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Health Care Law—Obligation of Indian Health Services to Fund the Administration of Tribe Run Health Care Services Has Expanded— San Carlos Apache Tribe v. Becerra, 53 F.4th 1236 (9th Cir. 2022)

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I. **Introduction**

The Indian Self Determination Education Assistance Act (hereinafter *ISDEAA*), enacted in 1975, granted indigenous tribes greater autonomy to control and administer health care services to tribal members.[1] The ISDEAA established a framework to allocate funding from the Indian Health Service (hereinafter *IHS*) directly to Tribes for the operation and management of their health care programs, including administrative "contract support costs" (hereinafter *CSC*).[2] Tribal health care programs are additionally funded through revenue generated from reimbursements by third-party insurers.[3] In *San Carlos Apache Tribe v. Becerra*,[4] the United States Court of Appeals for the Ninth Circuit considered, as a matter of first impression, whether the Indian Health Service was required to pay contract support costs related to administering health care services that the tribes provided using the third-party revenue funds.[5] The Ninth Circuit found that the ISDEAA necessarily requires the IHS to pay contract support costs for all activities required for

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[1] *See* Indian Self-Determination and Education Assistance Act, 25 U.S.C. § 5301 (1975).
[2] *See id.* (designating contract support cost funds to tribes for administration of health care programs). Contract support costs are funds allocated to Tribes under the ISDEAA that reimburse tribal contractors for expenses related to administration, management, and delivery of tribal health care programs. *Id.*; Indian Self-Determination and Education Act Amendments of 1987, Pub. L. No. 100–472, § 205, 102 Stat. 2285, 2292–94 (1988). Contract support costs include the tribal contractor's "reasonable costs" incurred "to ensure compliance with the terms of the contract and prudent management." *Id.*; *About IHS*, INDIAN HEALTH SERV., https://www.ihs.gov/aboutihs/#:~:text=The%20Indian%20Health%20Service%2C%20an,American%20Indians%20and%20Alaska%20Natives [https://perma.cc/923C-G7J8]. IHS is a federal agency within the Department of Health and Human Services and is responsible for providing health services to American Indians and Alaska Natives. *Id.* IHS's mission is "to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level." *Id.*
[3] *See id.*; Indian Health Care Improvement Act, Pub. L. No. 94-437, 90 Stat. 1400 (1976) (granting native American tribes ability to bill Medicare and Medicaid programs directly); *Indian Health Service: Information on Third-Party Collections and Processes to Procure Supplies and Services*, U.S GOVERNMENT ACCOUNTABILITY OFFICE, https://www.gao.gov/products/gao-22-104742 [https://perma.cc/N9RY-ESH9]. Third party funds are collected from the payments received from public programs such as Medicare or private insurers for patients' medical care. *Id.*
[4] *See* San Carlos Apache Tribe v. Becerra, 53 F.4th 1236 (9th Cir. 2022).
[5] *See id.* at 1236.

compliance with the Act, including portions of the program funded by third-party revenue.[6]

II. **Facts**

Located in eastern Arizona, the San Carlos Apache Reservation is home to approximately 10,815 individuals who belong to the San Carlos Apache Tribe (hereinafter *The Tribe*).[7] The Tribe is federally recognized and, as a result, is granted authority to manage and operate their own health care programs in accordance with the ISDEAA's provisions.[8] The Tribe receives funding to operate their health care programs from IHS, a federal agency within the Department of Health and Human Services responsible for providing health services to federally recognized tribes.[9] The contract between the San Carlos Apache Tribe and the federal government (hereinafter *The Contract*), through which the Tribe operates its health care programs, incorporates the ISDEAA provisions in conjunction with particular funding negotiations.[10] As statutorily provided, the Tribe

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[6] *See id.* at 1244; *see also* Indian Self-Determination and Education Assistance Act, 25 U.S.C. § 5301 (1975); 25 U.S.C. § 5325(a)(2) (1975). CSC is eligible for any administrative or other expense incurred in connection with the operation of the Federal program. *Id. See generally* Indian Health Care Improvement Act, Pub. L. No. 94-437 (1976) (providing tribes authority to use third-party revenue for ISDEAA health care programs).

[7] *See San Carlos Apache Tribe Community Profile*, NATIVE AM. ADVANCEMENT, INITIATIVES & RSCH. (Sept. 2023), https://naair.arizona.edu/san-carlos-apache-indian-tribe [https://perma.cc/7VQ3-EVBP]. Officially established in 1871, the reservation contains 1.8 million acres, spanning three counties across eastern Arizona. *Id.*

[8] *See* 53 F.4th at 1239. In congruence with the overall goal of the ISDEAA, the Tribe is able to exercise their sovereignty and self-determination by managing their own health care programs. *Id.*; Indian Self-Determination and Education Assistance Act, 25 U.S.C. ch. 14, subch, II § 5301 (1975) (explaining self-determination contracts provisions of ISDEAA); U.S. COMM'N ON C.R., BROKEN PROMISES: CONTINUING FEDERAL FUNDING SHORTFALL FOR NATIVE AMERICANS (Dec. 2018), https://www.usccr.gov/files/pubs/2018/12-20-Broken-Promises.pdf [https://perma.cc/Q2CK-EXVD]. "There are currently 573 federally recognized tribes across the U.S. Native American or Alaska Native tribal sovereign entities have a government-to-government relationship with the U.S. and are entitled to certain federal benefits, services, and civil rights protections." *Id.* at 12.

