



DEPARTMENT OF THE INTERIOR HEARINGS DIVISION

Pascua Yaqui Tribe of Arizona v. Acting Director, Tucson Area Office,
Indian Health Service

Docket No. IBIA 98-61-A (04/06/1999)

Related Indian Self-Determination Act cases:

Interior Board of Indian Appeals decision, 32 IBIA 98
Administrative Law Judge decision, 11/23/1998
Interior Board of Indian Appeals decision, 33 IBIA 88
Health and Human Services Appeals Board decision, 01/12/1999
Health and Human Services Appeals Board decision, 02/11/1999
Health and Human Services Appeals Board decision, 06/01/1999
Administrative Law Judge decision on remand, 08/18/1999
Health and Human Services Appeals Board decision, 10/12/1999



United States Department of the Interior

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April 6, 1999

PASCUA YAQUI TRIBE OF ARIZONA,	:	IBIA 98-61-A
	:	
Appellant	:	Indian Self-Determination Act
	:	
v.	:	Appeal from a decision dated October 20,
	:	1997, by the Acting Director, Tucson Area
ACTING DIRECTOR, TUCSON	:	Office, Indian Health Service, Tucson,
AREA OFFICE, INDIAN HEALTH	:	Arizona
SERVICE,	:	
	:	
Appellee	:	

RECOMMENDED DECISION

Appearances: Philip Baker-Shenk, Esq., and Christopher A. Karns, Esq., Washington, D.C., and Thomas Peckham, Esq., Minneapolis, MN, for Appellant

Barbara Hudson, Esq., Rockville, Maryland, and Tamara M. Ribas, Esq., San Francisco, California, for Appellee

Before: Administrative Law Judge Kuzmack

On February 20, 1998, Appellant Pascua Yaqui Tribe of Arizona (Tribe) filed with the Interior Board of Indian Appeals (Board) an appeal of an October 20, 1997, decision letter issued by the Acting Director of the Tucson Area Office (TAO), Indian Health Service (IHS), U.S. Department of Health and Human Services (HHS). That decision partially declined the Tribe's July 21, 1997, proposal to enter into a contract with IHS to assume a number of IHS health programs, functions, services, and activities (PFSA's) under the Indian Self-Determination and Education Assistance Act (ISDA), 25 U.S.C. §§ 450-450n (1994).¹ The Board assigned the matter to the undersigned for hearing and issuance of a recommended decision.

Under the ISDA, a tribe may contract with IHS for the delivery of the tribe's health care PFSA's. 25 U.S.C. § 450f(a)(1). The HHS Secretary must contract with the tribe, unless the

¹ All further citations to the United States Code are to the 1994 edition.

Secretary finds that one of five statutorily delineated reasons for declination exist. 25 U.S.C. § 450f(a)(2). The amount of funds provided shall not be less than the HHS Secretary would have otherwise provided for the operation of the contractible PFSA's. 25 U.S.C. § 450j-1(a)(1). This amount is known as the "Secretarial amount" or "section 106(a)(1) amount".

When contracting with a tribe under the ISDA, IHS is required to fund contract support costs (CSC) in addition to the Secretarial amount, 25 U.S.C. § 450j-1(a)(2), subject to the availability of appropriations and the qualification that the Secretary is not required to reduce funding for PFSA's serving a tribe to make funds available to another tribe or tribal organization. 25 U.S.C. § 450j-1(b). CSC consist of an amount for the reasonable costs for activities which must be carried on by a tribe as a contractor to ensure compliance with the terms of the contract and prudent management, such as overhead and startup expenses, but which normally are not carried on by the Secretary in his direct operation of the PFSA or which are provided to the Secretary from resources not available to the tribe (Tr. 1421-27; Ex. Q, p. 4). See 25 U.S.C. §§ 450j-1(a)(2), (a)(3).

One statutorily delineated reason for declination is that the proposed funding exceeds the Secretarial amount. 25 U.S.C. § 450f(a)(2)(D). This reason was IHS's primary rationale for partially declining the Tribe's proposal for ISDA contract funding of \$10,553,953 plus CSC. IHS determined that the Secretarial amount was more than \$5 million less than the proposed amount of \$10,553,953 and declined the proposal to the extent that it exceeded the Secretarial amount.

The dispute in this case is centered upon whether IHS properly determined the Secretarial amount in light of applicable standards, if any. The Tribe argues that an equitable standard applies by which the Secretary is obligated to distribute funding for health care PFSA's in an equitable manner and that IHS failed to approve sufficient funding for the Tribe to meet this standard. IHS argues that the determination was wholly discretionary (not subject to any standard) and that in any event, the Secretarial amount for the Tribe is equitable, given the level of health care services and funding for the Tribe in comparison to that of the other tribes funded by IHS.

A related issue is how much funding is needed by IHS to maintain its "residual" functions (residual funding). A portion of the health care PFSA's administered by IHS are non-contractible under the ISDA because they are "residual" functions, i.e., those PFSA's which are necessary for the United States Government to fulfill and maintain its moral and legal responsibilities based upon treaties, statutes, and Executive Orders and which must be carried out by Federal officials. The amount of funding potentially available for distribution to tribes as their Secretarial amounts or otherwise varies inversely with the amount of funding determined to be residual. The parties agree that some PFSA's are residual but cannot agree on the amount of funding necessary to maintain them.

A hearing was held on June 2 through 11, 1998, in Arlington, Virginia. The record contains exhibits that are extensive in number and length. I had ample time and opportunity to observe the thirteen witnesses who testified at the hearing. I observed nothing that called into question the credibility of any witness. On September 25, 1998, the final post-hearing brief was filed.

