Nos. 23-250, 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 NAFOA, FOUNDED AS NATIVE AMERICAN FINANCE OFFICERS ASSOCIATION, AS *AMICUS CURIAE* IN SUPPORT OF RESPONDENTS

Hyland Hunt
Ruthanne M. Deutsch
DEUTSCH HUNT PLLC
300 New Jersey Ave. NW
Suite 900
Washington, DC 20001
(202) 868-6915
hhunt@deutschhunt.com

C. Bryant Rogers
Counsel of Record
April Wilkinson
VANAMBERG, ROGERS, YEPA, ABEITA, GOMEZ & WILKINSON, LLP
347 East Palace Ave.
Santa Fe, NM 87501
(505) 988-8979
cbrogers@nmlawgroup.com

TABLE OF CONTENTS

TABLE OF AUTHORITIES

CASES

STATUTES

REGULATIONS

OTHER AUTHORITIES

INTEREST OF *AMICUS CURIAE*[1]

NAFOA was founded over 40 years ago as the Native American Finance Officers Association to highlight the role of tribal finance in fostering economic opportunities. NAFOA advocates for sound economic and fiscal policy to support Indian Country, develops innovative training programs in financial management, and convenes tribal leadership, experienced professionals, and economic partners to assess trends in tribal economic development and share resources with tribal financial professionals. As part of its mission to support and educate tribal financial professionals, NAFOA publishes the *Financial Reporting and Information Guide for Tribal Governments and Their Enterprises*, also known as the Orange Book, which covers all aspects of financial reporting in a tribal setting, including business activities, fiduciary activities, and federal tax and information reporting.

NAFOA and its members have deep experience administering the financial aspects of self-determination and self-governance contracts under the Indian Self-Determination and Education Assistance Act, 25 U.S.C. §§ 5301 *et seq*. (ISDA). NAFOA represents the tribal financial professionals who negotiate, report, and verify contract support costs, including indirect costs, on behalf of Tribes that operate their own health care programs under ISDA.

---

[1] No counsel for any party authored this brief in whole or in part. *Amicus curiae*, its members, its counsel, Bristol Bay Area Health Corporation, Sage Memorial Hospital, Salt River Pima-Maricopa Indian Community, and Winslow Indian Health Care Center made monetary contributions intended to fund the brief's preparation or submission.

NAFOA writes to share its expertise with the Court regarding what indirect contract support costs are, how they are tightly controlled, and their crucial impact on Tribes' ability to carry out transferred federal health care programs.

NAFOA submits that indirect support costs incurred to fund health care services under ISDA contracts with program income—*i.e.*, payments collected from Medicare, Medicaid, and other health insurance sources, as ISDA contracts require—are paradigmatic contract support costs that must be reimbursed under the governing statutory framework.

INTRODUCTION AND SUMMARY OF ARGUMENT

Congress had a single and simple goal in enacting the contract support cost mandate for ISDA contracts: parity. Funds made available to Tribes per their ISDA contracts—including the program income they generate—should be usable by them to provide the same amount of health care as when the contracted programs were operated by the Indian Health Service (IHS).

Parity is secured through concrete financial management controls that seek to ensure the federal government fully pays the contract support costs it owes, but not more. Day in and day out, tribal financial management professionals apply a set of carefully reticulated rules—including the indirect cost system and all of its accompanying controls—to identify and verify which costs are reasonable, allowable, and properly allocated to federal contracts,

including ISDA contracts. These background rules—which apply to all federal contracts, not just to ISDA contracts, and which the government's brief largely ignores—dispose of the unfounded policy concern that ISDA dollars might be used to subsidize non-ISDA programs. For example, tribal contractors can't build a new hospital and claim contract support costs for its construction costs. Indirect cost rules bar that.

Indirect cost rules likewise dictate that program income must be spent on program expenses, and federal program audits ensure that program income is spent in accordance with federal program requirements. ISDA makes that doubly clear—while also making plain that program income should increase a tribal contractor's resources to deliver medical care, not decrease them—just like program income does for IHS. Unless indirect costs related to program income expenditures are reimbursed as Congress intended, Tribes will be put in an inferior position to IHS, not on an equal footing.

Worse still, given the mechanics of the indirect cost system, the government's statutory reading would sometimes *decrease* the contract support costs IHS would pay for a Tribe to administer the same amount of federal health care dollars—simply because tribal contractors generate program income, as they are required to do by their ISDA contracts. And in all cases, the government's position would force IHS-ISDA contractors to either decrease the amount of program income they can spend for direct patient care (because they had to divert funds to pay for overhead costs the federal government refuses to cover), or to leave those overhead costs unpaid, causing a cascade of adverse financial management and compliance

deficiencies respecting those funds. ISDA bars the government from putting tribal contractors to this Hobson's choice.

Congress calibrated the right outcome here. Section 5326 was enacted to ensure that the government does not pay too much, *i.e.*, that IHS does not subsidize contract support costs for other federal and state programs. The government's theory, instead, would pay too little, taking IHS off the hook for contract support costs to administer the same health care program that IHS would have operated, including program-income-funded health care. Only the Tribes' position is just right—the Goldilocks one. And only the Tribes' position enables tribal contractors to deliver much-needed health care as IHS would, without being forced to divert crucial resources from delivering health care for patients to administrative overhead.

ARGUMENT

I. ISDA's Contract Support Cost Mandate Is Constrained By Settled Federal Contracting Principles And Rigorous Financial Controls.

