Mille Lacs Band of Ojibwe Indians

Executive Branch of Tribal Government
Office of the Chief Executive

Via E-mail

Virgil Wind
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Mille Lacs Band of Ojibwe
43408 Oodena Drive
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October 10, 2024

Hon. Roselyn Tso, Director
U.S. Indian Health Service
801 Thompson Avenue
Suite 300
Rockville, MD 20852

Re: Mille Lacs Band of Ojibwe Comment in Response to IHS Questions Concerning Implementation of *Becerra v. San Carlos Apache Tribe*

Dear Director Tso:

I am writing as the elected Chief Executive of the Mille Lacs Band of Ojibwe ("Mille Lacs Band" or "MLBO"), a federally-recognized, independent, and sovereign Indian Tribal Government with a separate, government-to-government Tribal Self-Governance Compact and Funding Agreement executed by the Indian Health Service ("IHS"). We appreciate this opportunity to comment in response to the questions IHS circulated in the wake of the U.S. Supreme Court's decision in *Becerra v. San Carlos Apache Tribe* earlier this year.

The Mille Lacs Band has had many decades of active involvement in the tribal assumption of federal programs under authority of the Indian Self-Determination and Education Assistance Act of 1975, as amended. We have been at the vanguard of the efforts by tribes to secure meaningful and effective implementation of the intent of Congress in enacting and amending that Act over decades. Full funding of our contract support costs has long been a top priority of the Mille Lacs Band, as has securing the legal authority to collect reimbursements from third party payors and maximizing that program income through extensive collection efforts.

The Mille Lacs Band was one of the ten initial Tribes selected by Congress in 1988 to participate in the Tribal Self-Governance Demonstration Project. The Mille Lacs Band was the first Indian Tribal Government to execute a Compact of Self-Governance with the U.S. Department of the Interior and one of the first to execute a Compact with the Indian Health Service. Each of the Mille Lacs Band's three Chief Executives preceding me (Hon. Art Gahbow, Hon. Marge Anderson, Hon. Melanie Benjamin) actively engaged in efforts at the national level to shape federal policy toward expanded Indian Self-Determination contracting and Tribal Self-

Governance compacting authority. Having taken office as Chief Executive a few months ago, it is my intention to continue and expand upon their efforts, maintaining the Mille Lacs Band's leadership role in Indian Self-Determination and Tribal Self-Governance that spans nearly five decades.

We Misi-zaaga'igani Anishinaabeg, as we call ourselves in our own language, have a 61,000-acre Reservation established under the 1855 Treaty of Washington (10 Stat. 1165) and exercise governmental jurisdiction over lands in the Minnesota counties of Aitkin, Crow Wing, Kanabec, Mille Lacs, Morrison, and Pine. We further exercise our treaty-protected reserved rights in territories ceded in the 1837 Treaty of St. Peters (7 Stat. 536) and 1842 Treaty of La Pointe (7 Stat. 591), which span from East-Central Minnesota, across Northern Wisconsin, and into the western portion of the Upper Peninsula of Michigan, including the portions of Lake Superior in Minnesota, Wisconsin, and Michigan.

Today, the Mille Lacs Band of Ojibwe has about 5,000 members that we serve from our headquarters located in East-Central Minnesota. Our Band's Department of Health and Human Services operates three medical clinics, behavioral health services, community support services, public health services, family services, and an office of quality and compliance, all with some funding support from the Indian Health Service under our Title V Self-Governance Compact and Funding Agreement.

The Mille Lacs Band of Ojibwe offers the following comments in response to the Indian Health Service's September 10, 2024, Dear Tribal Leader Letter initiating tribal consultation on implementation of the June 2024 Supreme Court decision issued in *Becerra v. San Carlos Apache Tribe*.

That *Becerra* decision means Tribal health programs like ours will finally receive full funding for our expenditure of money to further our Self-Governance Compact health program. This is vitally-needed funding that will help the Mille Lacs Band and others elevate the quality of health care in Indian country. The *Becerra* decision affirms that the Indian Self-Determination and Education Assistance Act ("ISDA") requires IHS to reimburse contract support costs associated with the expenditure of both IHS appropriations provided under ISDA contracts or compacts and program income that is earned under and spent in support of those contracts or compacts.

IHS has a long history of calculating contract support cost requirements. Current contract support cost procedures are set forth in IHS Manual Chapter 6-3. Given this long history, it should be easy for IHS to adapt existing procedures to expand contract support cost reimbursements to program income spending. But, instead, IHS's consultation questions suggest a desire to re-litigate the *Becerra* case by cutting back on tribal contract support cost requirements, by making the current process far more complicated than it already is, and by adding requirements and limitations that do not exist under current law simply to drive the overall federal cost number down.