25 C.F.R. § 900.165 provides that a recommended decision shall issue within 30 days of the end of any post-hearing briefing schedule. At the hearing the parties agreed to extend the 30-day time limit to 60 days (Tr. 2118-20) so that the deadline for issuance of this recommended decision was November 24, 1998. However, on October 27, 1998, Appellee filed a motion to dismiss premised on Section 328 of the omnibus appropriations bill for fiscal year (FY) 1999, which prohibits the use of FY 1999 funds to enter into any "new" contracts under the ISDA. On November 9, 1998, the Tribe filed its opposition. On November 20, 1998, Appellee filed its reply. On November 23, 1998, I dismissed the case. On December 22, 1998, the Tribe filed its objections to the dismissal with the Secretary of HHS. On January 15, 1999, Deciding Official Donald Garrett issued a Final Decision for the Secretary, reversing the dismissal and remanding the case for a decision on the merits. On January 28, 1999, Appellee filed a motion for an en banc review or in the alternative for reconsideration. On February 4, 1999, Mr. Garrett denied Appellee's motion for an en banc review or reconsideration. Consequently, the matter is now ripe for recommended decision.

Having carefully reviewed all evidence and briefs, and for the reasons set forth below, I conclude that the TAO Acting-Director's decision should be affirmed.

Statement of Facts

The HHS Secretary, through IHS, administers Indian health care PFSA's pursuant to the Act of November 2, 1921 ("Snyder Act"), 25 U.S.C. § 13, and other laws. See 25 U.S.C. § 1661. Under the Snyder Act, IHS has broad power to supervise and expend Congressional appropriations "for the relief of distress and conservation of health" of Indians. Id.

The Indian Health Care Improvement Act (IHCIA), 25 U.S.C. § 1601 et seq., enacted in 1976, supplements IHS's broad authority under the Snyder Act. In the IHCIA, Congress found that "the unmet health needs of the American Indian people are severe," 25 U.S.C. § 1601(d), and that "[a] major national goal ... is to provide the quantity and quality of health services which will permit the health status of Indians to be raised to the highest possible level." 25 U.S.C. § 1601(b); see also 25 U.S.C. § 1602. Despite these findings, the provision of health care services to Indians nationwide through IHS has been underfunded by Congress in recent years (Tr. 124, 908, 1006-07, 1339, 1429, 1439-40, 1445-47, 1497, 1736, 1971-72).

IHS has established a standard process for determining the health care service funding needs of each tribe which is referred to as the resource requirement methodology needs

assessment (RRMNA) (Ex. T-12; Tr. 147-50, 2023-24). Because Congressional appropriations are insufficient to fully meet these needs, IHS generally funds health care services for tribes at a level that is 60% of the RRMNA level (Tr. 216, 2024). Consequently, when IHS first provides health care services to a new tribe, its policy is to calculate the RRMNA level and then fund services at 60% of that level so that new tribes and pre-existing tribes are treated similarly (Tr. 125, 215-16, 1364, 1387, 1389, 2024).

Congressional appropriations for CSC are also insufficient. CSC for new or expanded ISDA contracts are funded through the Indian Self-Determination Fund (Tr. 1424, 1427, 1429). In each of the last three fiscal years (FY 1996 through FY 1998), Congress has appropriated only \$7,500,000 to this fund, despite the fact that the demand for CSC for new or expanded ISDA contracts exceeded \$65,000,000 as of March 31, 1998 (Tr. 1424, 1429, 1431, 1439-40, 1442-43, 1448, 1525; Ex. Q, pp. 23-24). Department of the Interior and Related Agencies Appropriations Act, 1998, Pub. L. No. 105-83, 111 Stat 1543, 1582 (November 14, 1997); Omnibus Consolidated Appropriations Act, 1997, Pub. L. No. 104-209, 110 Stat 3009, 3009-213 (September 30, 1996); Omnibus Consolidated Rescissions and Appropriations Act of 1996, Pub. L. No. 104-134, 110 Stat. 1321, 1321-189 (April 26, 1996).

There is also a funding shortfall of \$30 to \$40 million to meet the demand for recurring CSC funding (Tr. 1445-47). Recurring funds are funds which are received from year to year as opposed to non-recurring funds which are received on a one-time basis (Tr. G30-3 1).²

In consultation with representatives of Indian tribes, IHS developed a policy for determining CSC for each ISDA contract, allocating CSC, and prioritizing tribal requests for CSC funding in light of the funding shortfalls (Tr. 1429-30, 1434-35; Ex. Q). That policy provides for funding of new or expanded programs at 100 percent of the approved amount on a first-come, first-served basis until the Indian Self-Determination Fund is exhausted (Tr. 1429-32; Ex Q, p. 10). If funds are exhausted in any fiscal year, those tribes which do not receive funding are placed on a priority list (queue) and remain there in subsequent fiscal years and are considered in priority order when funding becomes available (Tr. 1429-32; Ex. Q, p. 10). The priority order is determined first by the fiscal year of the requested start date in the ISDA contract proposal and then those proposals with a requested start date within a given fiscal year are prioritized by the date IHS received their proposal (Tr. 1431-32, 1453-54; Ex. Q, pp. 10-11).

The Tribe's proposal has not yet been placed on the priority list because its CSC are still to be negotiated and determined by IHS (Tr. 1435-36, 1452-59, 1531-32; Ex. B, pp. 10-11).

² The first portion of the testimony of Elizabeth Guerra, the Health Systems Specialist for TAO, was transcribed in a separate volume which is paginated beginning at page 1. To differentiate from the transcript of June 2, 1998, which also is paginated beginning at page 1, a "G" is placed in front of the page numbers of Ms. Guerra's testimony in the separate volume.

Once the CSC are determined, the Tribe's proposal, like every other ISDA contract proposal, will be placed on the list in accordance with the fiscal year of the requested starting date and the date of IRS receipt of the proposal (Tr. 1436-37, 1532; Ex. B, pp. 10-11).