Under ISDA, the federal government must "'enter into a self-determination contract'" with any requesting Tribe, under which the Tribe "'plan[s], conduct[s], and administer[s]' health, education, economic, and social programs" that the relevant federal agency "otherwise would have administered." *Salazar v. Ramah Navajo Chapter*, 567 U.S. 182, 185

(2012) (quoting 25 U.S.C. § 5321(a)(1)).[2] Soon after the first ISDA contracts were in place, however, it "became apparent" that providing contracting Tribes with only the "secretarial amount"—the "funds … the Secretary 'would have otherwise provided for his direct operation of the programs'"—"failed to account for the full cost to Tribes of providing services." *Id.*

This shortfall occurs in part because contracting Tribes incur certain direct and indirect contract support costs that the federally operated program is not required to pay or which are paid from other federal sources (not funds appropriated for IHS programs).[3] Indirect costs—the main component of contract support costs at issue here—are needed to fund functions necessary to administer the contract and carry out the transferred program, including auditing or financial management activities that—if applicable to the federal agency at all—are covered by separately funded parts of the federal bureaucracy (*e.g.*, legal services, human resources management, building maintenance, and the like). *See Cherokee Nation*, 543 US at 635; Indian Health Manual § 6-3.2E(2) (examples of common indirect costs). Because

---

[2] In 2016, ISDA's provisions, originally codified at 25 U.S.C. §§ 450 *et seq*., were reclassified at 25 U.S.C. §§ 5301 *et seq*. This brief cites to ISDA's current code locations.

[3] Other components of contract support costs are start-up costs and direct contract support, *e.g.*, worker's compensation and unemployment costs and program-specific training for ISDA contract employees that are not properly categorized as indirect costs. *See Cherokee Nation of Oklahoma v. Leavitt,* 543 U.S. 631, 634 (2005); Indian Health Manual § 6-3.2. Although *amicus* agrees with Northern Arapaho Tribe's position that direct contract support costs are recoverable, this brief only addresses the duty to pay indirect costs.

of "concern with Government's past failure to adequately reimburse Tribes' indirect administrative costs, Congress amended ISDA to require" the Secretary to "pay the 'full amount' of 'contract support costs' related to each self-determination contract." *Salazar*, 567 U.S. at 186 (citation omitted; quoting 25 U.S.C. § 5325(a)(2), (g)).[4]

The indirect-cost component of contract support costs covers costs that "benefit[] more than one contract objective, or ... [that] are not readily assignable" to a specific contract. 25 U.S.C § 5304(f). This definition is not unique to ISDA; it is used throughout federal contracting. *See, e.g.*, 2 C.F.R. § 200.1 (same definition within Office of Management and Budget (OMB) Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards); *Rumsfeld v. United Techs. Corp.*, 315 F.3d 1361, 1363-64 (Fed. Cir. 2003) (indirect cost accounting in defense contracts).

In shorthand, indirect costs are overhead costs. ISDA specifically requires IHS to pay "any overhead expense incurred by the tribal contractor in connection with the operation of the federal program, function, service or activity pursuant to the contract." 25 U.S.C. § 5325(3)(A)(ii).

Although the overhead expenses category is broad, the obligation to pay is far from open-ended. On

---

[4] ISDA authorizes two different kinds of contracts, self-determination contracts under Title I, 25 U.S.C. § 5321, and compacts, or self-governance contracts, under Title V, *id*. § 5381. The cases before the Court relate to self-determination contracts, although the same indirect cost rules apply to both contract types (as well as to ISDA grants). *See id*. § 5388(c).

the contrary, a well-developed system governing the payment of indirect costs—within ISDA and across the federal contracting enterprise—ensures that indirect costs are carefully constrained on the front end, and audited and verified on the back end.

Under this system, any program income that is earned from billing Medicare, Medicaid, or private insurance must be expended to support the federal health care program operated by the tribal contractor under its ISDA contract in IHS's stead. And to the extent that tribal contractors have marginally greater spending flexibility than IHS—*i.e.*, to construct facilities—such construction expenses are excluded from indirect cost recovery.

This carefully calibrated system undercuts the government's speculative concern about IHS potentially being required to subsidize all manner of expenditures beyond the remit of the federal Indian health program.

Given how the indirect cost system operates, the government's approach would not operate as a needed bulwark against an unconstrained expansion of indirect cost recovery, as the government supposes. The controls are already in place. Instead, the government's atextual stance would go too far in the other direction. In some instances, the government's position would actually *reduce* the amount of indirect support costs recoverable for the same amount of direct federal funding, based solely on a tribal contractor's success at generating program income—income generation that is mandated by the very ISDA contracts at issue. And it would always put Tribes to the cruel choice of either spending less program income on patient care to cover overhead for those

expenditures, or leaving critical overhead functions unfunded (or else diverting general revenue to cover them). Forcing Tribes to choose between these adverse outcomes runs directly counter to what Congress intended.

A. An Extensive Network of Rules Constrains and Guarantees the Validity of Tribes' Indirect Costs.

1. How indirect costs are calculated.

Although different payment mechanisms can be negotiated, by far the most common way that indirect costs are calculated—for ISDA contracts and others—is by negotiation of an indirect cost rate. *See Cherokee Nation,* 543 U.S. at 634; 2 C.F.R. Part 200, Appx. VII § A.3. The indirect cost rate is then multiplied by an agreed direct cost funding base for each ISDA contract to generate the amount of overhead costs the relevant federal agency is responsible for paying under that contract.[5]

a. Negotiating the indirect cost rate. The indirect cost rate is negotiated by first establishing a

---

[5] This brief sets out the broad outlines of how the indirect cost system works. Further detail on the different kinds of rates that may be used and the mechanics of how the rates are calculated or adjusted based on an ISDA contractor's actual audited cost experience can be found in detailed templates published by the Interior Business Center, *Proposal Templates for Indian Tribal Governments*, http://tinyurl.com/ydvpjs3u ("Proposal Templates"), and in OMB guidance, 2 C.F.R. Part 200, Appx. VII. None of the potential variation in calculation mechanics is material to the question presented.

numerator consisting of a "pool" or compilation of costs incurred to administer a Tribe's ISDA and non-ISDA contracts, grants, and other funded activities (the indirect cost pool). 2 C.F.R. Part 200, Appx. VII § B.6 (defining the "indirect cost pool" as "the accumulated costs that jointly benefit two or more programs or other cost objectives"). Those costs must be verified by the government's negotiators to be reasonable, allowable and allocable costs under the applicable OMB standards. *See* 2 C.F.R §§ 200.400-200.405. The indirect cost pool effectively represents all of an ISDA contractor's overhead costs across all of the programs it administers.