[9] *See* Holly E. Cerasana, *The Indian Health Service: Barriers to Health Care and Strategies for Improvement,* 24 GEO. J. POVERTY L. & POL'Y 421, 422 (2017). "[IHS] is a federally funded health service provider that provides health services directly to beneficiaries or in conjunction with Native American tribes." *Id.* at 423. "All actions carried out by the IHS are 'directed toward developing an efficient and effective health care delivery system and promoting American Indian and Alaska Native participation and management of their own health care systems.'" *Id.*; *About IHS*, INDIAN HEALTH SERV., https://www.ihs.gov/aboutihs/#:~:text=The%20Indian%20Health%20Service%2C%20an,American%20Indians%20and%20Alaska%20Natives [https://perma.cc/ZZ3A-LE7E]. The IHS's role in providing health care services to Native American tribes is the result of the unique relationship between the federal government and American Indian tribes. *Id.* The relationship between the federal government and Indian tribes is based in the U.S. Constitution, treaties, laws, Supreme Court decisions, and Executive Orders. *Id.* The IHS is responsible for the provision of health services to approximately 2.6 million people who belong to 574 federally recognized tribes. *Id.*

[10] *See id.*; 53 F.4th at 1238-42. The Contract sets out an agreed upon amount of CSC funding to be paid out in accordance with Federal law. *Id.*

receives funds from IHS equivalent to what IHS would expend on the Tribe's health care if the Tribe were not administering its own program.[11] Additionally, IHS provides the Tribe with CSC for the Tribe to administer, operate, and manage the health care programs.[12]

> The parties agree that the CSC funding under this Funding Agreement (FA) will be calculated and paid in accordance with Section 106(a) of the [ISDA]; IHS CSC Policy (Indian Health Manual — Part 6, Chapter 3) or its successor; and any statutory restrictions imposed by Congress. In accordance with these authorities and available appropriations for CSC, the parties agree that under this FA the San Carlos Apache Tribe will receive direct CSC in the amount of $135,203, and indirect CSC in the amount of $423,731. These amounts were determined using the FY 2010 IHS CSC appropriation, and the San Carlos Apache direct cost base and indirect rate as of December 7, 2010, and may be adjusted as set forth in the IHS CSC Policy (IHM 6-3) as a result of changes in program bases, Tribal CSC need, and available CSC appropriations. Any adjustments to these amounts will be reflected in future modifications to this FA.

Id. at 1239-40.

[11] *See Fact Sheets: Tribal Self-Governance*, INDIAN HEALTH SERV. (July 2016), https://www.ihs.gov/newsroom/factsheets/tribalselfgovernance/ [https://perma.cc/X772-HU4F]. Tribal governments have the opportunity to assume responsibility for their own health care services through funding from HS or receive direct health services offered by IHS. *Id.*; 25 U.S.C. § 5325(a)(1) (1975).

> The amount of funds provided under the terms of self-determination contracts entered into pursuant to this chapter shall not be less than the appropriate Secretary would have otherwise provided for the operation of the programs or portions thereof for the period covered by the contract, without regard to any organizational level within the Department of the Interior or the Department of Health and Human Services, as appropriate, at which the program, function, service, or activity or portion thereof, including supportive administrative functions that are otherwise contractable, is operated.

Id.; 53 F.4th at 1238-39. Congress allocated CSC to tribes because it was too expensive for tribes to run their own health care programs. *Id.* The CSC was created to ensure that tribes could provide the same quantity of services as IHS would. *Id.*

[12] *See* 25 U.S.C. § 5325(a)(2) (1975).

> There shall be added to the amount required by paragraph (1) contract support costs which shall consist of an amount for the reasonable costs for activities which must be carried on by a tribal organization as a contractor to ensure compliance with the terms of the contract and prudent management, but which—
> (A) normally are not carried on by the respective Secretary in his direct operation of the program; or
> (B) are provided by the Secretary in support of the contracted program from resources other than those under contract.

Id.; Indian Self-Determination and Education Act Amendments of 1987, Pub. L. No. 100–472, § 205, 102 Stat. 2285, 2292–94 (amended 1988). Contract support costs include the tribal contractor's "reasonable costs" incurred "to ensure compliance with the terms of the contract and prudent management." *Id.* CSCs include direct, administrative, and overhead expenses for

Congress permits tribes to directly bill patients' health insurance providers to enhance program efficiency and ensure the tribes receive the maximum allocation of funds to which they are entitled.[13] Under the ISDEAA, the tribe may keep this third-party revenue so long as all funds from outside insurers are spent on additional health care for members of the tribe.[14] This revenue largely comes from Medicare, Medicaid, the Veterans Administration, and private insurance, and it makes up a significant part of the total IHS program funding.[15] Delivering services through third-party revenue results in significant administrative expenses, yet the Tribe was not granted any additional CSC to counterbalance the increased service costs.[16]

The Tribe filed a lawsuit against IHS contending that IHS is obligated to cover the additional CSC, and seeking retroactive CSC reimbursement for the program years 2011-2013.[17] The federal government rejected this contention, arguing that The Contract delineates specific calculations for the distribution of CSC.[18] Although The Contract does

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running tribal health care programs. *Id.*; BUREAU OF INDIAN AFFAIRS, INDIAN AFFAIRS MANUAL: INDIAN SELF-DETERMINATION CONTRACT SUPPORT COSTS 1 (Jan. 2017).

> [T]he ISDEAA authorizes funding for four types of CSC: pre- award, startup, direct, and indirect. Pre-award CSC are costs incurred before the start of an agreement. Startup CSC are costs incurred on a one-time basis during the initial year that the agreement is in effect. Direct CSC are costs incurred in connection with direct administration of the program. Indirect CSC are any additional administrative or other expense[s] related to the overhead incurred by the Tribal contractor in connection with the operation of the program.

Id.

[13] *See* 25 U.S.C. § 1641 (1994); 53 F.4th at 1239. Tribes were given the authority to bill outside insurers directly because the prior system, in which IHS billed insurers, led to slow and imperfect reimbursements. *Id.* Congress allowed direct billing to ensure tribes were not losing any of their third-party revenue due to inefficiencies of IHS's billing. *Id.*

[14] *See* 25 U.S.C. § 1641(d)(2)(A) (1994).