In its proposal, the Tribe did not include a requested starting date for the contract, stating, "The starting date shall be determined based on availability of contract support cost funding for the proposed contract . . . The Tribe expects to negotiate mutually agreeable starting date(s) for those particular program activities which the Tribe decides to assume and implement at its own financial risk in advance of receipt of the required allocation of contract support funds." (Ex. A, p. 8). Reuben Howard, the Executive Director of the Tribe's health programs, explained to IHS that the resolution of numerous outstanding issues, including the amount of CSC funds determined to be available, would bear upon the Tribe's decision of whether and when to enter into an ISDA contract for its health care services (Tr. 1592-93).

IHS received the Tribe's proposal on July 21, 1997 (Ex. B, p. 1). Thereafter, IHS and the Tribe negotiated and consulted regarding the proposal, and contract start dates were discussed (Tr. 983-87, 1592-93). Once the CSC amount is finalized, IHS intends to place the Tribe's proposal in the queue based upon a requested start date in FY 1998 and a proposal receipt date of July 21, 1997 (Ex. B, pp. 1041; Tr. 1452-54).

IHS is comprised of a Headquarters operation in Rockville, Maryland, and 12 area offices dispersed throughout the United States, including TAO in Tucson, Arizona (Tr. 341). A small portion of the Headquarters operation is also conducted in Tucson (Tr. 342).

Each year IHS receives two lump-sum appropriations from Congress: one for Indian Health Services and one for Indian Health Facilities (Tr. 74, 154-55, 343, 815; 1506). See, also, Pub. L. No. 104-208, 110 Stat 3009, 3009-212-15 (Jan. 3, 1996). The lump-sum amounts are derived from proposed funding levels for the various IHS health care PFSA's in the President's budget, which are referred to as sub-sub activities (Tr. 1221-32, 1506). After receiving the funds from Congress, IHS Headquarters allocates its lump sum appropriations to the area offices by sub-sub activity (Tr. 815, 1229). The area offices, including TAO, then obligate those funds by sub-sub activity to provide health services to Indians (Tr. 344).

Area offices oversee IHS service units which deliver the health care services to Indians (Tr. 341). Service units provide the health care services directly through Federally-operated health care facilities (Direct Services (DS)) (Tr. 344-45). To the extent that DS are not available, either because there is no Federally-operated facility in the area or because there is an area facility but the needed services are not available there, IHS indirectly provides the services by paying for the services of private health care providers under contracts and/or referrals (Contract Health Services (CHS)) (Tr. 344-45, 349, 1469; Ex. B, p. 2). Each service unit has both a DS budget and a CHS budget (Tr. 349).

A tribe may also enter into an ISDA contract or self-governance compact with IHS so that Federal funding is provided directly to the tribe for self-administration of the health care PFSA's formerly carried out by IHS for the benefit of the tribe (Tr. 345; Ex. Q, p. 2). Many tribes do not receive DS, but receive either CHS or self-administer their own health care through self-determination contracts or self-governance compacts (Id.)

TAO administers health care services for two tribes, the Tribe and the Tohono O'odham Nation (TON) (Tr. 355). TAO also oversees health care services for the Urban Group as one of its residual functions (Tr. 647). On the TON reservation, IHS operates a small direct care hospital in Sells, Arizona, 60 miles west of Tucson, and two health clinics, one located farther west in Santa Rosa, Arizona, and one situated adjacent to Tucson in San Xavier, Arizona (Tr. 355-57). TAO also provides CHS to TON (Tr. 357).

TAO does not provide DS to the Tribe, but rather, provides only CHS, primarily through a capitated health management contract with a non-profit, health maintenance organization (HMO), Southwest Catholic Health Network (Tr. G12-14, G18, G20, 356; Ex. T-79). That contract requires monthly prepayment of premiums to the HMO for each Tribal member enrolled in the HMO (Tr. G22, 356). Certain PFSA's, such as ambulance, physical therapy, mental health, and dental, are not provided through the HMO but through contracts with other private health care providers (Tr. G12-14).

Out of the 530 Indian tribes serviced by IHS, there is only one other tribe that is being serviced through an HMO (Tr. 341, 344, 2011, 2073). The other tribes serviced by IHS receive DS and/or CHS other than through an HMO (Tr. 151-53; Ex. B, p. 2).

Because of the underfunding of Indian health services, CHS provided other than through an HMO are rationed and/or deferred in accordance with a medical priority list (Tr. 124, 348, 908, 934-38, 1339, 1497, 1509, 1736, 1971-72; Ex. BB). Ms. Guerra testified that the Tribe's access to CHS, in comparison to that of TON, may be better for those services provided by the HMO because those services are prepaid and thus generally are not rationed or deferred (Tr. G28).

The benefits or services provided to the Tribe are similar to those provided to TON, although the delivery mechanisms differ (Tr. 154, G27-28, 2025). Dr. Thomas Lee Austin, a witness for the Tribe who has worked for IHS and served as a consultant to various tribes, testified that the service benefit package under the Tribe's HMO is comparable not only to the TON's package, but also to the packages of most of the tribes that have access to a full-service DS program and to a majority of the tribes served by IHS (Tr. 2024-26).

In contrast, Clifton Wiggins, a senior operations research analyst at IHS Headquarters, testified that the Tribe's health care service program was better than average, comparable in care and costs to those of the newer, better funded DS facilities (Tr. 73-74, 84-85, 299-300, 304-05).

Based upon figures for FY 1998, IHS health care services funding per capita for the Tribe was \$1,960 versus an average per capita figure of \$1,328 for all other tribes (Tr. 65-66, 107-08; Ex. H).