Next, an agreed direct cost funding base is established. Most often, this funding base includes all direct costs for all of the programs an ISDA contractor operates—*i.e.*, all allowable expenditures incurred under their ISDA and non-ISDA contract and grant awards and other funded programs—minus certain pass-throughs and exclusions that cannot reasonably be assumed to contribute to overhead costs. *See* 2 C.F.R. Part 200, Appx. VII § B.1 (definition of "base").[6]

To address pass-throughs and exclusions, the all-expenditure direct cost base must be adjusted downward to subtract "extraordinary or distorting expenditures." *Id.* Common exclusions include:

---

[6] The direct costs that are included in the base may vary by negotiation. Some Tribes use a direct cost base consisting solely of allowable expenditures for program salaries, or salaries and fringe benefits, in which case there are no adjustments to the base for pass-throughs or exclusions because the base is limited (by definition) to salaries. *See id.*

- expenditures for services acquired from subcontractors involving over $25,000 for a single procurement;
- expenditures made to acquire equipment above certain expenditure thresholds; and
- expenditures to pay contractors or subcontractors for facility construction (because they fall into exclusions for capital expenditures or subcontracts exceeding $25,000).

See 2 C.F.R. Part 200, Appx. VII § C.3; Proposal Templates, IDC Rate Template (direct cost base), Ex. C at n.1. Pass-throughs typically involve payments made by the contractor to individuals with "minimal administrative effort," like "scholarships, assistance payments, and payments to program participants." Proposal Templates, IDC Rate Template (direct cost base), Ex. C at n.2.

Once the numerator (the agreed indirect cost pool) and the denominator (the agreed direct cost base) are established, the indirect cost rate is generated by simple division. That negotiated rate "must be accepted by all federal awarding agencies." 2 C.F.R. § 200.414(c)(1).

b. Applying the indirect cost rate. Once the rate is established, a portion of the indirect cost pool is allocated to each program included in the direct cost base in proportion to its share of the direct cost expenditures in the base. *See* 2 C.F.R. Part 200, Appx. VII §§ A.3, B.1.

So, if a tribal contractor has $375,000 in indirect costs and operates a $1,000,000 health care program under an IHS-ISDA contract and a $500,000 criminal

justice program under a state contract, the calculation is as follows:

$375,000/$1,500,000 =	25% indirect cost rate
.25 * $1,000,000 =	$250,000 allocated to IHS-ISDA contract
.25 * $500,000 =	$125,000 allocated to state contract

The fact that $125,000 is allocated to the state-funded criminal justice program in this hypothetical does not mean that the $125,000 is reimbursed by the state program or other funders. The vast majority of non-ISDA contracts do not provide additional funding for indirect costs. For those contracts, the indirect cost rate serves to establish how much of the contract award can be used to pay for overhead (or, if that is not permitted, how much must be paid from other sources or not paid at all). But ISDA contracts are different, by Congress's express design. ISDA requires IHS to add indirect cost funding to the ISDA contract award so that tribal contractors can pay for the costs of administering those contracts without diluting the funding needed to pay for the governmental health care services the Tribes have contracted to provide.

When there is no add-on reimbursement for indirect costs (as is near-universal outside of ISDA), the direct costs of the programs operated under those contracts (the hypothetical $500,000 non-ISDA expenditures) nonetheless must still be included in the direct cost base. *See* Interior Business Center,

Indian Tribal Governments Frequently Asked Questions, http://tinyurl.com/2v2y78h7.

The hypothetical $250,000 allocated to the IHS-ISDA contract would be reimbursed by IHS. The more health care services a tribal contractor delivers through the program operated under its IHS-ISDA contract (whether paid with IHS-awarded ISDA funds or with program income generated and used to fund the same ISDA program), the larger the proportion of IHS-ISDA program expenditures within the direct cost base, and thus the greater the share of overhead that would be allocated to the IHS-ISDA program, all else being equal.

But that does not mean that Tribes can shoehorn any health care-related expenditure into their direct cost base. The same pass-throughs and exclusions that apply to the overall direct cost base also reduce the IHS-ISDA share of that base. These exclusions undercut the government's policy concern that if Respondents prevail, they could expand their health care programs beyond what IHS could have undertaken directly, leveraging the government's contract-support-cost dime. *See* Gov. Br. 28-31. The government focuses on facility construction, but construction expenditures are excluded from the direct cost base. So are large purchases exceeding exclusion thresholds, which will often cover new equipment, like new MRI machines or ambulances. In short, no matter the funding source, a tribal contractor generally cannot generate reimbursable indirect costs by expenditures to build or equip a hospital. The government's new-hospital hypothetical thus ignores the guardrails governing the indirect cost system.

2. How indirect costs are verified.

ISDA requires that a Tribe's estimated indirect costs be paid by the federal government at the beginning of each ISDA contract. 25 U.S.C. § 5325(a)(2). But the system does not rest on estimates alone—all paid costs must later be audited to verify that the expenditures were "reasonable," "allowable," and properly allocated to the ISDA contracts involved. *Id*. § 5325(a)(3)(A). As with other aspects of the indirect cost system, an extensive body of regulations and financial management standards governs whether an expenditure was reasonable, allowable, and allocable. *See* 2 C.F.R. §§ 200.403-200.405.

