Nos. 23-250 and 23-253

In The Supreme Court of the United States

XAVIER BECERRA, Secretary of Health and Human Services, et al.,

Petitioners,

v.

SAN CARLOS APACHE TRIBE,

Respondent.

XAVIER BECERRA, Secretary of Health and Human Services, et al.,

Petitioners,

v.

NORTHERN ARAPAHO TRIBE,

Respondent.

On Writs Of Certiorari To The United States Courts Of Appeals For The Ninth And Tenth Circuits

BRIEF OF *AMICI CURIAE* NATIONAL INDIAN HEALTH BOARD AND VARIOUS TRIBES AND TRIBAL HEALTHCARE ORGANIZATIONS IN SUPPORT OF RESPONDENTS

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INTEREST OF THE *AMICI CURIAE*[1]

Amicus National Indian Health Board ("NIHB") is a non-profit organization dedicated to strengthening healthcare for American Indian and Alaska Native people. NIHB represents tribal governments—both those that operate their own healthcare programs through contracting, and those receiving healthcare directly through Indian Health Service ("IHS") programs. NIHB advocates for the rights of all federally recognized Tribes through fulfillment of the federal trust responsibility to deliver healthcare and public health services to American Indians and Alaska Natives. Since 1972, NIHB has advised the U.S. Congress, IHS and other federal agencies, and private foundations on healthcare issues facing American Indians and Alaska Natives.

Amicus Great Plains Tribal Leaders Health Board is a consortium of 17 federally recognized Tribes and the leadership of one tribally operated IHS Service unit in the Great Plains region that advocates on Indian health issues and operates healthcare programs including the Oyáte Health Center in Rapid City, South Dakota.

Amicus National Council of Urban Indian Health is a national organization that advocates for the 41

[1] No counsel for a party authored this brief in whole or in part, and no counsel or party, other than *amici* and their counsel, made a monetary contribution intended to fund the preparation or submission of this brief.

Urban Indian Organizations that operate healthcare programs through contracts with IHS.

Amicus Southeast Alaska Regional Health Consortium is a consortium of 15 federally recognized Tribes that provides comprehensive healthcare services throughout Southeast Alaska.

Amicus Riverside San-Bernardino County Indian Health, Inc. is a consortium of nine federally recognized Tribes in Southern California that provides healthcare services to a population of over 17,000 patients.

Amici Fort Defiance Indian Hospital Board, Inc.; Muscogee (Creek) Nation Department of Health; Southern Ute Indian Tribe; and Spirit Lake Tribe are federally recognized Indian Tribes or tribal organizations that operate and/or receive healthcare services through healthcare programs operated through contracts with IHS.

All of the *amici* have a direct interest in ensuring that the United States honors its obligation to fully fund critical healthcare services to American Indian and Alaska Native people.

INTRODUCTION

Delivery of high-quality healthcare services is a fundamental component of the United States' trust

responsibility to American Indian and Alaska Native people. Consistently reaffirmed through legislation, judicial decisions, and executive proclamations, this deeply-rooted obligation arises from the "special trust relationship" between the United States and Indian Tribes, as reflected in, *e.g.*, U.S. Const. art. I, § 8, cl. 3, *see* S. Rep. No. 106-152, at 2 (1999), under which the United States owes Indian Tribes what this Court has characterized as "moral obligations of the highest responsibility and trust." *Seminole Nation v. United States*, 316 U.S. 286, 297 (1942). It also arises from numerous treaties by which Indian Tribes ceded millions of acres of land to the United States, often in exchange for express promises of healthcare services in perpetuity. *See* S. Rep. No. 106-152, at 2.

Congress has sought to fulfill the United States' healthcare obligations to Indian Tribes through two closely related statutes—the Indian Self-Determination and Education Assistance Act ("ISDA"), 25 U.S.C. § 5301 *et seq*., and the Indian Health Care Improvement Act ("IHCIA"), 25 U.S.C. § 1601 *et seq*. Enacted nearly contemporaneously in the mid-1970s and amended and interpreted in concert since then, these two statutes work together to govern funding and delivery of healthcare services to American Indians and Alaska Natives. The IHCIA establishes funding mechanisms for federal Indian healthcare programs and services, while the ISDA establishes self-determination principles under which many Indian Tribes now operate those programs and services on behalf of their

members under contracts with the federal government.

The ISDA requires the United States to pay "contract support costs" to Indian Tribes that have self-determination contracts with IHS, under which Tribes or tribal organizations operate healthcare programs funded by both IHS appropriations and "program income"—reimbursements for healthcare services provided to patients covered by Medicare, Medicaid, and private insurance carriers. *See* 25 U.S.C. § 5325. The ISDA provides that, in addition to the amount of funds appropriated by Congress (often called the "Secretarial amount," *see* 25 U.S.C. § 5325(a)(1)), the United States also must pay reasonable costs for activities that a Tribe or tribal organization, operating the program as a federal contractor, incurs to ensure compliance with the terms of the contract and prudent management. *See id.* § 5325(a)(2), (3). Contract support costs eligible for reimbursement are those incurred in connection with "the operation of the Federal program" that is the subject of the contract. *Id.* § 5325(a)(3)(A).

The question presented in this case is whether IHS must pay contract support costs for the additional administrative or other overhead expenses a Tribe incurs in connection with healthcare services the Tribe is required to perform with program income. Resolution of that question turns on whether expenditure of program income on tribal healthcare services is part of "the Federal program" operated by a Tribe under an ISDA contract. Because the answer to that question must be "yes" for the reasons explained herein, IHS is

required to pay contract support costs for overhead expenses Tribes incur in providing such services.