The per capita figures were based upon each tribe's "user population", which is defined as the number of Indians eligible for IHS services who have utilized those services at least once during the immediately preceding three-year period (Ex. W, p. 4). The most recent data available at the time the partial declination letter was issued was for fiscal years 1994 through 1996 (Tr. 169).

The average per capita figure of \$1,328 does not include funding for health care facilities and equipment (as opposed to health care services) provided for the benefit of tribes receiving DS (Tr. 107, 307). It does include facility and equipment funding for CHS in that facility and equipment costs incurred by private contractors are presumably passed on to IHS through the rates charged for CHS (Tr. 306). If DS health care facility and equipment costs are added, the average per capita figure rises to \$1,528 (Tr. 315, 322-23). The Tribe's per capita funding still exceeds the revised figure by over \$400.

Mr. Wiggins opined that per capita funding was the most important but not the only measure of whether a tribe was being treated equitably (Tr. 65-68, 253-54, 298-99). He also looked to measures of health care access and utilization and found that the Tribe's above average funding rate is consistent with the Tribe's above average service utilization rates (Tr. 71-72).

Using FY 1996 figures, the Tribe's outpatient visit rate is 6.4 per user as compared to average rates of approximately 2.5 to 5.4 for the 12 IHS areas (Tr. 69-72; Ex. JJ). The outpatient visit rate is a measure of the availability of health care services or the capacity of a health care program to meet patient needs (Tr. 70-71). FY 1996 figures also show that the Tribe's inpatient discharge rate of 116.7 per 1,000 users exceeds the average rate for all but one of the 12 IHS areas (Tr. 73-74; Ex. KK). Considering all factors, Mr. Wiggins concluded that the funding and services provided to the Tribe by IHS are above average and that if IHS were to reallocate funding among all tribes to achieve equity, the Tribe very likely would not receive any additional funding and might lose funding (Tr. 73-74, 84-85, 299-300).

IHS began providing health care services to the Tribe in 1980 (Ex. T-25; Tr. 1535-37). The initiation of services was precipitated by the September 18, 1978, Congressional designation of the Pasqua Yaqui Tribe as a Federally recognized tribe so that the Pasqua Yaqui Indians would be eligible for all Federal services and benefits provided to Indians because of their status as Indians (Exs. T-62, C-12). 25 U.S.C. § 1300f. Congress allowed individual Pasqua Yaqui one or two years to apply for membership in the Tribe. 25 U.S.C. § 1300f-2(A), (B).

The Tribe's members reside primarily in six traditional Arizona communities in the Tucson and Guadalupe areas, including its reservation located adjacent to Tucson (Ex. T-27). Tucson is located in Pima County and Guadalupe is located in Maricopa County. As of June 1997, 6,000 of the Tribe's 10,006 members lived in Pima County (Ex. T-31).

The concept of providing health care services to the Tribe through an HMO originated in a 1980 IHS proposal to the Tribe (Ex. T-25; Tr. 1536-38). IHS did not offer to provide health services directly to the Tribal members through a Government-owned facility because the closest existing facility in San Xavier was servicing TON and did not have sufficient capacity to serve the Tribe as well, and because Congress did not appropriate funds to build a facility to service the Tribe (*id.*). The Tribe desired DS and had many reservations about participating in an HMO program, including potential overdependency on uncertain federal funding for future tribal members (*id.*). Nevertheless, it accepted the proposal under protest because IHS offered no alternative to the HMO and its members were in need of health care services (*id.*).

In the fall of 1994 Congress took the extraordinary step of reopening the Tribe's enrollment by statute (Ex. T-62). Congress opened a three-year window until October 14, 1997, for Pascua Yaqui to apply for Tribal membership (Tr. 1614). A Congressional reopening of a tribe's enrollment is a rare event (Tr. 170).

In anticipation of the expiration of the HMO contract on May 31, 1997, IHS began, in October 1996, the process of developing a solicitation for a new HMO contract (Exs. T-79, T-80; Tr. G45-50). This process included review of revised financial reports from the HMO contractor (*id.*; Ex T-79). That review showed substantially higher rates for both utilization and costs of the HMO than were previously negotiated between IHS and the contractor (*id.*; Tr. G46).

Based upon the revised cost and utilization data, IHS concluded that the estimated cost (premiums) necessary to continue providing the then existing health benefit package under a new contract would exceed the then current CHS budget allocated for the HMO program (Ex. T-80; Tr. G46, G50, 1202-03, 1613-17). As a result, IHS informed the Tribe by letter dated December 13, 1996, that the solicitation for a new contract could not be released because of insufficient funds (Ex. T-80).

In October 1996, IHS also learned of the Tribe's projections (1) that tribal enrollment would increase by 3,500 members living in Pima County by October 1, 1997, because of the Congressional reopening of the Tribe's enrollment in 1994, and (2) that all of these projected new Tribal members would be eligible for enrollment in the HMO (Tr. G46, G109-13, 1765; Exs. T-6 1, T-65). IHS' December 1996 funding shortfall prediction was based upon an estimated HMO membership of 4,314 by June 1997. It did not take into account the Tribe's projected increase in HMO enrollment which would result from the reopening of enrollment (Ex T-80; G46, G50, 1202-03, 1613-17).

Thus, there were two components to the funding problem: (1) existing funding was not sufficient to meet anticipated increases in premiums upon the May 31, 1997, expiration of the HMO contract, and (2) this funding shortfall would be exacerbated by future increases in HMO enrollment attributable to the reopening of Tribal enrollment (Tr. 1616-17). In light of this funding problem, the TAO Acting-Director appointed a work group in December 1996 to assess options for maintaining the Tribe's health care services (Ex. T-11; Tr. G46-49). The work group concluded that, regardless of the option chosen, additional funding was needed to maintain services for the Tribe (Exs. T-11, T-65, T-116; Tr. G46-49, 1202-03, 1613-14, 1616-17, 1622-29, 1636-37, 2013-15).