After the close of an ISDA contract period, there is a "reconciliation" process (*see* Indian Health Manual §§ 6-3.1G(26), 6-3.2E(1)(b)(vi)), and later a formal audit-based truing-up process that ascertains the actual direct and indirect costs lawfully incurred for that period. This process is based upon, but is separate from, the regular single agency audit requirements ISDA contractors must comply with. 25 U.S.C. § 5305(f) (self-determination contracts); *id.* § 5386(c) (self-governance contracts).

The post-contract indirect cost auditing process also determines whether any increase or decrease in the negotiated rate is warranted for the next contract period based on the contractor's actual cost experience. Taken as a whole, the indirect cost system's *ex ante* exclusions and *ex post* verification systems work together to verify that the federal government fully covers the cost of overhead expenses that are "reasonable," "allowable," and incurred "in

connection with the operation of the Federal program," but does not provide more than needed to cover those costs. At the same time, the system safeguards federal resources from expenditures that do not meet those criteria.[7]

B. Any Expenditures of Program Income Are Also Tightly Constrained.

As the government acknowledges, Br. 38, like IHS, tribal contractors are required by their ISDA contracts to set up third-party billing systems to collect payments from Medicare, Medicaid, and private insurance for the federal health care services they provide. They are also restricted from engaging in this same kind of direct billing outside of their ISDA contract. Only "tribal health programs" operating a "health program … funded, in whole or in part" through an ISDA contract are authorized to directly bill Medicare and Medicaid for reimbursement under 25 U.S.C. § 1641. *Id.* § 1603(25) (defining "tribal health program"); *id.* § 1641(d)(2) (limiting direct reimbursements to "tribal health programs"). And, just as IHS is required to spend any such Medicare or Medicaid payments on a Tribe's health care when it directly operates health care programs for a Tribe, *id.* § 1641(c)(1)(B), tribal contractors must likewise spend collected Medicare or Medicaid funds on the federal health care program

[7] There is some variation in how often the true-up occurs (between one and three years) and in the type of indirect cost rate used (*e.g.*, a fixed rate, special rate, or lump sum amount). *See generally* n.5, *supra*; Proposal Templates, *supra*.

they operate in IHS's stead pursuant to their ISDA contracts.

This limit derives from both general federal contracting principles and ISDA. General contracting regulations specify that any payments from third-party payors constitute "program income" because such payments are "directly generated by a [federally] supported activity or earned as a result of the Federal award," including "fees for services performed." 2 C.F.R. § 200.201. Unless a statute or contract specifies otherwise, program income must be used to defray program costs—*i.e.*, spent on the program and used to reduce the amount of the federal award *Id.* § 200.307(e)(1). This is called the "deduction" model. But, when statutes or regulations *do* otherwise specify, as here, the "addition" model applies, whereby program income "may be added to the Federal award" and "must be used for the purposes and under the conditions of the Federal award." *Id.* § 200.307(e)(2).

ISDA adopts the addition model: program income must be added—it "shall not be a basis for reducing the amount of funds otherwise obligated to the contract." 25 U.S.C. § 5325(m). And it must be used to carry out authorized programs, services, functions, and activities under the tribal health program's ISDA contract.[8] Specifically, the "program

---

[8] A tribal contractor's authorized health care activities under its ISDA contract may include any activities which IHS is authorized to carry out, provided the activities are identified in the contractor's scope of work as set out in an annual funding agreement executed pursuant to that contract. 25 U.S.C. § 5329(c) (requiring annual funding agreements to specify the programs, services, functions, and activities to be undertaken); *see also id.* § 5385(d)(1) (requiring the same for funding

income … shall be used to further the general purposes of the contract." *Id.*

Moreover, when tribal contractors' direct and indirect contract support costs are audited, the audits must also confirm that program income was spent only for allowable purposes—*i.e.*, on the federal program transferred from IHS. *See, e.g.*, 2 C.F.R. Part 200, Appx. XI, Compliance Supplement 2023, at 4-93-210-2, -5, http://tinyurl.com/yjv9x35x (audit requirements for program income expenditures under IHS self-governance contracts). Here again, general contracting principles make plain that expenditures of "program income" are just as much part of the federal program as appropriated funding. *See* 2 C.F.R. §§ 200.501, 200.502(a) (specifying that "program income" must be counted in determining whether an entity has met the audit threshold of "expending $750,000 … in Federal awards"). And, as discussed above, the panoply of exclusions outlined above, including the construction exclusion, would apply to any expenditures of program income when indirect costs are calculated.

C. Unfunded Indirect Costs Reduce the Funding Available to Provide Health Care Under ISDA Contracts.

Tribes are thus required to spend their program income on their ISDA-contract health care programs. But, under the "addition model," such income does

---

agreements executed for IHS self-governance compacts). Expenditures which further those listed (and typically broadly defined) programs, services, functions, and activities "further the general purposes of the contract" under 25 U.S.C. § 5325(m)(1).

not—and cannot—substitute for the funding transferred from IHS. 25 U.S.C. § 5325(m).

Because of the way that indirect costs are calculated, however, any expenditures from program income for which indirect costs are not available will always reduce the amount that can be spent on health care services (or else force risky contract compliance shortfalls). The indirect cost allocation process will sometimes even reduce the amount of indirect costs payable by IHS for activities funded by the secretarial amount—even if nothing about the underlying contracted-for services or the secretarial amount changes.

To illustrate, consider a tribal contractor that administers only one ISDA contract (with IHS). Assume that contract has an agreed direct cost base of $1,000,000 (after deductions for pass-throughs and exclusions), and the contractor's overhead expenses (aka the "indirect cost pool") are $300,000. The indirect cost rate would be 30% ($300,000/$1,000,000) and the tribal contractor would be due an indirect cost payment of $300,000.