This brief focuses on the text and history of the IHCIA, which is *in pari materia* with the ISDA and bears directly on the question before the Court.[2] The statutory text, and its evolution through multiple amendments in which Congress acted to address specific problems surrounding funding, operation, and IHS oversight of federal Indian healthcare programs, confirm that Congress has always regarded third-party program income as an essential and integral component of "the Federal program"—whether that program is operated by IHS or by an Indian Tribe or tribal organization under the ISDA.

SUMMARY OF THE ARGUMENT

Congress first authorized IHS to bill and collect from Medicare and Medicaid in the initial enactment of the IHCIA in 1976. Congress recognized that chronic underfunding left Indian healthcare programs in a deplorable state, and that revenues from Medicare and Medicaid could provide essential *supplemental* funding to buttress consistently insufficient direct appropriations.

[2] The Brief of National Congress of American Indians and Various Tribes and Tribal Organizations as *Amici Curiae* in Support of Respondents focuses on the text and history of the ISDA.

Subsequent amendments to the IHCIA and ISDA expanded IHS's authority to collect from third parties, including private insurers, and cemented the role of third-party revenues as an essential element of funding for the Indian healthcare programs IHS operates.

When Congress amended the ISDA in 1994 to add the contract support cost and program income provisions at issue in this case, 25 U.S.C. § 5325(a)(3)(A)(i), (A)(ii); *id.* § 5325(m), third-party revenues had long been an integral element of IHS program funding. IHS collected and distributed Medicare and Medicaid reimbursements (the vast majority of program income) on behalf of Indian healthcare programs—whether operated by the agency or by a Tribe or tribal organization. IHS budget submissions to Congress confirmed that these third-party revenues were a paramount source of funding IHS used to pay for essential elements of Indian healthcare programs, including personnel, equipment, and supplies. Thus, when Congress amended the ISDA to mandate payment of contract support costs incurred in operating "the Federal ***program***," it was referring to a program that for nearly two decades Congress had deliberately funded in significant part with revenues from third-party sources—"***program*** income"—collected and distributed almost exclusively by IHS. *See infra* II.C.

Subsequent developments confirm Congress regards third-party revenue as an essential element of "the Federal program." For example, Congress appropriated supplemental funding to replace third-party reimbursements lost as a result of the COVID-19

pandemic and other extraordinary circumstances. *See infra* II.D.

While Petitioners contend that program income is not part of "the Federal program" operated by Tribes, IHS's conduct demonstrates otherwise. IHS now reports that 60 percent or more of the annual budgets of some IHS facilities comes from third-party revenues, and this program income is essential to IHS's ability to maintain facility accreditation, purchase medical supplies, and pay salaries of clinical personnel and other employees. Dep't of Health and Human Servs., *Fiscal Year 2024 Indian Health Service Justification of Estimates for Appropriations Committees*, CJ-193 (2023); *see infra* III.A.

Consistent with this reality, when IHS transfers control of a healthcare program to a Tribe or tribal organization, it routinely transfers third-party revenues generated by the program, along with employees and other program elements directly funded by that program income. For example, when IHS transferred control of a healthcare program to the Fort Defiance Indian Hospital Board, Inc. in 2010, IHS transferred millions of dollars of third-party program income and hundreds of critical employees—from physicians and pharmacists to IT and maintenance personnel—that IHS specifically identified as being funded with program income. This is standard operating procedure for IHS in effectuating the ISDA. *See infra* III.B.

IHS's own conduct confirms as a matter of practical reality what the statutes establish as a matter of

law: Third-party revenue continues to be an integral element of "the Federal program" operated by IHS since enactment of the IHCIA, and it remains part of the same "Federal program" when IHS transfers control to a Tribe or tribal organization. Congress has acknowledged the reality that program income is an integral, structural element of funding for federal Indian healthcare programs, and has legislated accordingly. IHS therefore must pay contract support costs incurred by Tribes and tribal organizations in expending program income to provide healthcare services. The Court should affirm the decisions below.

ARGUMENT

I. CONGRESS ENACTED THE IHCIA TO REDRESS CRITICAL FUNDING SHORTFALLS IN FEDERAL INDIAN HEALTHCARE PROGRAMS

A. Indian healthcare before the IHCIA

Before enactment of the IHCIA in 1976, the health of Indian people in the United States was abysmal—the result of underfunded and poorly-managed healthcare programs halfheartedly delivered by a federal government that often declared, but virtually never fulfilled, its trust responsibility to Indian Tribes.

The Snyder Act of 1921 was Congress's most comprehensive effort to provide for Indian healthcare before the IHCIA, but it was woefully inadequate because it defined only a vague mission and failed to

ensure adequate funding, resulting in rationed medical care for American Indian and Alaska Native people who received care from IHS.[3]

Without eliminating the Snyder Act, Congress sought to address weaknesses in the Indian healthcare system through enactment of the IHCIA. The IHCIA declares that "Federal health services to maintain and improve the health of the Indians are consonant with and required by the Federal Government's historical and unique legal relationship with, and resulting responsibility to, the American Indian people." 25 U.S.C. § 1601(1). Accordingly, "it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians . . . to ensure *the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy*." 25 U.S.C. § 1602(1) (emphasis added). Yet, throughout their history, the federal government and IHS have persistently underfunded and mismanaged tribal health programs.

When Congress enacted the IHCIA, the House Committee on Interior and Insular Affairs observed:

> The sad facts are that the vast majority of Indians still live in an environment characterized by inadequate and understaffed health facilities; improper or nonexistent waste disposal and water supply systems; and

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[3] *See generally* Abraham B. Bergman, et al., *A Political History of the Indian Health Service*, 77 Milbank Q. 571 (1999) https://www.jstor.org/stable/3350575.