[15] *See* Samantha Artiga, *Medicaid and American Indians and Alaska Natives*, KAISER FAM. FOUND. (Sept. 7, 2017), https://www.kff.org/medicaid/issue-brief/medicaid-and-american-indians-and-alaska-natives/ [https://perma.cc/NLZ6-84JY] (explaining revenue from third-party payers come from Medicare, Medicaid, the Veterans Administration, and private insurance). In 2017, $1.3 billion collected from third-party payers supplemented the $4.8 billion allocated to IHS programs by Congress. *Id.*

[16] *See* 53 F.4th at 1239.

> A simplified example clarifies this scheme. Assume that a tribe administers a $3 million health care program for its members. It costs the tribe $500,000 in administrative costs to do so. IHS therefore will pay the tribe $3.5 million. Additionally, the tribe recovers $1 million for those procedures from outside insurers. It is statutorily required to spend that $1 million on health care as well. But there is a hole in this statutory scheme. Who pays the CSC for that additional $1 million in health care that the tribe must provide with its third-party revenue?

Id.

[17] *See id.*

[18] *See id.* at 1239-40. The portion of The Contract concerning CSC states that the San Carlos Apache Tribe will receive direct CSC in the amount of $135,203, and indirect CSC in the amount

not include CSC for third-party revenue-funded health care programs in the contractually allocated amount of CSC to the Tribe, the Defendants argue that the provisions that outline CSC distribution under 25 U.S.C. § 5325(a) do not necessitate an adjustment to accommodate the administration of such programs.[19] Thus, the Defendants argue that the Tribe does not have a claim to this additional CSC because the Tribe already received the CSC amount specified in The Contract, and there is no statutory right to any additional CSC.[20]

III. **History**

The contemporary framework of Native American health care policy predominantly revolves around the principle of tribal self-governance.[21] Tribal sovereignty draws its roots from the long history of tribal self-governance that existed thousands of years before European colonization and from the collective aspiration of these communities to preserve their distinct identity.[22] Considered "domestic dependent nations," tribes have the ability to govern themselves so long as they do not, "conflict with the interest of the overriding [United States] sovereignty."[23] In 1911, Congress began

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of $423,731. *See* 53 F.4th at 1240. The defendants argue that because the language of The Contract between the government and the Tribe sets out an agreed upon CSC amount, the Tribe's claims are meritless. *Id.* This argument implicitly states that the terms of The Contract may not be overridden by the ISDEAA. *Id.*

[19] *See* 53 F.4th at 1239-40. The Defendants argue that there is no language within 25 U.S.C. § 5325 that would override the calculated amount of CSC allocated within The Contract. *Id.*

[20] *See id.* at 1244. The Defendant's argue that there is no entitlement to this additional CSC because under the ISDEAA, CSC is only required to be provided to Tribes for costs attributed to The Contract. *Id.* The Defendants contend that the third-party revenue was not directly attributable to The Contract between the Tribe and IHS meaning that there is no statutory right to this CSC. 53 F.4th at 1244.

[21] *See* 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, 16-18 (2015) (explaining legislation creating statutory basis for tribal self-governance). "The ISDEAA is largely concerned with strengthening tribal governments and tribal organizations on Indian reservations by emphasizing tribal administration of federal Indian programs, services, functions, and activities, as well as associated funds." *Id.* at 18. *See also About Us – What is the Tribal Self-Governance Program*, INDIAN HEALTH SERV. https://www.ihs.gov/selfgovernance/aboutus/ [https://perma.cc/EN7W-RXTQ] (last visited Oct. 14, 2023). "The ISDEAA was enacted to ensure 'effective and meaningful participation by the Indian people in the planning, conduct, and administration' of Federal services and programs provided to the Tribes and their members." *Id.*

[22] *See* Strommer & Osborne, *supra* note 21, at 6. "At the time of European 'discovery' of the New World, many tribes possessed sophisticated forms of government, as well as expansive systems of trade among themselves and with the early colonists." *Id.* In forming relationships with colonists, American Indians asserted their desire to remain a distinct people. *Id.*

[23] *See* Worcester v. Georgia, 31 U.S. 515, 521 (1832) (holding sovereign rights of tribal governments exist, conditionally). *See also* Danielle A. Delaney, *The Master's Tools: Tribal Sovereignty and Tribal Self-Governance Contracting/Compacting*, 5 AM. INDIAN L. J. 308, 316 (2017). Tribes embodied a sovereignty lesser than one of Western nation-states. *Id.* "In practice, the continued existence of tribes, their governments, and their lands exists upon the sufferance of the United States Congress under the plenary power doctrine." *Id.* at 315. The United States Congress, has powers under the plenary power doctrine, can "to limit, modify or eliminate the powers of local self- government which the tribes otherwise possess." *Id.*; Strommer & Osborne, *supra* note 21, at 6. United States early federal policy surrounding Native American authority was influenced by

appropriating general funds for Native American health care in response to the lack of resources and health care disparities within native tribes.[24] Nevertheless, the Native American population faced a disproportionate risk of contracting severe illnesses or health conditions compared to the general population due to inadequate facilities, shortages of personnel, lack of access to health care, and various other inadequacies.[25]

In response to these challenges, Congress enacted the ISDEAA which gave Tribes significantly more control over providing health services to tribal members.[26] Fundamentally, Congress enacted legislative measures to ensure "effective and meaningful participation by the Indian people in the planning, conduct, and administration" of

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the clear tribal sentiment that they prefer to continue governing their own land, on their own terms. *Id.* Post-Revolutionary War era, treaties between the tribes and the United States government formally recognized the tribal government. *Id.*

[24] *See* Act of Apr. 4, 1910, 36 Stat. 269; Geoffrey D. Strommer et al., *Tribal Sovereign Authority and Self-Regulation of Health Care Services: The Legal Framework and the Swinomish Tribe's Dental Health Program*, 21 J. HEALTH CARE L. & POL'Y 115, 121 (2019). Prior to appropriations made in 1911 for Indian health care, Congress heard pleas from the former Commissioner of Indian Affairs to provide money for Indian American hospitals "in the name of humanity." *Id.* In the period preceding the allocation of these general appropriations, "Indian health continued to be funded through patchwork legislation and from miscellaneous funds, and the modest increase in resources that accompanied the transfer proved inadequate to the task of ensuring minimum standards of health among Indian people." *Id.* The federal government has since viewed their obligation to provide for Indian health care as a moral imperative and public health necessity, given that colonialism directly introduced devastating new diseases which had harmful impacts on American Indian health was a direct result of colonialism. *Id.* at 121.