Now imagine the same scenario, except the tribal contractor generates $200,000 in program income from Medicare and Medicaid, which is expended—as it must be—to fund services under the ISDA contract. Assume now that the government is correct that those program-income expenditures were not made "in connection with the operation of the Federal program"—even though they were used to fund services under the program's scope of work—and therefore the overhead connected to those expenditures does not qualify as a contract support cost. 25 U.S.C. § 5325(a)(3)(A)(ii). If that were so, then

indirect cost recovery to support the overhead for services paid with third-party revenue would not be available—forcing IHS-ISDA contractors to choose between providing less patient care or leaving critical overhead functions unfunded.

Worse still, the denial of indirect cost recovery for overhead to administer program-income-funded services can sometimes actually result in IHS paying *less* in indirect costs for the same size secretarial-amount-funded program. This is a consequence of how the indirect cost system allocates overhead costs among different contract programs (or here, if the government were to prevail, between two halves of the same program). Consider our same hypothetical ISDA contractor with a $1,000,000 secretarial amount and 30% indirect cost rate, meaning IHS would owe $300,000 in indirect costs. Now assume the contractor generated just $50,000 in program income. If everything else stayed the same, under the government's theory, the program income would be added to the base, and part of the overhead would be allocated to the program income share of the base (and thus be unreimbursed). IHS would now owe less than $300,000 in indirect costs—even though the $1,000,000 secretarial amount and the overhead required to administer it remained the same.[9]

---

[9] The size of the reduction depends on how the contractor chooses to address the shortfall in indirect costs, *e.g.*, leaving it unfunded, paying it from general tribal revenue, or diverting program income to cover it. If the contractor used general revenue, IHS would owe $285,714 in indirect costs, a reduction of $14,286, because the indirect cost rate would change from 30% to 28.57% ($300,000/$1,050,000). To aid understanding, the indirect cost illustrations in this brief have been simplified,

All else is not always equal, of course, because the more program income an ISDA contractor generates and spends (as required) on its IHS-ISDA program, the more overhead costs it will incur. Delivering more health care services necessarily entails more overhead—for example to recruit, hire, and onboard additional doctors and nurses to serve more patients. And if overhead increases commensurately with any new dollar of program income, then the indirect cost reduction discussed above might not occur (though there would still be a shortfall requiring diversion of program income from health care services to overhead).

But historically, overhead costs are relatively inelastic compared to direct costs.[10] This makes sense;

---

although the basic point holds. In reality, the calculation will typically involve base expenditures from many more funding agencies, none of which generate any indirect cost burden to IHS due to 25 U.S.C. § 5326. *See* Proposal Templates, *supra*. The financial impact of a ruling for Respondents will vary for different IHS-ISDA contractors based on a panoply of factors: how many different funding sources they have; the relative size of programs funded by those other funding sources, as compared to the IHS-funded program (including program income); the amount of program income expenditures relative to IHS-funded expenditures; how much program income is used to pay for pass-throughs and exclusions which do not generate any indirect cost obligation; and whether the additional overhead required consists of fixed or variable costs. *See* Resp. Br., No. 23-253, at 40-41.

[10] Historically, a direct cost base must increase by $4 to generate a $1 increase in the overhead required to administer that (expanded) base. U.S. GAO, No. RCED-99-150, Indian Self-Determination Act—Shortfalls in Indian Contract Support Costs Need to be Addressed, at 29-30 (June 1999), http://tinyurl.com/3f5c3cjb ("GAO Report"). So, adding $50,000 to

tribal contractors trying to free up as many resources as possible for health care services will resist diverting resources to hire additional administrative employees until the workload makes it unsustainable to continue without new positions. The more they maximize administrative efficiency—the more they minimize increases in overhead as they increase services—the more Tribes would lose ground under the government's theory, because less of those overhead costs would be reimbursed, even as they deliver more health care.

Even if tribal contractors avoid a reduction in indirect cost payments, they would still in all cases face a shortfall under the government's theory, when measured against the program that IHS could carry out. Either they divert program income to cover the overhead needed to administer program income expenditures—delivering less health care than IHS could deliver with the same amount of program income. Or they choose health care, and leave crucial administrative functions unfunded. IHS, which can fall back on the federal bureaucracy, never faces this dilemma.

Choosing to fund health care over administration creates a bigger problem than it solves. Forcing IHS-ISDA contractors to operate in the face of indirect cost shortfalls gives rise to all kinds of administrative and financial management system deficiencies. It hampers contractors' ability to properly account for those funds and to maintain compliance with their

---

the original $1,000,000 base in the hypothetical would not typically require much, if any, increase in the overhead needed to administer the base funds.

ISDA contract management obligations, which require them to have sufficient systems and personnel in place to ensure compliance. *See* 25 C.F.R. Part 900, subpt. F; GAO Report, *supra*, at 3, 7, 31, 39-40. As the Senate Indian Affairs Committee noted in approving what became the ISDA amendments requiring payment of contract support costs, the failure to fully pay indirect costs "has resulted in financial management problems for Tribes as they struggle to pay for federally mandated annual single-agency audits" and "financial management systems," among other shortfalls. S. Rep. No. 100-274, at 2627 (1988). The same adverse consequences—or worse—flow from the non-funding of overhead to administer program income because, as discussed above, program income expenditures must be audited, too.

As Respondent Tribes explain, the costs to administer expenditures of program income on program activities specified in the tribal contractors' scope of work fit comfortably within the terms of ISDA's contract support cost mandate. *See* Resp. Br., No. 23-250, at 21-26. Overhead expenses that are verified to be reasonable and allowable, incurred to support the tribal contractor's delivery of health care services under its ISDA contract, and paid for by income generated under its ISDA contract, are recoverable indirect costs under ISDA.