> continuing dangers of deadly or disabling diseases.
>
> These circumstances, in combination, cause Indians and Alaska Natives to suffer a health status far below that of the general population and plague Indian communities and Native villages with health concerns other American communities have forgotten as long as 25 years ago.

H.R. Rep. No. 94-1026, pt. 1, at 15 (1976), *as reprinted in* 1976 U.S.C.C.A.N. 2652, 2654. Despite existing healthcare programs, Congress found, "the unmet health needs of the American Indian people are severe and the health status of the Indians is far below that of the general population of the United States." 25 U.S.C. § 1601(5). Inadequate funding was the primary cause of these failures. In 1976, "[p]er capita expenditures for Indian health purposes [were] 25 percent below per capita expenditures for health care in the average American community." H.R. Rep. No. 94-1026, pt. 1, at 16 (1976), *as reprinted in* 1976 U.S.C.C.A.N. 2652, 2655.

Recognizing that increased funding was the key to reducing healthcare disparities, Congress enacted the IHCIA with the specific goal of "rais[ing] the status of health care for American Indians and Alaska Natives . . . to a level equal to that enjoyed by other American citizens." *Id.* at 13. The primary statutory and programmatic means to meet that goal were to "provide the direction and financial resources to overcome the inadequacies in the existing Federal Indian health

care program," and—in concert with the recently-enacted ISDA (passed in 1975)—to "invite the greatest possible participation of Indians and Alaska Natives in the direction and management of that program." *Id.*

The core elements of Congress's strategy to achieve this goal were (1) increased, adequate funding combined with (2) increased tribal participation and control over delivery of federally-funded programs and services. Congress advanced these mutually-reinforcing goals through the IHCIA and the ISDA—statutes that, because of their inextricably intertwined history, subject matter, and text, must be read *in pari materia*: they "are to be taken together, as if they were one law." *United States v. Stewart*, 311 U.S. 60, 64 (1940); *see Navajo Health Found.—Sage Mem'l Hosp., Inc. v. Burwell*, 263 F. Supp. 3d 1083, 1165 (D.N.M. 2016), *appeal dismissed*, No. 18-2043, 2018 WL 4520349 (10th Cir. July 11, 2018).[4]

[4] Seeking to separate contract support cost obligations from program income, Petitioners ascribe significance to the fact that tribal entities' authority to collect from third parties "does not come from ISDA," but rather from the IHCIA. Pet'r's Br. 23. But the ISDA provisions before the Court concern contract support cost obligations directly related to funding mechanisms governed by the IHCIA. Given the clear, deep, and longstanding interrelationship between the two statutes, there is no merit to the suggestion that the Court could ignore the IHCIA in interpreting the ISDA provisions at issue.

B. In the IHCIA, Congress established Medicare and Medicaid reimbursements as an integral source of funding for federal Indian healthcare programs

Congress recognized that Indian healthcare funding was inadequate in part because IHS and tribal facilities lacked access to funding sources available to other healthcare providers. "Prior to the enactment of the Indian Health Care Improvement Act in 1976, IHS facilities, like all other Federal health facilities, were not eligible for payment for services they provided to Medicare or Medicaid beneficiaries." H.R. Rep. No. 99-94, pt. 1, at 28 (1985). Accordingly, "[i]n order to assure eligible Indians had access to the same quality of care that other Medicare and Medicaid ben[e]ficiaries had, Congress, in Title IV of [the IHCIA], made qualified IHS (or tribally operated) facil[i]ties eligible for Medicare and Medicaid reimbursement." *Id*. Specifically, provisions of the IHCIA authorized IHS to bill Medicare and Medicaid for services provided by IHS and tribally-operated facilities. Indian Health Care Improvement Act, Pub. L. No. 94-437, tit. IV, §§ 401 (Medicare), 402 (Medicaid), 90 Stat. 1400, 1408-1410 (1976), codified at 42 U.S.C. § 1396j and 42 U.S.C. § 1395qq.

Congress intended for Medicare and Medicaid reimbursements to provide critical *supplemental* funding for IHS programs, to improve and expand existing services—*not* to replace existing appropriations. H.R. Rep. No. 94-1026, pt. 1, at 108 (1976), as *reprinted in* 1976 U.S.C.C.A.N. 2652, 2746 ("[T]he Committee

firmly expects that funds from Medicare and Medicaid will be used to expand and improve current IHS health care services and not to substitute for present expenditures."). For example, Medicaid payments IHS was allowed to collect under the IHCIA were "viewed as a much-needed supplement to a health care program which has for too long been insufficient to provide quality health care to the American Indian." H.R. Rep. No. 94-1026, pt. 3, at 21 (1976), *as reprinted in* 1976 U.S.C.C.A.N. 2782, 2796. In hearings of the House Subcommittee on Indian Affairs, it was further emphasized that Title IV of the IHCIA was intended "to expand and improve existing IHS facilities, not supplant them." Hearings before the Subcomm. on Indian Aff. of the Comm. on Interior and Insular Aff., 94th Cong. 194 (1975) (statement of Hon. Lloyd Meeds, Chairman, Subcomm. on Indian Aff.).

Accordingly, from the first enactment of the IHCIA, third-party revenues (and activities funded by these revenues) became a central part of federal healthcare programs operated by IHS or by Tribes pursuant to ISDA contracts. Importantly, however, IHS at that time retained full control over collection and distribution of Medicare and Medicaid funds among IHS and tribal facilities. Congress had not yet granted Tribes or tribal organizations the authority to collect from third parties.