[25] *See* Strommer et. al., *supra* note 24, at 124. "Still, the poor state of Indian health was appalling, and the House Committee on Interior and Insular Affairs noted that Indians and Alaska Natives 'suffer a health status far below that of the general population[.]'" *Id.*; Alex Dyste, *It's Hard Out Here for an American Indian: Implications of the Patient Protection and Affordable Care Act for the American Indian Population*, 32 MN J. L. & INEQ. 95, 101 (2014) (discussing many contributing factors to tribal health care disparities). The factors that contribute to Indian American health care disparities are not mutually exclusive; these elements often overlap. *Id.*

[26] *See* Donald Warne & Linda Bane Frizzell, *American Indian Health Policy: Historical Trends and Contemporary Issues*, AM. J. PUB. HEALTH 263 (2014). The Act authorizes tribes to assume management of Indian Health Service programs. *Id.* "[A]ny program, function, service, or activity of the IHS can be assumed by the tribe." *Id.* *See also* Indian Self-Determination and Education Assistance Act, 25 U.S.C. § 5301 (1975); Strommer et al. *supra* note 24 at 126. (describing how ISDEAA allows tribes to assume federal programs to provide health care to tribes); *Tribal Self-Governance Program*, Indian Health Serv., https://www.ihs.gov/selfgovernance/aboutus/, [https://perma.cc/4JM9-NX9E].

> Under the ISDEAA, Tribes and Tribal Organizations have the option to either (1) administer programs and services the IHS would otherwise provide (referred to as Title I Self-Determination Contracting) or (2) assume control over health care programs and services that the IHS would otherwise provide (referred to as Title V Self-Governance Compacting or the TSGP).

Id. The options provided to Tribes under the ISDEAA are not exclusive and can be combined based upon an individual tribe's needs and circumstances. *Id.*; Strommer & Osborne, *supra* note 21 at 18. "The ISDEAA is largely concerned with strengthening tribal governments and tribal organizations on Indian reservations by emphasizing tribal administration of federal Indian programs, services, functions, and activities, as well as associated funds." *Id.*

Federal services by allowing Tribes to assume control of federal programs via contractual arrangements with the federal government.[27] Congress also allowed Tribes to directly invoice outside insurers as a means to mitigate the inefficiencies and inaccuracies that were historically associated with the IHS billing process.[28] The Tribes can keep the third-party revenue so long as such revenue is used to provide additional health services, improvements to health care facilities, or other health care related services.[29] The

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[27] *See* Tribal *Self-Governance Program*, INDIAN HEALTH SERV., https://www.ihs.gov/selfgovernance/aboutus/ [https://perma.cc/4JM9-NX9E] (explaining methods which tribes may exercise autonomy in health care administration); *see also* 25 U.S.C. § 5301(a)(1975).

> The Congress, after careful review of the Federal Government's historical and special legal relationship with, and resulting responsibilities to, American Indian people, finds that—
> (1) the prolonged Federal domination of Indian service programs has served to retard rather than enhance the progress of Indian people and their communities by depriving Indians of the full opportunity to develop leadership skills crucial to the realization of self-government, and has denied to the Indian people an effective voice in the planning and implementation of programs for the benefit of Indians which are responsive to the true needs of Indian communities; and
> (2) the Indian people will never surrender their desire to control their relationships both among themselves and with non-Indian governments, organizations, and persons.

Id.; Tribal *Self-Governance Program*, INDIAN HEALTH SERV., https://www.ihs.gov/selfgovernance/aboutus/ [https://perma.cc/4JM9-NX9E]. "Today, self-governance compacting affords Tribes the most flexibility to tailor health care services to the needs of their communities." *Id.* Self-governance helps tribes gain more autonomy in the management and delivery of their health care programs. *Id.*; U.S. COMM'N ON C.R., *supra* note 8.

> The principle of self-determination entails the promotion of the government-to-government relationship among tribes and federal, state, and local governments, and "the minimization of the historically pervasive presence of the federal government and its trustee agents in the institutions of tribal governance, the provision of public services to Native Americans, and the selection, design and implementation of economic and community development plans and projects."

Id.

[28] *See* 25 U.S.C. § 1641(1994); 53 F.4th at 1239. Tribes were granted the ability to directly bill external insurers because the previous practice, wherein the IHS handled insurance billing, resulted in delayed and incomplete reimbursements to tribes. *Id.* This shift towards direct billing was implemented by Congress to safeguard against any loss of third-party revenue that tribes might experience due to the inefficiencies associated with the IHS's billing procedures. *Id.*

[29] *See* 53 F.4th at 1239; 25 U.S.C. § 1641(d)(2)(a)(1994).

> All amounts so reimbursed shall be used by the tribal health program for the purpose of making any improvements in facilities of the tribal health program that may be necessary to achieve or maintain compliance with the conditions and requirements applicable generally to such items and services under the program under such title and to provide additional health care services, improvements in health care facilities and tribal health programs, any health care-related purpose.

ISDEAA's authorization to divert third-party revenue back into the tribal health care programs is intended to supplement those underfunded health care programs by allowing Tribes greater access to the same funding resources from which the general population benefits.[30] This practice of tribal self-governance by contracting with the federal government has yielded markedly improved health outcomes.[31] Despite health advances, severe health disparities for Indigenous people who live in the United States continue to persist because the IHS is still chronically underfunded.[32] The third-party revenue is an essential component of the IHS and tribal health program budgets, yet the persistent funding shortfalls remain a formidable challenge to achieving health equity for indigenous communities.[33]

Id.