II. Program Income Expenditures Satisfy Section 5326 Because They Are Directly Attributable To ISDA Contracts.

As a backstop, the government argues that 25 U.S.C. § 5326 independently bars the government from paying such indirect costs. Gov. Br. 40-43.

Section 5326 permits IHS to pay contract support costs "only for costs directly attributable to [ISDA] contracts" and not for "costs associated with any contract, grant, cooperative agreement, self-governance compact or funding agreement between an Indian Tribe or tribal organization and any entity other than [IHS]." 25 U.S.C. § 5326. All of those instruments are forms of funding award documents.

But as the government acknowledges (Br. 8), section 5326 was enacted to reverse a specific court decision, *Ramah Navajo Chapter v. Lujan*, 112 F.3d 1455 (10th Cir. 1997). *Lujan* related to an entirely different scenario—where a Tribe operated two distinct types of programs under different contracts, one under ISDA (which covered indirect costs) and the others under a different state/federal program (which did not). Congress enacted section 5326 to ensure that IHS would not be required to subsidize non-IHS-ISDA programs. It has no bearing here, where no non-IHS-ISDA program is involved.

A. Section 5326 Was Enacted to Counter a Decision About a Scenario Not Implicated Here.

1. In *Lujan*, the tribal contractor operated several programs under ISDA contracts covering a variety of services, and two criminal justice programs under contracts with New Mexico that were funded by (much smaller) federal non-ISDA grants from the Department of Justice. 112 F.3d at 1458-59. The ISDA contracts paid for indirect costs; the New Mexico grants did not, and also did not allow any of the award funds to be used to pay for such costs. *Id.* at 1463. The government stipulated that addition of the small

amount of grant funds did not require an increase in the overhead needed to administer the ISDA and non-ISDA grant funds. Tr. of Proceedings Vol. I, Jan. 16, 2001, at 13-14, in *Ramah Navajo Chapter v. Babbitt*, CIV 90-957H (D.N.M. Jan. 16, 2001) (discussing stipulation on inelasticity of overhead costs). As discussed above, all direct costs supported by a contractor's overhead must be included in the direct cost base, regardless of whether any indirect costs are themselves recoverable under the respective contracts. Yet doing so reduces the amount of overhead expenses that the ISDA contracts will cover. *See* Section I.C, *supra*.

The Tenth Circuit held that it violated ISDA for the Bureau of Indian Affairs (BIA) not to fund the Tribe's full overhead costs in these circumstances. Focusing on the ISDA provision specifying that the government is not authorized "to fund less than the full amount of need for indirect costs *associated with* a self-determination contract," 25 U.S.C. § 5325(d)(2) (emphasis added), the court held that "associated with" was ambiguous. 112 F.3d at 1461-62. Applying the Indian canon, the court interpreted the statute to require "full funding of indirect costs and prohibit any adverse adjustments stemming from the failure of other agencies to pay their full share." *Id.* As a result, the court held that ISDA required BIA to pay any indirect-cost shortfall caused by non-ISDA grants, because by "including the [non-ISDA] funds in the direct costs base, defendants effectively and knowingly reduced the amount of [indirect cost] funding … and thereby deprived plaintiff of full indirect costs funding." *Id.* at 1463.

A partial settlement of the initial claims in the *Lujan* class action against the federal government followed the Tenth Circuit's decision. *Ramah Navajo Chapter v. Babbitt,* 50 F. Supp 2d 1091 (D.N.M. 1999).

2. The Department of the Interior and its subsidiary agencies went swiftly to Congress to change the law so that Interior would not be required to subsidize the indirect cost burden associated with non-ISDA programs. In a hearing before a Senate Appropriations Subcommittee, BIA objected that the *Lujan* decision required the Bureau "to pay contracting and compacting Tribe's support costs shortfalls of *other* Federal and State programs." Department of the Interior and Related Agencies Appropriations for Fiscal Year 1999: Hearing before a Subcommittee of S. Comm. on Appropriations, S. Hrg. 105-817, at 281 (1998) (emphasis added). The Department's 1999 budget justification included proposed legislative language to prohibit payment of contract support costs associated with contracts with entities *other* than an Interior agency, Department of the Interior and Related Agencies Appropriations for Fiscal Year 1999: Hearing before a Subcommittee of H.R. Comm. on Appropriations, 105th Cong., pt. 2, at 1552 (1998), and explained that the *Lujan* decision wrongly held BIA "responsible for the contract support costs associated with all Federal programs," *id.* at 1566. As the Bureau later explained, it "believe[d] *other* Federal Agencies should pay their own contract support costs to the Tribes." *See* Department of the Interior and Related Agencies Appropriations for Fiscal Year 2000: Hearing before Subcomm. of S. Comm. on Appropriations, S. Hrg. 106-382, at 173 (1999) (emphasis added).

Congress acted to address Interior's complaints. Referring to the "flawed [*Lujan*] settlement," the House Appropriations Committee proposed statutory language "that limits the Department of the Interior's liability for payment of contract support costs to only those contracts entered into with Interior bureaus." H.R. Rep. No. 105-609, at 57 (1998). As legislative proposals evolved, a 1998 appropriations bill added the requirement that costs be "directly attributable" to ISDA contracts. *See* Pub. L. No. 105-277, 112 Stat. 2681, 2681–280 (1998). In 1998, section 5326 was enacted, governing IHS-ISDA contracts, and a comparable statute was enacted for BIA-ISDA contracts. *See* 25 U.S.C. §§ 5326-5327.