Therefore, on February 24, 1997, the TAO Acting-Director submitted to the IHS Director a request for additional funding for FY 1997 and FY 1998 (Ex. T-65). Because of the imminent expiration of the HMO contract, the request was characterized as urgent (id.).

After a month passed without receipt of additional funding, the TAO Acting-Director decided that the only feasible course of action was to extend the existing HMO contact for six months to November 30, 1997, and to request from the IHS Director supplemental non-recurring funding to cover the extension premiums for the remainder of FY 1997 (June 1, 1997 through September 30, 1997) (Ex. T-6 1; Tr. 1943-44). By letter dated March 27, 1997, the request was made (Ex. T-61).

Meanwhile, for purposes of planning and facilitating a Tribal effort to lobby Congress for additional funding for the Tribe's health care needs, IHS agreed to the Tribe's HMO membership estimates of 4,500 members for the short-term and 7,814 for the long-term (Tr. G51-53, G 109-10, 1613-2 1; Ex. T-6 1). Two explanations were given for the derivation of the 7,814 figure. One is that it represents the sum of the IHS projection of 4,314 HMO members by June 1997 and the Tribal projection of 3,500 additional Tribal members all eligible for HMO enrollment (Tr. G51-53, G109-13). The other is that it is the sum of the agreed short-term HMO membership estimate of 4,500 and a Tribal projection of 3,314 additional HMO enrollees by October 30, 1998, resulting from the open enrollment (Ex. Y-3 1; Tr. 1767-71).

When this sum was calculated in June 1997, the actual HMO membership was 4,184 (id.). Because the immediate planning and lobbying horizon was FY 1998, the 7,814 figure was reduced in the spring of 1997 to 6,640 to reflect the Tribe's most recent projection of the number of HMO enrollees by the end of FY 1998 (4,500 short-term estimate for lobbying + 2,140 projected new enrollees by September 30, 1998) (Tr. 1620-2 1; 1634-35, 1767-70; Ex. T-31).

Numerous IHS witnesses testified that the Tribe's projections of 7,814 or 6,640 HMO members were not substantiated or realistic (see, e.g., Tr. G53-54, 1211). Certainly, the Tribe's assumption that all projected new Tribal members from Pima County would be eligible for HMO enrollment was not realistic.

To be eligible for enrollment in the HMO health plan, a person not only must be an enrolled member of the Tribe and a resident of Pima County, but also must not have an alternate resource available to them, such as private health insurance, Medicaid, or Medicare (Tr. G25). As of June 1997, only 70% of the Tribe's membership living in Pima County was enrolled in the HMO (4,184 HMO members ÷ 6,000 Tribal members living in Pima County) (Exs. T-31, LL). Based upon such historic patterns, an assumption that 100% of new Tribal members living in Pima County would join the HMO was not realistic.

At the other extreme, it would not be realistic to project no increase in HMO membership. A realistic projection would involve multiplying the 70% HMO enrollment rate by a reasonable estimate of the expected number of new Tribal members who would be living in Pima County.

In June 1997, the Tribe estimated the future addition of 3,500 such Tribal members. Multiplying this figure by 70% results in a product of 2,450. Adding this product to the June 1997 membership of 4,184 results in an estimated total of 6,634 HMO members, an amount very close to the Tribe's revised projection of 6,640 HMO members.

On April 11, 1997, \$585,000 in supplemental funding was provided to TAO from the IHS Director's Emergency Fund (Tr. 164-66). The supplemental funding was provided on a non-recurring basis as a stop-gap measure to insure continuity of health care for the Tribe while affording TAO more time to resolve the recurring need for additional funding (165-66, 369, 1252-53, 1255, 1333-37, 1484-86, 1488, 1494-95, 1611, 1926, 1928-30, 1943-44). The Director expected that TAO would avert any future emergency need for funding by such means as negotiating or soliciting a new scope of health care services within recurring resources prior to the November 30, 1997, expiration of the HMO contract extension (Tr. 369, 1928-30).

After IHS received the Tribe's ISDA contract proposal on July 21, 1997, it negotiated and consulted with the Tribe regarding the proposal (see, e.g., Tr. 983-87, 1592-93). They discussed residual funding but could not agree on an amount (Tr. 986).

The negotiations were suspended by Mr. Howard on August 27, 1997, because IHS' lead negotiator, Robert Price, the IHS Tribal Affairs Officer, told him that the amount of residual funding for TAO was not negotiable (Tr. 985-86; Ex. VV). Mr. Price's position was based upon agency policy that the area residual funding amount must be negotiated with all affected tribal organizations which, in TAO's case, included three entities: the Tribe, TON, and the Urban Group (Tr. 645-46, 984-87, 1104-05). Eventually, IHS resumed negotiations on two tracks: One solely with the Tribe regarding its proposal and one with all three tribal entities regarding the residual funding (Ex. VV).

By letter dated October 20, 1997, the Secretary's representative, the TAO Acting-Director, partially declined the Tribe's proposal (Ex. B). In general, IHS partially declined the

Tribe's proposal to extent that IHS lacked sufficient funds to fully fund certain portions of the proposal (Ex. B). Post-declination consultations between IHS and the Tribe led IHS to discover and correct some minor errors in the amounts which IHS determined to be available to the Tribe under the ISDA (the corrected Secretarial amounts are found in Ex. HH a copy of which is attached hereto as an addendum) (Tr. 818- 9, 844-45, 962-65).