II. IHCIA AND ISDA AMENDMENTS DEMONSTRATE THAT THIRD-PARTY REVENUES ARE AN ESSENTIAL ELEMENT OF "THE FEDERAL PROGRAM" FOR WHICH IHS MUST PAY CONTRACT SUPPORT COSTS

Statutory amendments and other developments related to the IHCIA and the ISDA after 1976 further demonstrate that Congress intended third-party revenues and the activities they support to be critical elements of federal Indian healthcare programs—whether operated by IHS or by Tribes or tribal organizations—and Congress has legislated in light of that understanding.

When Congress amended the ISDA in 1994 to require payment of contract support costs incurred by Tribes in operating "the Federal program" taken over from IHS through an ISDA contract, 25 U.S.C. § 5325(a)(3)(A) (added by Pub. L. No. 103-413, § 102(14)(C), 108 Stat. 4250, 4257-58 (1994)), Congress knew that collection and expenditure of third-party revenues—which Congress defined as "program income," 25 U.S.C. § 5325(m)—had long been an integral part of the very same "Federal program" operated by IHS.[5]

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[5] Tellingly, Petitioners characterize the mechanics of an ISDA contract as an agreement between a Tribe and IHS "in which the tribe agrees to undertake *the federal program or programs previously administered by the agency* on the tribe's behalf." Pet'r's Br. 3 (emphasis added). And Petitioners are correct: the "program or programs," including the program income they generate and spend, remain exactly the same under IHS or tribal

A. 1988 IHCIA amendments authorized IHS to collect reimbursement from private insurance carriers

In 1988, Congress recognized that private health or accident insurance carriers and workers' compensation programs were frequently denying payment to IHS because IHS did not charge eligible Indians for services it rendered. *See* H.R. Rep. No. 100-222, pt. 2, at 19-20 (1987). This was a problem because IHS and tribal programs were unable to collect payment from sources that were commonly available to private physicians or hospitals. *Id*. Congress accordingly amended the IHCIA in 1988 to give IHS "the right to recover the reasonable expenses incurred" in providing health services

> to any individual to the same extent that such individual, or any nongovernmental provider of such services, would be eligible to receive reimbursement or indemnification for such expenses if—(1) such services had been provided by a nongovernmental provider, and (2) such individual had been required to pay such expenses and did pay such expenses.

Indian Health Care Amendments of 1988, Pub. L. No. 100-713, § 206, 102 Stat. 4784, 4811 (1988).

Like Medicare and Medicaid collections, the revenues IHS collects from private insurers are intended to supplement, not replace or offset, existing funding

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control—at least in all respects material to the issues before the Court.

for Indian healthcare programs. In enacting the 1988 amendments, Congress intended that these funds would provide additional resources "without reducing Federal appropriations for other IHS activities." H.R. Rep. No. 100-222, pt. 2 at 21 (1987).

Thus, with the 1988 amendments, IHS was empowered to collect reimbursement for healthcare services provided through its programs from Medicare, Medicaid, and private insurance carriers. As further detailed below, IHS used this authority to capture an increasing proportion of its overall program funding. IHS, other Executive Branch entities, and Congress have all recognized that revenues from Medicare, Medicaid, and private insurance are, and long have been, an indispensable element of the agency's funding of Indian healthcare programs.

B. 1992 IHCIA amendments extended third-party collection rights to tribal contractors, while IHS continued to collect and distribute third-party revenues on Tribes' behalf as "program income"

Congress amended the IHCIA again in 1992, in part to address concerns that insurance carriers refused to reimburse Tribes that operated healthcare programs under ISDA contracts, even though the 1988 IHCIA amendments establishing a right of recovery against private insurers had been intended to extend to tribal governments. S. Rep. No. 102-392, at 20-21

(1992), *as reprinted in* 1992 U.S.C.C.A.N. 3943, 3962-63. Accordingly, Congress amended the IHCIA to clarify that tribal health contractors have a right to recover against private insurance companies. Indian Health Amendments of 1992, Pub. L. No. 102-573, § 209, 106 Stat. 4526, 4551 (1992).

The 1992 amendments also imposed new requirements on IHS in relation to third-party revenues the agency collected on behalf of tribal contractors. Congress adopted these provisions in response to concerns that program income was being used as a reason to diminish appropriations, as well as to better incentivize collection and reporting of third-party revenues. A provision in the amendments required that payments received by IHS or a tribal contractor "shall not be considered in determining appropriations for health care and services to Indians." Indian Health Amendments of 1992, Pub. L. No. 102-573, § 401, 106 Stat. 4526, 4565 (1992). And the 1992 amendments required that 80 percent of funds collected by IHS must be returned to the facility where the services being billed were performed. *See id.* § 402; S. Rep. No. 102-392, at 29 (1992), *as reprinted in* 1992 U.S.C.C.A.N. 3943, 3971. This provision arose from concern that IHS's practice of diverting third-party revenues away from the facilities that generated them failed to incentivize effective billing and collection practices. *See id.*; H.R. Rep. No. 102-643, pt. 1, at 51 (1992).

IHS still collected Medicare and Medicaid reimbursements on behalf of most tribal contractors, with

the exception of four Tribes participating in a "demonstration program" that allowed Tribes to collect from Medicare and Medicaid directly. Indian Health Care Amendments of 1988, Pub. L. No. 100-713, § 402, 102 Stat. 4784, 4818-20 (1988). Thus, at the time of the 1992 amendments, IHS continued to collect third-party revenues for the hundreds of Tribes that were not included in the demonstration program. IHS then transferred those funds to each contracting Tribe through its ISDA contract by modifying the Tribe's contract to reflect the amount of program income earned by the Tribe through IHS billing and collection. S. Rep. No. 106-152, at 2-3 (1999).