The text and legislative history of these statutes confirm that they were enacted to repudiate the *Lujan* holding by barring IHS and BIA from funding indirect costs that are allocated within the indirect cost system to contracts or grants awarded by *other* federal or state agencies. Neither *Lujan* nor the congressional repudiation of it addresses the situation here, where there is only one federal program at issue, operated under an IHS-funded ISDA contract, and where the agency's indirect cost payment would otherwise be improperly diluted because of program income that is mandated by the contract.

B. Section 5326 Does Not Bar Payment of Indirect Costs for Expenditures Funded by ISDA Contract Program Income.

Section 5326 shields IHS from funding *other* agencies' contract support costs by permitting IHS to fund only those indirect costs which are (1) "directly

attributable" to its ISDA "contracts, grants and compacts" and (2) not "associated with" any "contract, grant, cooperative agreement, self-governance compact or funding agreement" between a Tribe and "an entity other than" IHS. 25 U.S.C. § 5326.

This provision poses no bar to contract support costs incurred to spend IHS-ISDA program income on services encompassed by IHS-ISDA contracts. Both criteria are satisfied. Such expenditures are "directly attributable" to the ISDA contract because the generation and spending of revenue from third-party payors is tightly tied to a tribal contractor's ISDA contract. And there is no other relevant contract with which the expenditures could be "associated."

1.a. The government acknowledges (Br. 38) that a tribal contractor's *collection* of third-party revenue is "directly attributable" to its ISDA contract. Rightly so. Not only do the Tribes' ISDA contracts require them to establish third-party billing systems, but their authority to bill Medicare and Medicaid derives from their status as ISDA contractors, aka "tribal health care programs." 25 U.S.C. §§ 1603(25), 1641(d)(2)(A). Although the government portrays the Indian Health Care Improvement Act as a statutory authority untethered to any ISDA contract requirements, the third-party billing requirement in fact is linked to that Act's "payor of last resort" rule, which requires tribal contractors to seek reimbursement from Medicare, Medicaid, and private insurance *before* costs for a patients' services can charged against their IHS-ISDA funds. *See* 25 U.S.C. § 1623(b).

The government's attempt to carve out the *spending* of third-party revenue as an entirely distinct

activity governed by the Indian Health Care Improvement Act and not by ISDA cannot be squared with ISDA's specific—and auditable—limits on the spending of the "program income" generated by the Tribes' IHS-ISDA contract programs. As discussed above, this "program income" must be spent on the "general purposes of the contract," 25 U.S.C. § 5325(m), and audits regularly confirm that expenditures fall within those limits. *See* Section I.B, *supra*. Discretion to choose among authorized purposes does not defeat the direct link between the ISDA contract and program income spending. *See* Resp. Br., No. 23-250, at 38-39.

Other statutory provisions reinforce this tight linkage between ISDA contracts and the expenditure of program income generated by ISDA contracts. Unlike for most Medicare and Medicaid providers, reimbursement rates for most ISDA contractor-provided services are promulgated by IHS, in coordination with the Centers for Medicare and Medicaid Services. *See* 88 Fed. Reg. 87,789 (Dec. 19, 2023); 42 C.F.R. § 405.2462(f)(4); Ctrs. for Medicare & Medicaid Servs., *Comparing Reimbursement Rates*, http://tinyurl.com/3s5e63hf (describing the "Indian Health Service rate"). Further, in authorizing payment of contract support costs "under section 5325(a)(2), (3), (5), and (6)" for self-governance contracts, ISDA expressly requires the Secretary to include funds that "are specifically or functionally related to the provision by the Secretary of services and benefits to the Indian Tribe." 25 U.S.C. § 5388(c). Third-party revenue is "functionally related" to the Secretary's provision of services because IHS itself uses the third-party revenue it generates to provide

health care services when it directly operates health care programs. Both generation and expenditure of third-party revenue are thus "functionally related" to the operation of IHS-ISDA programs.

b. Because the costs at issue are "directly attributable" to an IHS-ISDA contract, they also necessarily satisfy the second section 5326 criterion—not being associated with a *non*-IHS contract—although that criterion is also independently satisfied, as discussed below. Stated another way, expenses that satisfy the first criterion will always meet the second. *See* Resp. Br., No. 20-250, at 41; Pet. App., No. 23-253, 25a n.12. Conversely, overhead associated with non-ISDA grants awarded by IHS will never satisfy the first criterion.

2. Besides being "directly attributable" to IHS-ISDA contracts, overhead costs incurred to spend program income also satisfy section 5326 because they are not "associated with" any "contract, grant, cooperative agreement, self-governance compact, or funding agreement" awarded by "any entity other than the Indian Health Service." 25 U.S.C. § 5326.

Those listed instruments are all forms of funding award documents. When such instruments are used to award federal funds, they are classified as "Federal Awards." 2 C.F.R. § 170.305; *see also* 31 U.S.C. §§ 6303-6305. Such federal awards can only be created by the written approval of an authorized federal awarding official or contracting officer. 48 C.F.R. § 2.101 (defining a federal "contract" as "a mutually binding legal relationship obligating the seller to furnish the supplies or services … and the buyer to pay for them" and "contracting officer" to mean "a person with the authority to enter into …

contracts"); *Favor TechConsulting, LLC v. United States*, 129 Fed. Cl. 208, 212 (2016) ("As a matter of law, … a contract is not awarded until the Contracting Officer signs the document."); *Caddell Constr. Co. v. United States,* 120 Fed. Cl. 724, 726 (2015) ("In order for a contract to be deemed awarded, the contracting officer must have signed and mailed the award letter."). Such federal award instruments constitute contracts enforceable by and against the United States. *See* 41 U.S.C. § 7102(a).