The Mille Lacs Band of Ojibwe respectfully but firmly calls upon IHS to reconsider its miserly and over-complicated proposals and instead embrace fully the *Becerra* decision. Current IHS policy at Section 6-3.1.B. already lists seminal "Guiding Principles" which include that "[t]he process should be simple and efficient;" should "minimize future litigation;" should "assure[ ] that post year-end reconciliation will not take several years;" and should "minimize burdens imposed upon Tribes and IHS." The direction suggested by IHS's questions would abandon all those admirable goals. This must stop. After all, the matter at hand concerns Indian health care in an environment of historic underfunding, preceded by the imposition of traumatic and deadly government policies and practices. Tribes have long endured, for many years back far beyond the six-year statute of limitations on claims, IHS denial of full funding of our contract support costs. We urge IHS to do more than just listen to the comments below. We respectfully insist that you redirect implementation of the *Becerra* decision in specific ways that honor our comments and requests.

In the next portion of this document, we restate each of IHS's questions and then add our Mille Lacs Band responsive comments and requests in ***bold italics***. For efficiency, we will use the acronym "T/TO" or "Ts/TOs" to refer to tribes and tribal organizations who have assumed IHS programs, functions, services or activities, or portions thereof, pursuant to ISDA authority.

IHS Question 1

The Contract Support Costs Advisory Group ("CSCAG") recommended that Contract Support Costs ("CSC") related to program income expenditures in the upcoming year may initially be calculated based on program income expenditures in the most recently completed year. What documentation would you recommend be used to verify program income expenditures?

(a) If the Negotiated Indirect Cost Rate Agreement does not clearly show program income expenditures, can you recommend other forms of verification that could be used?

(b) Even if verified, are program income expenditures from a prior year a reliable number to use to estimate expenditures for a future year? If possible, please provide an estimate on how much variability in program income expenditures is typical.

MLBO Response

- ***Initial calculations of CSC due on program income spending in the upcoming year should reflect the T/TO's best estimate of anticipated program income spending in that year.***
    - ***Acceptable documentation should include, at the T/TO's option, a statement, certified by the T/TO, showing—***

- ***program income spending in the most recently completed year (including a calculation of the amount of CSC need, showing pass-throughs and exclusions associated with that program income spending), and***

- ***projected or budgeted program income spending in the upcoming year, if the projected or budgeted amount differs from such spending in the most recently completed year (again, including a calculation of the amount of CSC need showing pass-throughs and exclusions associated with that program income spending).***

➢ ***The T/TO's certification should state that its calculation represents a good-faith estimate of the spending that the T/TO anticipates incurring in the coming year, and that the person making the estimate is authorized to certify the estimate on behalf of the T/TO. IHS should allow the form and content of such certifications to be as simple as the certifications accompanying Contract Disputes Act claims.***

➢ ***In the event reconciliation occurs, verification of program income spending may be determined from examination of T/TO audit reports and T/TO-certified supplemental schedules. In limited circumstances the IHS may need to request to see T/TO general ledger trial balances, internal financial statements, indirect cost rate agreements and related proposals as further evidence of the T/TO's expenditures. Such requests should be limited to the minimum degree necessary.***

IHS Question 2

Tribes, Tribal Organizations, and the IHS serve non-beneficiaries at varying levels and degrees. Some may expand services to a broader range of non-beneficiaries under a "Section 813" resolution, 25 U.S.C. 1680c(c). The CSCAG's Tribal Representatives also recommended that program income expended on services to non-beneficiaries not be accounted for, in part due to overly burdensome data collection. The CSCAG's Federal Representatives noted, because the law requires full-cost recovery for those services, there would be no CSC need generated related to non-beneficiary expenditures (in other words, those services should be self-sustaining).

a. We are asking for your recommendations on what documentation T/TOs suggest is reliable to indicate how program income is being spent as it relates to providing services to non-beneficiaries that will ensure that T/TOs are not reimbursed twice for providing those services, since full-cost recovery is necessary in these instances?"

MLBO Response

- ***Tribal services to non-beneficiaries occur in a variety of circumstances, including services to many patients not covered by 25 U.S.C. 1680c(c) and who are instead covered by such statutes as 25 U.S.C. 1680c(a) & (b), the Emergency Medical Treatment & Labor Act ("EMTALA"), annual appropriations laws, and other provisions of law. Ts/TOs also commonly provide health care services to our non-Indian employees (including commissioned corps officers and federal employees) working in tribally-contracted facilities. Ts/TOs typically do not maintain systems for distinguishing among all these diverse non-Indian patients. To identify such individuals would therefore require the development of new data reporting across numerous different Electronic Health Record systems and would involve excessive costs and workforce hours far disproportionate to any benefit realized.***
    - ***Moreover, the level of care furnished to non-Indians is typically a fraction of the level of care delivered to Indian patients. The data infrastructure to measure this difference, however, does not exist.***
- ***The vast majority of Ts/TOs do not serve a majority of non-beneficiaries relative to their beneficiary user population. The fact that IHS can identify a few tribal sites (out of hundreds) that do so does not justify the imposition of new data collection and reporting requirements on all Ts/TOs.***
    - ***Just because a T/TO serves a large percentage of non-beneficiaries does not necessarily mean that its contract support cost need will increase by a proportional—or even significant—amount as a result of services to those individuals.***