[30] *See* U.S. COMM'N ON C.R., *supra* note 8 at 65. The U.S. Commission on Human Rights has noted that vast health disparities exist between Native Americans and other population groups. *Id.* The Commission has acknowledged that current federal funding efforts have been inadequate to fulfill the government's promise to provide for the health and wellbeing of tribal citizens. *Id.* *See also* CRISTINA BOCCUTI ET AL., THE ROLE OF MEDICARE AND THE INDIAN HEALTH SERVICE FOR AMERICAN INDIANS AND ALASKA NATIVES: HEALTH, ACCESS AND COVERAGE 2 (Kaiser Fam. Found., 2014). "[B]ecause IHS is the payer of last resort, IHS providers must collect payment from third-party insurers when providing services to American Indian or Alaska Native patients with health insurance. These collections help reduce financial shortfalls between capacity and need." *Id.*

[31] *See* Steven L. Mangold, *Progress in Self-Determination: Navigating Funding for ISDA Contracts after Salazar v. Ramah Navajo Chapter*, 38 AM. INDIAN L. REV. 261, 270-71 (2018). Tribes have excelled in running their contracted federal programs and have seen improvements in the quality of the programs that are administered within the tribe. *Id.*

[32] *See* Artiga, *supra* note 15. IHS funds are not equally distributed across different tribal health care facilities and remain consistently insufficient to meet tribal health care needs. *Id.*; Donald Warne & Linda Bane Frizzell, *American Indian Health Policy: Historical Trends and Contemporary Issues*, 104 AM. J. PUB. HEALTH 263, 265 (2014). "[B]etween 1993 and 1998, IHS appropriations increased by 8%, while medical inflation increased by 20.6%." *Id.*; *Disparities*, INDIAN HEALTH SERV., https://www.ihs.gov/newsroom/factsheets/disparities/ [https://perma.cc/8TDF-52C6] [hereinafter *IHS Disparities*]. "American Indians and Alaska Natives born today have a life expectancy that is 5.5 years less than the U.S. all races." *Id.*

[33] *See Indian Health Service: Information on Third-Party Collections and Processes to Procure Supplies and Services*, U.S. GOV'T ACCOUNTABILITY OFF. (Mar. 10, 2022), https://www.gao.gov/products/gao-22-104742 [perma.cc/SF83-XFVH]. "The Indian Health Service's (IHS) third-party collections—that is, payments for patients' medical care received from public programs such as Medicaid and Medicare or from private insurers—increased from about $943 million in fiscal year 2015 to about $1.15 billion in fiscal year 2019 at its federal facilities." *Id.* "IHS relies on these funds to procure medical supplies and services needed for its operations." *Id.* *See also* Boccuti et al., *supra* note 30, at 2.

> In the aggregate, IHS facilities will collect an estimated $217 million in Medicare reimbursements for services they provide to Medicare beneficiaries in 2014. Though a relatively small part of their operating budgets, these collections are important sources of revenue for these providers, given the fiscal pressures inherent in their IHS funding.

Id. As a result of the third-party revenue funds, there is an ability to provide greater services and serve a larger share of patients. Artiga, *supra* note 15. The third-party revenue has helped increase program funding and now makes up a large percentage of both IHS and tribal health

Managing tribal health care programs demands extensive administrative efforts that can incur significant expenses.[34] As previously discussed, providing CSC through the ISDEAA's enactment to support the execution of tribal health services has been the solution to governmental funding deficiencies since 1987.[35] However, the ISDEAA may not inherently mandate the allocation of CSC for the administration of services funded by third-party revenue.[36] In a D.C. Circuit case, *Swinomish Indian Tribal Cmty. v. Becerra*, the Court found that the IHS need not pay CSC for health care services administered by third-party funds.[37] The Court determined that CSCs are only required under the ISDEAA to fund activities that "ensure compliance with the terms of the contract" between the tribe and the IHS.[38] The D.C. Circuit judges determined that the "contract" only contains the agreement that the tribe provide certain services to its community in exchange for a specific amount of money allocated to provide those services.[39] The Court further highlighted that the Act requires additional CSC funding, only to cover the cost of

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care budgets. *Id.*; Brief for Native American Tribes et al. as Amici Curiae Supporting Appellant at 30-31, San Carlos Apache Tribe v. Becerra, 53 F.4th 1236 (2022) (No. 21-15641), 2021 U.S. 9th Cir. Briefs LEXIS 8235.

[34] *See* Strommer & Obsorne, *supra* note 21, at 50. "If these administrative or overhead costs are not fully paid, tribes must often re-direct program funds to cover these necessary expenses, thus lowering the level of services provided (or at least funds spent) below what the Secretary would have otherwise provide." *Id.*

[35] *See* Strommer & Obsorne, *supra* note 21, at 50. "In 1987, responding to 'the overwhelming administrative problems caused by indirect cost shortfalls,' Congress amended the ISDEAA by adding a new section 106, which requires payment of full contract support cost (CSC) funding." *Id. But see* Mangold, *supra* note 31, at 264 (2018).

> However, Congress has often imposed a cap on the amount of funds a Secretary could allocate for ISDA contract support costs. The amount in this cap has been sufficient to cover any tribe's claim to its CSCs under an individual self-determination contract, but insufficient to cover the costs for all tribes' contracts collectively.

Id.

[36] *See generally* 53 F.4th at 1244 (evaluating whether additional CSC is required for administration of third-party revenue funded services); Swinomish Indian Tribal Cmty v. Becerra, 993 F.3d 917 (D.C. Cir. 2021) (discussing issue of whether CSC should be allocated for services administered using third-party revenue).

[37] *See* Swinomish Indian Tribal Cmty. v. Becerra, 993 F.3d 917, 922 (D.C. Cir. 2021).