The Secretarial amount for each PFSA for which the Tribe proposed to contract with a few exceptions, was determined by IHS as follows (see generally, Ex. HH): First, IHS reviewed its records to ascertain the amount of recurring funds allocated by Headquarters to TAO (the area allowance) for that PFSA from the IHS FY 1997 Congressional appropriation for Indian Health Services (Tr. 221-23, 819-28, 929, 955-57, 1067, 1070, 1469, 1747).

IHS used FY 1997 figures because IHS had not yet received a final Congressional appropriation for FY 1998 as of the date of partial declination (Tr. 828). In FY 1997, as usual, IHS received two lump-sum appropriations from Congress: one for Indian Health Services in the amount of \$1,806,269,000 and one for Indian Health Facilities in the amount of \$247,731,000 (Tr. 74, 343, 1506). Pub. L. No. 104-208, 110 Stat 3009, 3009-212-15 (Jan. 3, 1996).

Out of the Indian Health Services appropriation, Congress specifically earmarked \$356,325,000 for CHS and \$7,500,000 for CSC (Tr. 1232; 1429-32). 110 Stat at 3009-213. Except as specifically directed by Congress, the Director of IHS, in consultation with the tribes, determines the area allowances (how the lump-sum appropriations are allocated among the various area offices and the many PFSA's) (Tr. 1965-66).

From the area allowance for each PFSA, TAO subtracted the TAO residual amount, if any, to obtain the amount of TAO's available area allowance (base program funding) under the ISDA for the two tribes served by TAO (Ex. HH; Tr. 1067). As previously noted, the residual amounts are the funds required for those PFSA's which are necessary for the United States Government to fulfill and maintain its moral and legal responsibilities based upon treaties, statutes, and Executive orders and which must be carried out by Federal officials (Ex. PP, p. 1; Ex. W, p. 4).

When a tribe contracts under the ISDA for a PFSA, it is eligible to receive not only an equitable portion of the base program funding for that PFSA, but also an equitable portion of the funding for administrative support functions for that PFSA carried out at the Area Office and IHS Headquarters (Tr. 364-65; Ex. Q, p. 3). A tribe's equitable share of the funding for these administrative support functions is referred to as its "tribal share" (id.). Sometimes, it is referenced by its two components, the "Area Office tribal share" and the "Headquarters tribal share".

Several IHS policies indicate that the term "tribal share" does not refer to a tribe's equitable share of service unit or base program funding (see, e.g., id.; Ex. W, p. 4). Confusingly,

however, IHS has a policy entitled, "Tribal Shares Transfer Schedule Policy", that pertains to the transfer to tribes of not only their tribal shares, but also their allocable shares of other funding for which they are eligible under the ISDA (Ex. M).

Pursuant to IHS policy, the determination of each tribe's tribal share is based upon a tribe's "user population," which is defined as the number of individuals that have utilized the IHS health care system at least once within the most recent three-year period for which data is available (Tr. 54-57, 169, 176, 190-92, 362, 1009). The tribe's percentage share of the relevant total user population is multiplied by the available administrative support funds (after subtraction of the residual amount) to calculate the tribe's tribal share (Ex. HH; Tr. 86-90, 1067-68).

This policy was established by the IHS Director in consultation with two work groups comprised, in part, of tribal representatives (Ex. H; Tr. 89-93). The Tribal Co-Chair for one of the groups was Jack Ramirez (now deceased), the then Associate Director of Managed Care Services for the Tribe (Ex. H).

Mr. Wiggins explained that the tribes wanted a stable base for determining tribal shares and that user population, which grows on average at only two to three percent per year, fit the bill (Tr. 89-93, 176). In furtherance of this goal, it was agreed and established as policy that the user populations used to determine the tribes' headquarters shares would be recomputed only once every three to five years. (Tr. 89-93).

For this purpose, the user populations were last computed in approximately FY 1995 and are scheduled to be recomputed by FY 2000 (Tr. 89-93, 176). The Tribe's user population for headquarters share purposes was computed to be 3,839, resulting in a headquarters share of \$166,993 in the declination letter (Tr. 89-94, 1742-43).

TAO used the Tribe's user population to calculate the Tribe's percentage (equitable) share of the base program funding for each PFSA that was available to both the Tribe and TON (Tr. 54-57, 362-64, 839; Ex. HH). For such purposes, IHS determined the Tribe's user population to be 4,069 based upon the most current data available at the time of partial declination of the Tribe's proposal: user population data for the three-year period from FY 1994 through FY 1996 (Tr. 362-64, 1009, 1012; Exs. E, G). This figure amounted to 17.88% of the total TAO user population of 22,758 (the sum of the user populations of TON and of the Tribe) (Tr. 364, Ex. E, p. 4). The Secretarial amounts were then determined by multiplying 17.88% by the available amounts to arrive at the Tribe's equitable share of each PFSA available to both the Tribe and TON (Ex. HH).

The amounts determined by IHS to be immediately available to the Tribe were lower than the Secretarial amounts for most of the PFSA's, however, because the immediate availability of the Secretarial amounts depended upon whether they were encumbered (Ex. M). Encumbered resources are defined as those portions of the PFSA funding that are currently committed as

compensation for on-duty permanent employees or as payment for goods and services in binding contracts (Ex. W, p. 3; Tr. 99-100, 209-212, 831-33, 959). Liquid (unencumbered) resources are defined as the balance of resources for the PFSA that are not encumbered (Ex. W, p. 3).

The IHS' Tribal Shares Transfer Schedule Policy provides that IHS shall transfer on the effective start date of an ISDA contract 100% of that portion of the contract applicant's allocable share that is in liquid form (Ex. M, p. 3; Ex. O; Tr. 209-12). It also requires transfer of at least 50% of encumbered portion of the allocable share within 12 months after the start date and transfer of 100% of the encumbered portion within 24 months of the start date (Ex. M, p. 3; Ex. O).