C. When Congress amended the ISDA in 1994 to require payment of contract support costs incurred by Tribes in operating "the Federal program," third-party revenues had long been an integral element of "the Federal program" operated by IHS

Congress amended the ISDA in 1994 to update the contract support costs provisions, adopting the statutory language at the heart of the dispute now before the Court regarding the scope of "the Federal program," 25 U.S.C. § 5325(a)(3)(A)(i), (A)(ii), and the "program income" provisions, *id.* § 5325(m). The historical context of those amendments makes plain that "the Federal program" for which Congress commanded IHS to pay contract support costs included activities funded by third-party revenues.

As discussed above, at the time of this enactment in 1994, IHS routinely collected third-party revenues on behalf of tribal contractors, including Medicare, Medicaid, and private insurance reimbursements, and IHS distributed these payments to tribal contractors through their ISDA contracts as program income. IHS still managed collection and distribution of virtually all third-party revenues.[6] And IHS's own submissions to Congress confirmed the central role of third-party revenues in program funding. For example, IHS's 1994 Budget Justification to Congress projected $120 million in collections from Medicare and Medicaid in fiscal year 1994, and told Congress that Medicare and Medicaid "funds have been used primarily for personnel services, equipment and supplies, and facility maintenance and improvement." Dep't of the Interior & Related Agencies Appropriations: Hearings before a Subcomm. of the Comm. on Appropriations, 103rd Cong., 1st sess., IV, at 69 (1993).

When Congress amended the ISDA in 1994, it acted against the backdrop of prior legislation and

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[6] With respect to the four Tribes participating in the demonstration program permitting direct tribal collection from Medicare and Medicaid, Congress expressly required that any funds they recovered be used first to maintain compliance with Medicare and Medicaid requirements, and that any excess funds be used "in accordance with the regulations of the Service applicable to funds provided by the Service under any contract entered into under the [ISDA]." Indian Health Care Amendments of 1988, Pub. L. No. 100-713, 102 Stat. 4784, 4819 (1988). This further evidences Congress's intent to treat third-party revenues collected by Tribes as an integral element of the Federal program being operated by Tribes under contracts with IHS.

agency practice, both of which treated third-party revenues as an integral part of federal Indian healthcare programs managed by IHS. *See St. Louis, I.M. & S.R. Co. v. United States*, 251 U.S. 198, 207 (1920) ("Congress must be presumed to have known of its former legislation . . . and to have passed . . . new laws in view of the provisions of the legislation already enacted."). Accordingly, the 1994 ISDA amendments referring to "the Federal ***program***," 25 U.S.C. § 5325(a)(3)(A)(i), (A)(ii) (emphasis added), and "***program*** income," *id.* § 5325(m) (emphasis added), inescapably refer to the same thing: the federal ***program*** under which IHS (on behalf of nearly all Indian Tribes) had for nearly two decades collected and distributed "**program** income" as an essential element of **program** funding. *See Erlenbaugh v. United States*, 409 U.S. 239, 243 (1972) ("[A] legislative body generally uses a particular word with a consistent meaning in a given context."); *Sage Mem'l Hosp.*, 263 F. Supp. 3d at 1162, 1165-66 (concluding ISDA's "text and the legislative history . . . provide that expenditures made with third-party revenues in support of programs administered under a self-determination contract are spent on the federal program and are therefore eligible to be reimbursed as [contract support costs]").

Further confirming this interpretation, Congress has regularly directed, in annual appropriations bills dating back to 1989, that "amounts received by tribes and tribal organizations" under the provisions authorizing third-party collections "shall be reported and accounted for and available to the receiving tribes and

tribal organizations until expended." Department of the Interior and Related Agencies Appropriations Act, 1989, Pub. L. No. 101-121, 103 Stat. 701, 733 (1989); *see*, *e.g.*, Consolidated Appropriations Act, 2023, Pub. L. No. 117-328, 136 Stat. 4459, 4809 (2022). That Congress in annual appropriations acts has consistently required reporting and accounting of program income collected on behalf of Tribes further confirms that Congress regards these funds as part of "the Federal program" that Tribes operate under ISDA contracts.

Petitioners strive to invert the plain meaning of the "program income" language in sections 5325(m) and 5388(j), arguing that Congress's express statements that program income "shall not be a basis for *reducing*" funding for tribally-operated programs, 25 U.S.C. § 5325(m)(2) (emphasis added), actually means program income cannot be a basis to *increase* funding to Tribes. *See* Pet'r's Br. 16. The argument is untenable. Congress easily could have adopted statutory language limiting the United States' contract support cost obligations to directly appropriated funds; it did not. Congress enacted language specifying that program income is purely supplemental to the base funding amount because Congress was concerned about *too little* funding to Tribes, not *too much* funding (a concern that was well placed given the abysmal history of underfunding and agency mismanagement). The plain language of the statute sets a floor on tribal funding—not a ceiling. Indeed, Petitioners' interpretation would financially penalize Tribes for entering into self-determination contracts because it would force Tribes

to bear overhead costs associated with program income that IHS does not bear—an outcome directly contrary to Congress's clearly-stated intent to ensure tribally-operated programs are placed on a financial footing equivalent to that of IHS. *See*, *e.g.*, Br. of Resp. San Carlos Apache Tribe 9.

In light of the statutory text, history, and context, Petitioners' position—that program income and associated activities are not part of "the Federal program" for which Tribes are entitled to contract support costs—is without merit.