In short, the "problem" that IHS is trying to solve here has not been shown to be a significant problem at all; yet IHS seeks a "solution" that burdens all Ts/TOs with documentation requirements that will be extremely difficult (if not impossible) to meet and that serves no potentially legitimate purpose in the vast majority of cases.

- ***As for full cost recovery, the premise of the IHS consultation question—that "full cost recovery is necessary" and therefore all such services are self-sustaining—is both incorrect and an oversimplification.***
    - ***First, 25 U.S.C. § 1680c(c)(3)(A) only imposes a full cost recovery obligation <u>on IHS</u> (<u>not</u> tribally furnished care), with IHS required to develop a "schedule of charges" to reimburse IHS's "actual cost of providing the health services."***
        - ***IHS's schedule of charges has nothing to do with reimbursement of higher tribal costs, much less tribal contract support costs that IHS does not incur.***

- ***To be clear, section 1680c(c)(3)(A) does not address tribal charges for reimbursement of tribal costs.***

- ***Second, unlike the IHS, Ts/TOs are free to provide services to non-beneficiaries based on other factors and considerations wholly independent of any notion of full cost recovery. In fact, many Ts/TOs require non-beneficiary patient volume to justify retention of qualified medical staff and the provision of specialty services. In such cases, services to eligible Indians are expanded or improved regardless of whether or not each individual service to a non-beneficiary is "fully reimbursed." The ISDA empowers Ts/TOs to make these decisions in order to best serve their citizens and communities.***

- ***Finally, full cost recovery is also commonly not achieved because of patient inability to pay, inadequate (or rejected) third-party payments, and competing pressures on tribal health care systems (including unique events like COVID).***

- ***With specific regard to non-beneficiary services covered by 25 U.S.C. 1680c, that section expressly "deem[s]" all services provided pursuant to that section to be "provided under the ISDA agreement." It is therefore contrary to law for IHS to treat program income spending on <u>non</u>-beneficiary services differently, under <u>Becerra</u>, than program income spending on beneficiary services.***

- ***IHS's approach would destroy ISDA parity and create a "funding gap." When IHS earns program income in connection with services to non-beneficiaries, both IHS's internal overhead and the resources of <u>other</u> government agencies (e.g., the Office of Personnel Management, the General Services Administration) are available to support the subsequent spending of that income on additional health care services. CSC covers what IHS resources do not. As the Supreme Court said in <u>Becerra</u>: "Contract support costs are necessary to prevent a funding gap between tribes and IHS."***

- ***IHS has collected data concerning non-Indian patients in the course of negotiating leases under 25 U.S.C. 5324(l). IHS can always reference this data in deciding whether to open a dialogue with a T/TO concerning the relative cost of non-beneficiary versus beneficiary services. But given economies of scale, no T/TO should be required to provide additional justification regarding overhead costs associated with services to non-beneficiaries unless health care expenditures on such non-beneficiary patients constitute over 50% of its overall health care spending, in which case the matter might then be subject to further individual negotiations between the T/TO and IHS.***

  - ***IHS must not lose sight of the fact that, in the real world, a T/TO may conclude that expanding care to non-beneficiaries may be the only way to have a sufficient patient load to justify a higher level of care, a piece of new***

equipment, or a treatment modality that would otherwise not be supportable if the health program resources are limited solely to the Secretarial amount and revenue associated with beneficiary users.

- ***IHS should recognize that the operation and expansion of tribal health care programs that directly benefit Indian patients, particularly in rural or small-population areas, would often not be possible without the provision of services to non-beneficiaries.***

IHS Question 3

The CSCAG's Tribal Representatives proposed that the negotiations process allow for certification of expenditures of program income. For your review and comment, I have included a draft of the *IHS Contract Support Costs Certification of Estimated Program Income Expenditures* form as an Enclosure to this letter. The IHS could potentially use this draft form in ISDA negotiations between T/TOs and the IHS to establish the estimate of CSC need and funding prior to the contract year. During negotiations based on responses to the certification, additional documentation may be requested from the T/TOs.