[38] *Id.* at 920. "When the Act speaks of contract support costs, it does not mention money received from third parties, like insurance providers. Instead, the Act says reimbursements for contract support costs cover activities that 'ensure compliance with the terms of the contract' conducted by the tribe 'as a contractor.'" *Id.*

[39] *See id.*

> The scope of contract support costs is thus limited to those under *one* "contract" — the one between a "contractor" (the tribe) and the contracting agency (Indian Health Service). In *that* contract, a tribe promises to provide certain services to its community. In exchange, the government promises to provide the tribe with a certain amount of money — the secretarial amount — for those services.

Id.

complying with that contract.[40] The Court concluded that third-party insurance revenue is generated from other distinctly separate contracts, with outside insurers.[41]

IV. **Court's Reasoning**

In *San Carlos Apache Tribe v. Becerra*, the Ninth Circuit held that the IHS is required to pay CSC for the third-party revenue-funded portions of the Tribe's health care program.[42] The Court rejected the Defendant's argument that the request for additional CSC funds was precluded by the wording of The Contract between the Tribe and the Defendants, which specified a CSC amount that excluded the extra funds.[43] The Contract itself was not dispositive because the contractual language allowed for flexibility in the amount of available CSC appropriations, permitting adjustments to CSC amounts under certain circumstances.[44]

The Court then determined whether the ISDEAA which outlines the provisions for providing CSC associated with self-determination contracts, compelled the Defendant to provide additional funds for administration of the third-party revenue funded activities.[45] The language of the statute provides that any activities the Tribe is required

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[40] *See id.* "[T]he Act requires additional government funding to cover a tribe's cost of complying with the terms of *that* contract". *Id.*

[41] Swinomish Indian Tribal Cmty v. Becerra, 993 F.3d 917, 920 (D.C. Cir. 2021). "[W]hen the Act speaks of contract support costs, it does not mention money received from third parties, like insurance providers. Instead, the Act says reimbursements for contract support costs cover activities that 'ensure compliance with the terms of *the* contract' conducted by the tribe 'as a contractor.'" *Id.* The Court notes that the ISDEAA speaks of contract support costs without mentioning the additional insurance money and speaks about insurance money without mentioning contract support costs. *Id.* This supports the Court's opinion that IHS does not have to provide CSC for the outside insurance funded programs. *Id.* Swinomish Indian Tribal Cmty. v. Becerra, 993 F.3d 917, 920 (D.C. Cir. 2021).

[42] *See* 53 F.4th at 1244. The Court reversed the district court's dismissal of the San Carlos Apache Tribe's claim against the federal government alleging that they were entitled to CSC for the third-party revenue funded portions of the Tribe's health care program. *Id.*

[43] *See id.* at 1240. The Contract between the Tribe and the Defendants had allocated $135,203 of direct CSC**,** and $423,731 in indirect CSC. *Id.* However, The Contract did not include any CSC for administering the third-party revenue funded costs. *Id.*

[44] *See id.*

> This argument ignores the flexibility written into the Contract, which allows those amounts to be adjusted in the event of changes to "program bases, Tribal CSC need, [or] available CSC appropriations." A determination that the Tribe is owed CSC by statute for third-party-revenue-funded portions of its health-care program would fall under this umbrella. Additionally, because the Contract incorporates the provisions of the ISDA, if that statute requires payment of the disputed funds, it controls.

Id.

[45] *See id.* Even if the court had earlier found that The Contract did not allow for the additional CSC, the federal law controls. *Id.* Thus, the court should analyze the statutory language to interpret whether the additional CSC should be provided to the tribes. *Id.*; *see also* 25 U.S.C. § 5325(a) (1975).

to perform to comply with the terms of The Contract are eligible for CSC.[46] Explicitly departing from the decision of the D.C. Circuit, the Court held that the language of 25 U.S.C. § 5325(a) does not limit the CSC solely to activities described in a particular contract, instead it authorizes payment of CSC for "*all* activities – regardless of funding source – that are required for compliance with The Contract."[47] Although the D.C. Circuit determined that the third-party revenue-funded programs were not a direct part of "the Federal Program," outlined within the ISDEAA, the Ninth Circuit pointed out that the administrative costs were, at the very least, incurred in connection with "the Federal Program."[48]

Because The Contract incorporates the ISDEAA, the Tribe would not be in compliance with The Contract if they did not spend the third-party revenue on its health care programs.[49] Therefore, under The Contract's language, the third-party revenue-funded health care programs are eligible for CSC, because CSC is allowed for any activities

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[46] *See* 53 F.4th at 1241. CSC is required to be paid "for the reasonable costs for activities which must be carried on by a tribal organization as a contractor to ensure compliance with the terms of the contract." *Id.*

[47] *See* 25 U.S.C. § 5325(a) (1975). This statute allocates CSC for all administrative expenses "incurred by the tribal contractor in connection with the operation of the Federal program." *Id.*; *see also* 53 F.4th at 1241. The Court disagreed with the D.C. Circuit's contention that "the Federal Program" did not cover the third-party funded activities. *Id.*

[48] *See* 53 F.4th at 1238. The Federal Program is the mechanism which the federal funds traditionally allocated to IHS are distributed directly to tribes to allow tribes to establish and manage their own health care programs. *Id.*

> It is entirely possible to read "the Federal program" as encompassing those portions of the Tribe's healthcare program funded by third-party revenue. This is the program that the Tribe operates under Federal directive, via Federal contract, in the Federal government's stead; it is therefore possible that all activities required by the Contract, regardless of funding source, comprise one "Federal program"…But even if "the Federal program" does not refer to those third-party-revenue-funded healthcare activities… statutory language does not limit CSC to "the Federal program"; it limits CSC to costs "incurred by the tribal contractor in connection with the operation of the Federal program." That language contemplates that there are at least some costs *outside* of the Federal program itself that require CSC.