A paradigmatic example of such a funding award would involve programs funded and governed by a contract with a federal agency other than IHS. The *Lujan* case—which section 5326 countermanded—provides an example; expenditures funded and governed by a grant awarded by New Mexico are "associated with" a grant from an entity other than IHS. But there are health care examples, too. For example, the Department of Health and Human Services can award Substance Abuse and Mental Health Services Administration Tribal Opioid Response Grants to Tribes, including but not limited to ISDA contractors. *See* 42 U.S.C. § 290ee-3 note. That tribal contractor would not be entitled to IHS-funded indirect costs arising from expenditures of those grant funds because those expenditures are "associated with" a non-IHS contract which funds and governs them.

There is no analogous contract here. The only contracts suggested by the government (Br. 27) are participation agreements with Medicare and Medicaid authorities and agreements with private insurers that facilitate reimbursement. As the government concedes (Br. 38), costs to administer any

such billing agreements are both "directly attributable" to the ISDA contracts and not "associated with" any non-IHS contract, because it is impossible to comply with the ISDA contract without creating mechanisms to collect Medicare, Medicaid, and private insurance. And if *billing* is not "associated with" any third-party payor contracts, then *a fortiori* spending that program income—which is governed (and mandated) by ISDA and not by any of the hypothesized contracts—is likewise not "associated" with a non-IHS contract (such as a patient's third-party health insurance policies or a tortfeasor's liability policy).

What's more, ISDA contractors are not required to enter contracts with anyone in order to submit claims for Medicare and Medicaid reimbursement. 25 U.S.C. § 1641(d), 42 U.S.C. § 1396d(l)(2)(B)(iv) (Medicare); *id.* § 1396j (Medicaid); 42 C.F.R. §§ 405.2434, 405.2462(f) (Medicare). They only have to enroll as an ISDA contractor and certify compliance with all Medicare and Medicaid patient and provider eligibility and billing requirements in their claim submissions, 42 U.S.C. §§ 1320-a7, 1396j; 42 C.F.R. § 413.65(m); U.S. Department of Health & Human Servs., Office of Inspector General, *General Compliance Program Guidance* (Nov. 2023), http://tinyurl.com/4cddwb2j. Those compliance certification submissions (even though labeled "agreements" to comply with Medicare and Medicaid requirements, 42 C.F.R. § 405.2434), are not "contracts" with the Centers for Medicare & Medicaid Services or the Department of Health and Human Services—much less contracts within the meaning of section 5326—because they do not award any funds,

do not involve the execution of an instrument binding on the United States by a federal awarding official or contracting officer, and do not obligate the federal government to do anything. *See PAMC, Ltd. v. Sebelius*, 747 F.3d 1214, 1221 (9th Cir. 2014) (rejecting hospital's "complain[t] of legislative impairment of their contract rights" based on purported "agreements with the Secretary" because by "joining the Medicare program, ... the hospitals received a statutory entitlement, not a contractual right").

Nor do payments recovered under policies between a patient and their insurance company require any kind of contract to be executed by an IHS-ISDA contractor. ISDA contractors are authorized to seek reimbursement by statute based on such policies, or liability policies of third-party tortfeasors. 25 U.S.C. § 1621(e). Although tribal health care programs could potentially enter into contracts with insurance providers to purchase health insurance, *e.g., id*. §§ 1642, 1647b, those are not like the funding award instruments referenced in section 5326.

Such insurance policy arrangements or Medicare/Medicaid billing submissions—which allow recovery or reimbursement for particular services for certain types of covered patients—are far from the heartland of the essential funding sources that section 5326 is concerned with: "contract[s], grant[s], cooperative agreement[s], self-governance compact[s], or funding agreement[s]." *Id*. § 5326. All of these involve the award of federal (or state) funds by an "entity other than" IHS, and are awards evidenced by the signature of an authorized federal (or state) awarding official. *Gustafson v. Alloyd Co.,* 513 U.S.

561, 575 (1995) (*noscitur a sociis* canon should be applied to give meaning to an undefined word in list of words in a statute consonant with other words in the list).

Congress sought to stop IHS from subsidizing those sorts of contracts precisely because other entities were responsible for funding them. The contracts hypothesized by the government are "agreements," different in kind; the only administrative work related to such agreements is the submission of claims—which the government admits is a proper contract support cost. The only contract that constrains expenditures of program income is the ISDA contract, which limits the expenditures to contract purposes. Section 5326 thus poses no bar to indirect cost recovery.

* * *

Indian health care is chronically underfunded.[11] Every dollar consumed in covering indirect costs is a dollar that cannot be spent to provide much-needed health care services to patients. Congress has long recognized that funds "needed for community and economic development" should not be "diverted to pay for the indirect costs associated with programs that are a federal responsibility." S. Rep. No. 100-274, at 2627. Reasonable and allowable overhead costs incurred to fund medical care with income generated

---

[11] Nat'l Council of Urban Indian Health, *Advancing Health Equity Through the Federal Trust Responsibility*, at 15 (May 2022), http://tinyurl.com/57baesvn (per capita health care expenditures are $15,763 for Medicare (2020), $12,223 for Veterans Affairs medical care spending (2021), $10,680 for national health care spending, $9,726 for Medicaid spending (2021), and $4,140 for IHS spending (2021)).

from a Tribe's ISDA health care program must be reimbursed.

CONCLUSION

The judgments should be affirmed.

Respectfully submitted.

Hyland Hunt
Ruthanne M. Deutsch
DEUTSCH HUNT PLLC
300 New Jersey Ave. NW
Suite 900
Washington, DC 20001
(202) 868-6915
hhunt@deutschhunt.com

C. Bryant Rogers
Counsel of Record
April Wilkinson
VANAMBERG, ROGERS, YEPA, ABEITA, GOMEZ & WILKINSON, LLP
347 East Palace Ave.
Santa Fe, NM 87501
(505) 988-8979
cbrogers@nmlawgroup.com

February 20, 2024