D. Congress's actions after the 1994 ISDA amendments confirm that third-party revenue remains a critical element of "the Federal program"

Subsequent amendments to the IHCIA authorized Tribes to bill and collect from third parties directly. *See* Alaska Native American Indian Direct Reimbursement Act of 2000, Pub. L. No. 106-417, 114 Stat. 1812 (2000) (rewriting IHCIA § 405). IHS oversight of third-party revenue collection ended only in 2010, and Tribes may now directly "bill for, and receive payment for, health care items and services" covered by third-party payers, including Medicare and Medicaid. 25 U.S.C. § 1641(d)(1). But the transition from IHS collection of third-party revenues on behalf of Tribes to direct collection by Tribes—a shift designed to *help* tribal healthcare programs—does not mean that activities

funded by program income are no longer part of "the Federal program."[7]

Indeed, later actions by Congress demonstrate that third-party revenues continue to be a critical part of "the Federal program." For example, in 2017 Congress appropriated $29 million to IHS for "costs related to or resulting from accreditation emergencies." Consolidated Appropriations Act, 2017, Pub. L. No. 115-31, div. H, title II, 131 Stat. 135, 484 (2017). This appropriation was necessary largely due to IHS facilities in the Great Plains region that lost or risked losing accreditation, which in turn threatened to deprive those facilities of the ability to collect third-party revenues (primarily from Medicare and Medicaid), leading to devastating losses of funding.[8] Congress's actions in response to this emergency illustrate that third-party revenues remain a critical part of "the Federal program" because Congress saw fit to appropriate additional funds to make up for the loss or potential loss of that program income.

Consistent with Congress's action in response to these accreditation emergencies, IHS itself has

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[7] The 2010 IHCIA amendments also added a payer of last resort provision, under which Tribes are *required* to bill Medicare, Medicaid, and private insurers whenever possible. *See* The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2901(b), 124 Stat. 119, 333 (2010), 25 U.S.C. § 1623(b).

[8] *See* Kevin Abourezk, *Another Indian Health Service hospital placed in "immediate jeopardy" status*, INDIANZ.COM (Nov. 6, 2017), *at* https://indianz.com/News/2017/11/06/another-indian-health-service-hospital-p.asp#:~:text=The%20Centers%20for%20Medicare%20and,death%20or%20impairment%20to%20patients.

emphasized that it "places the highest priority on accreditation and certification standards for its healthcare facilities," and "[t]hird-party revenue is essential to maintaining facility accreditation, certification and standards." Dep't of Health and Human Servs., *Fiscal Year 2024 Indian Health Service Justification of Estimates for Appropriations Committees*, CJ-193 (2023).

Further underscoring the centrality of third-party revenues in funding federal Indian healthcare programs, in the midst of the COVID-19 pandemic, Congress appropriated $2 billion "for lost reimbursements, in accordance with section 207 of the Indian Health Care Improvement Act (25 U.S.C. 1621f)." American Rescue Plan Act of 2021, Pub. L. No. 117-2, § 11001(a)(1)(A), 135 Stat. 4, 240 (2021). These funds were intended to compensate IHS and tribal programs for lost third-party revenues. 25 U.S.C. § 1621(f). In other words, when IHS and Tribes were unable to collect sufficient third-party revenues as a result of the COVID-19 pandemic, Congress intervened to replace the essential lost revenues with direct funding.

Congressional action has consistently reaffirmed that, as a matter of law and actual practice, third-party revenues remain essential to operation of "the Federal program"—whether the particular program in question is operated by IHS directly or by a Tribe or tribal organization under an ISDA contract.

E. Per capita expenditures on Indian healthcare continue to lag behind other federal healthcare spending, and payment of contract support costs on services funded by program income is necessary to progress toward parity

Despite improvements to the ISDA and the IHCIA intended to provide more funding for Indian healthcare programs, per capita and total expenditures for healthcare services provided by IHS severely lag behind those of other federal healthcare programs. For example, in 2017 "IHS per capita spending was ***$4,078***, as compared to $8,109 for Medicaid, $10,692 for [the Veterans Health Administration], and $13,185 for Medicare." U.S. Gov't Accountability Off., GAO-19-74R, *Indian Health Service: Spending Levels and Characteristics of IHS and Three Other Federal Health Care Programs* 5 (2018) (emphasis added).

Petitioners protest that paying contract support costs on third-party revenues will cost the federal government more money.[9] This may be so, but it should not sway the Court. Congress will need to appropriate additional funds to meet the federal government's obligations under the ISDA—through mandatory appropriations—so that increases in contract support costs

[9] Even if Petitioners' speculative estimates of increased spending necessary to pay contract support costs on program income are accepted, the increase is minimal in comparison to total federal healthcare spending, the overwhelming majority of which goes to Medicare and Medicaid, and not tribal healthcare programs. For example, IHS's total spending in 2017 of $6.68 billion was only about one percent of spending for each of Medicare and Medicaid. GAO-19-74R, *supra*, at 5.

will not result in a decrease of funds for direct healthcare services, including those services provided to sovereign tribal nations that choose to receive their healthcare directly from IHS. But the vagaries of Congressional appropriation processes are of no moment to the task before this Court—interpreting the plain meaning and intent of 25 U.S.C. § 5325, which requires IHS to pay contract support costs on the entire "Federal program," including program income.

For far too long, the federal government has fallen well short of its legal and "moral obligations" to American Indians. *Seminole Nation*, 316 U.S. at 297. This Court has rightly rejected the notion that agency concerns about spending can extinguish those obligations. *See generally Salazar v. Ramah Navajo Chapter*, 567 U.S. 182 (2012). Because third-party revenues and associated activities are, and long have been, a critical part of "the Federal program," IHS must pay contract support costs attributable to third-party revenues.