This policy was developed and recommended by the IHS Business Plan Workgroup (Tr. 95; Ex. O). Of the 12-15 individuals comprising the group, 75% represented various tribes and 25% were Federal employees (Tr. 97). The policy requires timely transfer of PFSA funding, while allowing IHS sufficient time to downsize, discharge obligations, and otherwise liquidate the encumbered resources (Tr. 95-99; Ex. O).

TAO calculated the amount of encumbered resources for each PFSA and then subtracted that amount from the available area allowance to arrive at the amount of liquid resources (Ex. HH). Then, TAO determined the amount immediately available for transfer to the Tribe by multiplying the amount of liquid resources by the Tribe's percentage of the total user population (17.88%), where applicable (Ex. HH).

The chart attached to this Recommended Decision as addendum 1 is a reproduction of Exhibit HH, which evidences the amounts proposed by the Tribe for each PFSA, the Secretarial amounts and amounts immediately available to the Tribe, as determined and corrected post-declination by IHS, and the methods by which IHS determined those amounts. As shown by the chart, the amounts proposed by the Tribe equal the Secretarial (Pascua Yaqui 106(a)(1)) amounts determined by IHS for the following PFSA's: AIDS Coordinator, Pascua Yaqui-Health System Delivery, Mental Health, and Headquarters Shares (see also Tr. 1738-39).

However, at the hearing, Mr. Howard testified that the Tribe no longer agreed with the Secretarial amount of \$166,993 for its headquarters share because the Tribe relied upon IHS' calculation of the amount and the Tribe later discovered that the calculation was based upon a user population of 3,839 rather than 4,069 (Tr. 1742-43). He did concede that the IHS determined Secretarial amounts for Social Services and Alcohol/Substance Abuse were correct (Tr. 1739-42, 1748). For the agreed upon Secretarial amounts, the Tribe used the same methodology as IHS in calculating them (Tr. 1748).

The Tribe also used the same methodology as that used by IHS to calculate the Secretarial amounts for Administration and Management and Chief Medical Officer (see Ex. A, p. 14).

However, it arrived at larger amounts because it subtracted lesser amounts for residual funding (compare Ex. A, p. 14, with Ex. HH).

For CHS, the Tribe did not use the same methodology as IHS in calculating the Secretarial amount of \$9,721,263 (Tr. 948-49). That amount included \$9,343,277 for the HMO program (Ex. A, p. 15). Unlike the other PFSA Secretarial amounts proposed by the Tribe, the proposed HMO program amount was not based upon the recurring funding amount but upon the following calculation: \$ 117.26 (monthly premium per HMO member) x 6,640 (estimated HMO members) (Tr. 1749; Ex. A, p. 15). Mr. Howard acknowledged that if the Tribe had relied upon recurring funding amounts, including the related user population figures, to calculate the Secretarial amounts for CHS (including the HMO program) as well, it would have arrived at the same Secretarial amount as that calculated by IHS: \$4,313,836 (Tr. 1747-49).

The Tribe also proposed to receive monies from TAO's Facility Support fund. That fund is used to support the operation and maintenance of buildings belonging to TON at San Xavier (Tr. 997-98). Consequently, IHS determined that those funds are not available to the Tribe as monies the Secretary would have otherwise provided to the Tribe (id.; Ex. HH).

Discussion

The Tribe's grounds for appeal are numerous. Except to the extent the contentions of errors of fact or law have been expressly or impliedly addressed in this recommended decision, they are rejected on the ground they are, in whole or in part, contrary to the facts and law, are immaterial, or are beyond the scope of this proceeding.

Under the ISDA and its implementing regulations, the HHS Secretary is directed, upon the request of any Indian tribe, to enter into a self-determination contract with the tribe so that the tribe may plan, conduct, and administer health care PFSA's administered by the Secretary for the benefit of the tribe. See 25 U.S.C. § 450f and 25 CFR Part 900. Upon the request of a tribe, the Secretary shall also provide technical assistance to the tribe to develop a new contract proposal or to provide for the assumption of the PFSA's by the tribe. 25 CFR § 900.7. The Secretary must approve a contract proposal and award the contract within 90 days after receipt of the proposal unless the Secretary provides written notification to the applicant that contains a specific finding that clearly demonstrates that (or that is supported by a controlling legal authority that) one or more of five specific reasons for declination exist, together with a detailed explanation of the reason(s) for the declination and, within 20 days, provides any documents relied on in making the decision. See 25 U.S.C. §§ 450f(a)(1), (a)(2); 25 C.F.R. §§ 900.21, 900.22, 900.29.

The Secretary may decline to contract only if she makes a specific finding that one or more of five statutorily and regulatorily delineated reasons exist for declination. 25 U.S.C. § 450f(a)(2); 25 C.F.R. §§ 900.21, 900.22. The Secretary must approve any severable portion of

a proposal that does not support a declination finding. 25 U.S.C. § 450f(a)(4); 25 C.F.R. § 900.25. With respect to those portions which are declined, the Secretary must provide technical assistance to overcome the stated reasons for declination and must provide any necessary requested technical assistance to develop any modifications to overcome the reasons for declination. 25 U.S.C. §§ 450f(b)(2), 450h(d); 25 C.F.R. § 900.30.

In the instant case, the Secretary's delegate, the TAO Acting-Director, partially declined the Tribe's proposal based upon three statutory grounds found at 25 U.S.C. § 450f(a)(2):

(C) the proposed project or function to be contracted for cannot be properly completed or maintained by the proposed contract;

(D) the amount of funds proposed under the contract is in excess of the applicable funding level for the contract, as determined under section 450j-1(a) of this title; [and]

(E) the [PFSA] (or portion thereof) that is the subject of the proposal is beyond the scope of [PFSA's] covered [by the ISDA] because the proposal includes activities that cannot lawfully be carried out by the contractor.