MLBO Response

- ***See our response to Question 1. The form should be modified to account for the options described there and be in a form similar to a CDA certification.***
- ***The form should not ask whether the T/TO serves non-beneficiaries or what percentage of total encounters or users are for non-beneficiaries, for the reasons stated above.***
- ***If the form asks anything about services to non-beneficiaries, it should be limited to the following question: "In your best estimate, do health care expenditures on services to non-beneficiary patients constitute more than 50% of all your health care spending?"***
- ***Authorized tribal officials must not be required to execute attestations/certification "upon penalty of perjury." The False Claims Act provides the government with ample protection against submitting fraudulent demands to the government, and for this reason, the Contract Disputes Act contains no such requirement. IHS has no reason to include such a requirement here.***

IHS Question 4

The CSCAG's Federal Representatives noted that compensation received from third-party payors may currently reimburse some costs that might also be proposed for CSC reimbursement. The CSCAG's Tribal Representatives indicated that they did not believe this issue needs to be addressed. We are asking for your recommendations on what documentation the IHS can use to

ensure the program expenditure has not already been fully reimbursed, and there is, in fact, a CSC need.

MLBO Response

- ***A reduction in the amount of contract support costs otherwise due is only appropriate when, as stated in the ISDA, the payment of contract support costs would duplicate any funds provided in the Secretarial amount. 25 U.S.C. 5325(a)(3) (concluding sentence) (CSC "funding shall not duplicate any funding provided under subsection (a)(1)") (emphasis added). This express language addresses the duplication issue in its entirety and does not permit IHS to claim a so-called 'duplication' offset in connection with any other source of funding outside of the Secretarial amount.***

- ***Moreover, IHS's concern in Question 4 confuses (a) the manner in which a payment of program income is calculated for a service performed yesterday, and (b) the overhead that will be incurred when spending that program income tomorrow on health care. As the Supreme Court noted in Becerra, the ISDA is crystal clear that contract support costs are due on the expenditure of all program income so long as the spending furthers the "general purposes" of the contract. For IHS to propose to not compute contract support costs on a share of that program income is to defy the Supreme Court's decision, invite unnecessary complexity, and further litigation.***

- ***As a factual matter, it is impossible to determine what portion, if any, of a payment from a third party may be reimbursement of administrative costs incurred when the service for which the payment was made was furnished to the patient. Third-party payments are not broken down that way. Tribal providers have no way to discern how third-party payments were calculated when they were paid, much less why requested amounts were not paid or only partially paid. Moreover, third-party payments do not account for the variation in T/TO-by-T/TO administrative costs, adjusted through T/TO-unique negotiations that reflect actual costs in each of a wide-range of diverse locations, and that are already reflected in each tribal provider's indirect cost rate used to calculate the amount of CSC due.***

- ***Compensation from third-party payers is typically a lump sum that does not break out reimbursements for patient care (direct) v. administrative (indirect) costs. A payment comes from a black box and bears no relation to the actual administrative costs incurred in delivering any particular service. It is therefore impossible to prove how any reimbursement aligns with the CSC that was incurred in connection with the reimbursed service. And, to restate the point made earlier, the reimbursement for a previously provided service has nothing to do with the CSC that is incurred later in connection with a future service that is funded with that program income.***

- ***Even if it is assumed that program income includes some unknown amount of overhead reimbursement, the subsequent spending of the program income does not***

impose any less of a burden on agency overhead or on non-IHS resource overhead from other federal agencies. This is because 100% of the program income payment is being used to provide health care which requires full federal administrative support under Becerra.

- ***Further, Congress has prohibited any reduction in ISDA funding on account of third-party payments. 25 U.S.C. 5388(j) (final sentence) ("[Program income] shall not result in any offset or reduction in the amount of funds the Indian tribe is authorized to receive under its funding agreement in the year the program income is received or for any subsequent fiscal year.").***

- ***Accordingly, to the question posed at the end of this item, there is no "documentation" in existence that would address IHS's baseless concern. More fundamentally, theoretical documentation regarding the details concerning program income received misses the point; what is key is documentation concerning the CSC a T/TO incurs when it later spends that program income. This is what the law requires be reimbursed.***

In conclusion, IHS has repeatedly acknowledged its legal obligation, as declared in *Becerra*, to reimburse the Mille Lacs Band of Ojibwe's CSC incurred in operating the entire federal program covered by its ISDA agreement, including the expenditure of program income to carry out the general purposes of our ISDA agreement. We insist that IHS adhere to the statutory commands in 25 U.S.C. 5329(c) and 25 U.S.C. 5321(g) requiring IHS to liberally construe all provisions of the Act for our benefit, and discontinue the persistent search by IHS for ways to reduce our CSC reimbursement rights under ISDA.

Thank you for considering our requests and comments.

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Virgil Wind
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Mille Lacs Band of Ojibwe