Id. at 1242-1243. Thus, even if the costs were not considered part of the "Federal program" the costs are nevertheless recoverable by the Tribe because they were incurred in connection with the "Federal program." *Id.* at 1243. The Court also mentioned that the third-party revenue is an additional benefit which allows the Tribe to expand program services, thereby expanding the "Federal Program" in a sense. *Id.*

[49] *See* 53 F.4th at 1242.

> [T]he contracts and the statute both require tribes to spend their third-party revenue on healthcare services. Thus, the "cost of complying" with a contract between IHS and a tribe *includes* the cost of conducting those additional activities, because but for conducting those activities, the Tribe would not be in compliance with the Contract.

Id.

performed in connection with The Contract.[50] There are no other provisions within the statute that unambiguously exclude the third-party-funded portions of the Tribe's health care program from CSC reimbursement.[51]

V. **Analysis**

The Ninth Circuit Court decision to deem programs funded by third-party payors eligible for CSC was the correct choice, as these programs constitute an essential component of the entire tribal health care system.[52] The third-party revenue from outside insurers must be used on health care services and, therefore, is an integral part of tribal health care budgets.[53] Services funded by third-party revenue should provide CSC, similar to services funded through Congressional appropriations because both serve the same purpose: supporting tribal health care administration.[54] Moreover, the ISDEAA's language and legislative history does not indicate that services funded by outside payors should not be entitled to CSC funding allocations.[55]

The outcome of *San Carlos Apache Tribe v. Becerra* fulfills the statute's legislative intent that the ISDEAA provide tribes with control over their health care systems, while also ensuring tribes receive enough funding to address the health care needs of their population.[56] Despite appropriations made towards tribal health care through the IHS,

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[50] *See* 53 F.4th at 1242; *see also* 25 U.S.C. § 5325(a); Indian Self-Determination Amendments of 1987, Pub. L. No. 100–472, § 205, 102 Stat. 2285, 2292–94 (1988) (explaining requirements for receiving CSC).

[51] *See* 53 F.4th at 1243; *see also* 25 U.S.C. § 5325(a); Indian Self-Determination Amendments of 1987, Pub. L. No. 100–472, § 205, 102 Stat. 2285, 2292–94 (1988).

[52] *See* Artiga, *supra* note 15. Revenues from third-party payers constitute a significant portion of IHS funding. *Id.*; *see also* Mangold, *supra* note 31, at 271-2721. "Without funding for these costs, 'tribal resources' which are needed for community and economic development must instead be diverted to pay for the indirect costs associated with programs that are a federal responsibility.'" *Id.*

[53] *See* 53 F.4th at 1236, 1239; *see also* Indian Health Amendments of 1992, Pub. L. No. 102-573, tit. II, § 209, 106 Stat. 4526, 4551 (1992); Indian Health Care Improvement Act, Pub. L. No. 94-437 (1976) (allowing tribal health programs to bill third party payers); BOCCUTI ET AL., *supra* note 30, at 2. Collection from third-party insurers provides significant revenue sources for tribal health care systems. *Id.*

[54] *See* 53 F.4th at 1240.

[55] *See id.* at 1244. There is no evidence that Congress intended to exclude CSC for third party revenue funded programs. *Id.; see also* Indian Health Amendments of 1992§ 209; Indian Health Care Improvement Act.

[56] *See* 53 F.4th at 1236; Indian Self-Determination and Education Assistance Act, 25 U.S.C. § 5301 (1975); *see also* Cerasana, *supra* note 9, at 424.

> The primary goal of the ISDEAA was to provide tribes with more control and decision-making authority over the operation of their health programs, as well as to give tribes the ability to design programs to meet what they perceive to be the most urgent health issues in their communities. In addition, Congress declared that "a major national goal . . . is to provide the quantity and quality of educational services and opportunities which will permit Indian children to compete and excel in the life areas of their choice, and to achieve the measure of self-determination essential to their social and economic well-being."

wide disparities in the health outcomes of indigenous people still exist.[57] The revenue from third-party payors constitutes a large portion of IHS's funding and plays a crucial role in enhancing health care quality and accessibility.[58] The United States Government has a responsibility to Native American tribes to not only provide proper health care services but also protect tribal self-determination.[59] Thus, the Federal government must address the chronic underfunding of tribal health care while concurrently ensuring that tribes possess the autonomy to oversee these programs.[60]

The objective of allocating CSC appropriations to tribes is to prevent any diminution in program resources that may occur due to high administrative costs and to enable tribes to independently manage programs, thereby upholding tribal self-determination.[61] The ISDEAA includes CSC provisions to prevent tribes from redirecting their general health program funds to cover administration and overhead costs rather than health care services.[62] The argument that IHS should not provide additional administrative costs for third-party revenue funded activities contradicts the legislative intent of creating CSC provisions in the first place, as failure to provide the additional

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Id.; *see also* Strommer & Osborne, *supra* note 21, at 137.

[57] *See* Artiga, *supra* note 15. There are disparities in fund distribution among facilities, and the funds reaching tribal communities are still inadequate to meet health care demands. *Id.* Consequently, the accessibility of services through IHS greatly differs depending on the location, and American Indians and Alaska Natives (hereinafter *AIANs*) relying solely on IHS often face challenges accessing necessary care. *Id.*; *see also* U.S. COMM'N ON C.R., *supra* note 8. "Federal programs designed to support the social and economic well-being of Native Americans remain chronically underfunded and sometimes inefficiently structured, which leaves many basic needs in the Native American community unmet and contributes to the inequities observed in Native American communities." *Id.*; *see also* IHS Disparities *supra* note 32. American Indians have a life expectancy that is over five years lower than the life expectancy of all other race populations. *Id.*

[58] *See* Artiga, *supra* note 15. "A total of $1.3 billion will be collected from third-party payers in [2017], with the largest share—$810 million—coming from Medicaid." *Id.*; *see also* BOCCUTI ET AL., *supra* note 30, at 2. Third party revenue funded health services are a necessary component in helping to overcome the IHS's prevalent funding shortfalls. *Id.*

