and expanded

20 piece. Congress, from time to time, appropriates

21 ISD funds. I don't -- I'm going to say maybe years

22 ago it was a separate appropriation, there were X

23 funds, but for the past many years, it's just been

24 part of the general contract support cost

25 appropriation except that in the appropriation

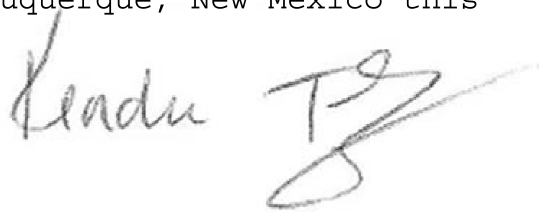
1 STATE OF NEW MEXICO)
)
2 COUNTY OF BERNALILLO)

3 REPORTER'S CERTIFICATE

4 BE IT KNOWN that the foregoing transcript of proceedings was taken by me; that I was then and
5 there a Certified Court Reporter and Notary Public in and for the County of Bernalillo, State of New
6 Mexico, and by virtue thereof, authorized to administer an oath; that the witness before
7 testifying was duly sworn by me; that the foregoing pages contain a true and accurate transcript of the
8 proceedings, all to the best of my skill and ability.
9
BE IT FURTHER KNOWN THAT examination of
10 this transcript and signature of the witness was requested by the witness and all parties present.
11 On ___________, a letter was mailed or delivered to Mr. Wolak regarding obtaining signature of the
12 witness.

13 I FURTHER CERTIFY that I am not related to nor employed by any of the parties hereto, and
14 have no interest in the outcome hereof.

15 DATED at Albuquerque, New Mexico this , 2016.
16



17

18

19
____
Kendra D. Tellez
20 License Expires: 12/31/16
CCR-CRR-RMR
21

22

23

24

25