III. WHILE PETITIONERS INSIST PROGRAM INCOME IS NOT PART OF "THE FEDERAL PROGRAM," IHS CONTINUES TO TREAT PROGRAM INCOME AS A CRITICAL PART OF TRIBALLY OPERATED PROGRAMS, INCLUDING BY TRANSFERRING PROGRAM INCOME, AND PERSONNEL FUNDED BY PROGRAM INCOME, TO TRIBES THAT ASSUME CONTROL OF IHS HEALTHCARE PROGRAMS UNDER ISDA

Petitioners concede, as they must, that "IHS . . . collects and spends third-party income in the course of

running its own programs." Pet'r's Br. 17. Congress and the Executive Branch have acknowledged the reality that third-party revenues have long played an essential role in maintaining IHS programs. Yet Petitioners ask the Court to embrace the fiction that, when those same programs are transferred to tribal control under an ISDA contract, third-party revenues somehow lose their connection to "the Federal program"—as though collection and expenditure of program income were a unique tribal innovation, entirely independent of "the Federal program" transferred from IHS to tribal control. Petitioners' portrayal is not only inconsistent with the statutory language, but is also belied by IHS's own conduct.

A. IHS budgeting documents show that IHS treats program income as an essential part of its programs

A 2022 report of the Government Accountability Office noted:

> IHS increasingly relies on funding from third-party collections for its operations, including to procure medical supplies, pharmaceuticals, and health care services. Third-party collections represent a significant portion of IHS facilities' health care delivery budgets. For example, IHS's fiscal year 2021 budget justification noted that some IHS health care facilities reported that 60 percent or more of their annual budgets rely on revenue collected from third-party payers.

U.S. Gov't Accountability Off., GAO-22-104742, *Indian Health Service: Information on Third-Party Collections and Processes to Procure Supplies and Services* 2 (2022); *see also* U.S. Gov't Accountability Off., GAO-10-42R, *Indian Health Service: Updated Policies and Procedures and Increased Oversight Needed for Billings and Collections from Private Insurers* 2 (2009) ("According to IHS, [third-party] funds were used to purchase new medical equipment and medical supplies, and to provide compensation and benefits for IHS employees."); U.S. Gov't Accountability Off., GAO-19-612, *Indian Health Service: Facilities Reported Expanding Services Following Increases in Health Insurance Coverage and Collections* 15 (2019) ("Third-party collections across all federally operated IHS facilities increased 51 percent from fiscal year 2013 through fiscal year 2018," to a total of approximately "$1.07 billion.").[10]

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[10] In a seminal 2004 report, the U.S. Commission on Civil Rights recognized the increasing importance of third-party revenues in funding IHS programs and the practical reality that Congress and IHS both unequivocally regarded third-party revenues as integral to IHS funding. The Commission wrote: "Regardless of the level to which IHS is able to raise third-party reimbursements, the *entire system's* reliance on any third-party funds recovered will be real and substantial. Furthermore, even though congressional intent in assigning appropriations is difficult to surmise, the consistent widening of the gap between program-level funding and budget authority—and the resulting plateau in spending power—creates a strong presumption that third-party collections are being used to justify lower levels of appropriated funding." U.S. Comm'n on Civil Rights, *Broken Promises: Evaluating the Native American Health Care System* 101 (2004) (emphasis added).

Indeed, IHS was projected to collect $1.76 billion in third-party revenues for fiscal year 2023, and IHS predicts that these collections will increase to $1.83 billion in 2024. Dep't of Health and Human Servs., *Fiscal Year 2024 Indian Health Service Justification of Estimates for Appropriations Committees*, at CJ-193 (2023). IHS again noted that "[p]ublic and private collections represent a significant portion of the IHS and Tribal health care delivery budgets," and "[s]ome IHS health care facilities report that 60 percent or more of their yearly budget relies on revenue collected from third party payers." *Id*. IHS itself declares that it uses these critical funds to "maintain[ ] facility accreditation, certification and standards of health care" and "to improve the delivery of and access to health care for [American Indian and Alaska Native] people." *Id*.

In other words, IHS and other Executive Branch actors trumpet the centrality of program income in funding Indian healthcare programs operated by both IHS and Tribes, yet when asked to pay legally mandated contract support costs attributable to expenditure of those revenues, Petitioners argue that program income somehow is unrelated to the very same programs. This is contrary not only to the statutory provisions directly governing contract support costs, but also to the fundamental and overarching Congressional policy requiring parity in funding between "programs and facilities operated by Indian tribes" and "programs and facilities operated directly by the Service." 25 U.S.C. § 1602(7); *see also* 25 U.S.C. § 1680a (requiring IHS to fund certain activities of tribal

healthcare programs "on the same basis as such funds are provided to programs and facilities operated directly by the Service").

B. The experience of Tribes and tribal organizations that have assumed operation of formerly IHS-operated healthcare programs demonstrates that program income is an integral part of "the Federal program"

Petitioners contend the ISDA creates "a comprehensive and coherent scheme to (1) transfer IHS's appropriated funding to the contracting Tribe, and (2) fill specific gaps in that funding so that the tribes are not put at disadvantage when running the transferred program in IHS's stead." Pet'r's Br. 19. But Petitioners' characterization elides a critical fact: when IHS transfers control over a particular healthcare program to a Tribe or tribal organization, IHS does not simply "transfer IHS's appropriated funding to the contracting tribe," as Petitioners claim. IHS *also* transfers third-party funds generated by that program—because those funds are inextricably part of "the Federal program" being transferred to tribal control. 25 U.S.C. § 5325(a)(3)(A)(i), (A)(ii). Real-world experience confirms this fact.