[59] *See* U.S. COMM'N ON C.R., *supra* note 8, at 8, 12 (explaining trust relationship between federal government and Native Americans); Strommer & Osborne, *supra* note 21, at 8. Even though the federal government is not specifically involved in tribal health programs, the federal interest in development of robust tribal health programs is strong. *Id.*

[60] *See* U.S. COMM'N ON C.R., *supra* note 8 at 1. "Since our nation's founding, the United States and Native Americans have committed to and sustained this special trust relationship, which obligates the federal government to promote tribal self-government, support the general welfare of Native American tribes and villages, and to protect their lands and resources." *Id.* "Over the years, Native American health care has been chronically underfunded. In 2016, IHS health care expenditures per person were only $2,834, compared to $9,990 per person for federal health care spending nationwide." *Id.* at 66-67. *See also* IHS Disparities *supra* note 32. The American Indian people have a long history of experiencing a lower status of health outcomes in comparison with other American demographics. *Id.*

[61] *See* Strommer & Osborne, *supra* note 21, at 49, 50 (discussing importance of CSC in administration of health care services). *See also* UNITED STATES COMM'N ON C.R., *supra* note 8, at 71. "According to HHS, 'now that contract support costs are fully funded, tribes are showing more interest in contracting and compacting' with IHS to operate their own health care systems—an outcome consistent with the goal of tribal self-determination." *Id.*

[62] *See* Strommer & Osborne, *supra* note 21, at 50-51. Full funding to cover CSCs is essential for tribal organizations to maintain responsible management and meet their contractual commitments under the ISDEAA. *Id.*

CSC may lead to tribes depleting their resources or rejecting contract programs, ultimately hindering their path to self-determination.[63] To use third-party revenue to fund additional health care programs creates additional expenses such as: insurance management costs, property and personnel management systems, and facilities overhead.[64] Inevitably, tribes will be forced to use part of their overall health care funding to pay for administrative third-party services, thus depleting tribal health care resources.[65] The unfortunate reality of current tribal health care funding should be at the heart of deliberations concerning the allocation of additional CSC.[66] Allowing CSC to compensate third-party health care programs achieves the legislative goals of ISDEAA to ensure a meaningful improvement in Native American health, while also supporting tribal self-determination.[67]

VI. **Conclusion**

In *San Carlos Apache Tribe v. Becerra*, the Ninth Circuit considered whether the health care programs funded by third-party revenue qualified as actions performed in compliance with ISDEAA. Moreover, the court considered whether IHS held an obligation to cover the associated CSC for administering these health care services under

[63] *See* Mangold, *supra* note 31, at 275. The 1999 General Accounting Office Report found that shortfalls in CSC funding resulted in the depletion of tribal resources to cover the additional administrative costs. *Id.* Some tribes were forced to decline the opportunity to contract programs, and this hindered their progress towards achieving self-determination. *Id.* "Indeed, the effects appear to mirror the deficiencies in the former, inadequate federal policy toward Indian tribes that Congress described as a reason to initiate the ISDA scheme." *Id.* at 275-276. *See* UNITED STATES COMM'N ON C.R., *supra* note 8, at 71. "According to HHS, 'now that contract support costs are fully funded, tribes are showing more interest in contracting and compacting' with IHS to operate their own health care systems—an outcome consistent with the goal of tribal self-determination." *Id.*

[64] *See* Brief for the Native American Tribes, Tribal Organizations, Indian Health Boards and The National Congress of American Indians as Amicus Curiae Supporting Appellant at 31-32, San Carlos Apache Tribe v. Becerra, 53 F.4th 1236 (2022) (No. 21-15641) (describing costs to tribes in September 27, 2021 filing); Strommer & Osborne, *supra* note **Error! Bookmark not defined.**, at 50. CSCs help cover the essential and non-negotiable costs to run the health care programs. *Id.* Adequate CSC is necessary to avoid adverse consequences that may arise if tribes are unable to fund administrative costs. *Id.*

[65] *See* Strommer & Osborne, *supra* note **Error! Bookmark not defined.**, at 51. If tribes were to use direct program funds to address the CSC deficits, this would diminish the resources allocated to already underfunded services. *Id.* The use of direct funds to pay for administrative costs due to a lack of CSC is considered by some to be "in effect imposing a financial penalty on tribes for exercising their right to self-determination." *Id.*; Brief for the Native American Tribes, Tribal Organizations, Indian Health Boards and The National Congress Of American Indians as Amicus Curiae Supporting Appellant, *San Carlos Apache Tribe v. Becerra*, 53 F.4th 1236 (2022) (No. 21-15641) (quantifying CSC withholding impact on tribes health care budgets in September 27, 2021 filing). "To prevent the 'diminution in program resources' or 'diver[sion] of program funds' that Congress sought to avoid when programs are transferred from IHS to tribal control, tribes must *also* be able to recover CSC on *all* of the funding that supports the federal program, including third-party expenditures." *Id.* at 39; *see also* Mangold, *supra* note 31, at 264-265. Confronted with budget shortfalls due to inadequate CSC funding, agencies have sought to distribute authorized funds through pro rate distribution, resulting in tribes receiving incomplete reimbursement of administrative and indirect expenditures. *Id.*

[66] *See* U.S. COMM'N ON C.R., *supra* note 8, at 1-4 (discussing government responsibility to support well-being of Native American communities).

[67] *See* Strommer & Osborne, *supra* note 21, at 264-265.

the ISDEAA. The Court determined that utilizing these funds for program administration constituted a fundamental component of ISDEAA compliance, thus mandating the IHS to reimburse the Tribe for the associated CSC. In doing so, the Court not only upheld the law but also emphasized the enduring importance of tribal sovereignty and the vital nexus between health care and self-determination.