For example, in 2010, the Fort Defiance Indian Hospital Board, Inc. ("FDIHB"), a tribal organization of the Navajo Nation, assumed control from IHS of a major healthcare program centered on the Fort

Defiance Hospital and the Nahata' Dzill Health Center. Self-Determination Contract between Fort Defiance Indian Hospital Board, Inc. and the Secretary of the Department of Health and Human Services, Jan. 28, 2010, at p. 1, Attachment 1, Attachment 2.[11]

When FDIHB took over the Federal program from IHS, IHS agreed to transfer to FDIHB "any third party collections, credits or refunds received by the IHS, an IHS service unit or the FDIHB after March 30, 2010 that relate to care provided by the Fort Defiance Service Unit." *Id*. at Attachment 2, Section 4(H). IHS further agreed to transfer to FDIHB all available unobligated allowances for various third-party revenues, including for Medicare, Medicaid, and private insurance. *Id*. at Attachment 2, Section 4(I). FDIHB was also required under its contract to collect funds from Medicare and Medicaid and use those funds as allowed by applicable law. Further, FDIHB was required to use program income recovered from third parties—specifically including third-party funds recovered "*for services previously provided by the IHS* through a [program, function, service, or activity] now operated by the FDIHB." *Id*. at Attachment 2, Sections 6 & 7 (emphasis added).

Consistent with these contract provisions, during the transition period in 2010, IHS transferred to FDIHB well over $5 million in third-party revenues

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[11] *Available at* https://assets-global.website-files.com/6568c72009cab329bdad2b1c/65c549b9237fe0381fb73f37_Fort%20Defiance%20IHB%20FY2010_AFA.pdf.

generated by the program when it had been under IHS control, including periodic ongoing transfers of amounts received by IHS after FDIHB assumed control of the facilities.[12]

In assuming control of the program, FDIHB also assumed IHS's employment relationship with hundreds of program employees. And IHS documents provided to FDIHB during the transition identified ***more than 500*** of these IHS employees as being funded by Medicare, Medicaid, or private insurance. *See* Program Personnel Worksheet, 5-7, 14.[13] These third-party-funded positions covered a broad swath of the program that IHS operated before FDIHB took over the program under its ISDA contract, including doctors, physician assistants, nurses, medical technicians, radiology staff, laboratory and pathology staff, surgical staff, respiratory therapists, psychologists and other mental health staff, emergency room personnel, biomedical engineering staff, medical records staff, clerical staff, security personnel, housekeeping,

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[12] *See* Feb. 18, 2010 Letter from Anita R. Shirleson, Contracting Officer, to Elmer Milford, and collected funding memoranda, *available at* https://assets-global.website-files.com/6568c72009cab329bdad2b1c/65c549b7c1fb656b005aae8d_Other%20IHS%20Funds%20(002).pdf.

[13] *Available at* https://assets-global.website-files.com/6568c72009cab329bdad2b1c/65c549b91609365aa07b17d2_Exhibit%2018%20-%20FDH_2010%20-%20Program%20Personnel%20Worksheet_Redacted.pdf. Lines 356-433 on the Program Personnel Worksheet reflect positions funded by Medicare, lines 437-919 reflect positions funded by Medicaid, and lines 924-988 reflect positions funded by private insurance revenues.

pharmacists and pharmacy staff, social workers, IT staff, food service staff, and others. *Id*.

In sum, when IHS operated this "Federal program" before transferring it to FDIHB in 2010, IHS collected third-party revenues and used those funds to pay for clinical staff and other essential program personnel. When IHS transferred "the Federal program" to FDIHB, it also transferred third-party revenues and hundreds of employees IHS had been paying with those revenues.

Amici are aware of numerous similar examples in which IHS transferred control of healthcare programs to Tribes or tribal organizations, along with the program income those programs generated and the employees funded by that program income when IHS operated those facilities or programs.

The example of FDIHB shows why Petitioners' arguments lack merit. FDIHB contracted with IHS to operate the entire "Federal program," including substantial portions of the program that were already funded by Medicare, Medicaid, and private insurance collections before IHS transferred the program to FDIHB. Those third-party revenues were an essential element of the program under IHS control, and they remained an essential element of the program under tribal control. In operating the program, FDIHB bears additional overhead costs associated with the employees and services funded by program income—costs not borne by IHS. If the United States does not pay contract support costs attributable to the expenditure of

program income to employ these personnel and provide additional healthcare services, FDIHB must divert other funds to cover those costs. The effect is to financially penalize FDIHB for taking over the program—in direct contravention of the statutory scheme and Congress's express commands.

To avoid this inappropriate and unfair outcome, and to honor the legal obligations to Indian Tribes and tribal organizations that Congress has expressly established, the United States must pay contract support costs associated with expenditure of program income.

CONCLUSION

The Court should affirm the decisions below.

* * *

Program income and the activities it funds are a critical and integral part of "the Federal program" that Indian Tribes and tribal organizations contract to operate under the ISDA. Congress's many enactments related to third-party revenues confirm that for decades this source of funding has been an integral part of federal Indian healthcare programs, whether managed directly by IHS or by Indian Tribes or tribal organizations under the ISDA. The text, history, and context of the IHCIA and the ISDA confirm that the United States is obligated to pay Tribes and tribal organizations contract support costs on third-party revenue generated by tribally operated healthcare programs.

Nonetheless, the federal government must ensure that funding of these costs does not directly or indirectly diminish the funding of essential health services, especially those services funded by discretionary appropriations. This includes services provided to Tribal nations that exercise their sovereign right to have healthcare provided directly by IHS.

Respectfully submitted,

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