The applicable funding level, as determined under 25 U.S.C. § 450j-1(a),

(1) . . . shall not be less than the . . . Secretary would have otherwise provided for the operation of the program or portions thereof for the period covered by the contract, without regard to any organizational level within . . . [HHS], . . . at which the [PFSA] or portion thereof including supportive administrative functions that are otherwise contractible, is operated.

(2) There shall be added to the amount required by paragraph (1) contract support costs

(Emphasis added). As previously noted, the amount required by paragraph (1) is typically referred to as the "section 106(a)(1) amount" or the "Secretarial amount" (Tr. 359).

Once the Secretarial amount is determined and awarded to a tribe under an ISDA contract, that amount may not be reduced by the Secretary in subsequent years except under very limited circumstances. 25 U.S.C. § 450j-1(b)(2). "Notwithstanding any other provision [of the ISDA], the provision of funds under [the ISDA] is subject to the availability of appropriations and the Secretary is not required to reduce funding for programs, projects, or activities serving a tribe to make funds available to another tribe or tribal organization under [the ISDA]." 25 U.S.C. § 450j-1.

With regard to the Tribe's appeal, "the Secretary has the burden of proof to establish by clearly demonstrating the validity of the grounds for declining the contact proposal (or portions thereof)." 25 U.S.C. § 450f(e)(1); accord 25 C.F.R. § 900.163. The legislative history of 25 U.S.C. § 450f(e)(1) and the preamble to the implementing regulation, 25 C.F.R. § 900.163, indicate that the "clearly demonstrates" standard is an intermediate standard that is higher than a "preponderance of the evidence" standard but lower than a "clear and convincing evidence" standard. See 140 Cong. Rec. H11140-01, H11142-43; 140 Cong. Rec. S14677-02; 61 Fed. Reg. 32,482, 32, 497 (June 24, 1996).

Factors or Standards Relevant to a Proper Determination of the Secretarial Amounts

IHS's partial declination was based primarily upon the ground that the proposed funding for each of several PFSA's exceeded the amount the Secretary would have otherwise provided (the Secretarial amount). IHS has the burden of clearly demonstrating the validity of this ground for declination.

Its validity depends upon whether IHS correctly determined the Secretarial amounts. A major point of contention is what factors and/or standards are relevant to a proper determination of the Secretarial amounts.

The Tribe argues that TAO improperly limited its search for available funds to the funds previously allocated by IHS Headquarters to TAO for the PFSA's in question. The Tribe maintains that "[i]f funds are available anywhere in the agency that have not been previously allocated to another tribe, they must be made available under the directive language of [25 U.S.C. §] 450j-l(a)(1) to fund ISDA contract proposals." (Tribe's opening posthearing brief, p. 29).

The Tribe's position was specifically rejected in California Rural Indian Health Board v. Shalala, No. C-96-3526 (N.D. Cal. 1998). In that case, a tribal organization, which proposed to contract with IHS under the ISDA, argued that the Secretary and others violate the ISDA by not making available to ISDA contractors "other available agency funds not otherwise obligated to particular Tribal programs." Id., p. 23. The court ruled that "the agencies' decision to retain and/or distribute otherwise unobligated funds is not inconsistent with the ISDA" Id., p. 24.

More importantly, the Tribe's position is contrary to the Supreme Court's holding in Lincoln v. Vigil, 508 U.S. 182 (1993). In Lincoln, the Court found that an IHS decision to discontinue a program was unreviewable under 5 U.S.C. § 701(a)(2) because the decision was committed to agency discretion in that the relevant statutes (the Snyder Act, IHCA, and lump-sum appropriations act) were drawn so that a court would have no meaningful standard against which to judge the agency's exercise of discretion. 508 U.S. at 190-93.

The Court reasoned that a fundamental principle of appropriations law is that a lump-sum appropriation without statutory restrictions as to what can be done with the funds gives rise to a clear inference that Congress does not intend to impose legally binding restrictions. Id. at 192. As long as the agency allocates the funds to meet permissible statutory objectives, courts may not intrude under § 701(a)(2). Id., at 193. While the holding in Lincoln was qualified by recognition of the possibility that the applicable operative statute(s) might circumscribe or restrict the agency's discretion, id. at 193, the Court also recognized that the Snyder Act and IHCIA speak in general terms about Indian health and lack any restrictions on program funding allocations. Id. at 194-95.³

Relevant HHS precedent is also contrary to the Tribe's position. See Native American Center of Recovery, DAB No. C-93-083 (Decision, November 12, 1993). In Native American Center of Recovery, Administrative Law Judge Mimi Hwany Leahy found, "Where [a tribal organization] requires \$299,276 to provide services under the proposed [ISDA] contract, and has no funds allocated for the purchase of those services and does not choose to reallocate funds as suggested by [the tribal organization], IHS properly [declined the tribal organization's proposal]." Citing to Lincoln, Judge Leahy reasoned, "While IHS has the discretion to take funds from its lump-sum appropriation and reallocate them between programs, [a tribal organization] cannot compel IHS to do so."

In sum, IHS is not required to make available for the Tribe's ISDA contract unobligated funds anywhere in the agency that have not been previously allocated to another tribe. It need only make available those funds which the Secretary would have otherwise provided, and the sources of those monies typically are those at any Departmental level allocated for the PFSA's in question. IHS has no legal obligation to reallocate funds to those PFSA's to fund the Tribe's contract. In fact, its allocation of funds among the PFSA's is not reviewable.

This is not to say that the this office has no jurisdiction to review what funds existed and the purposes of those funds. To determine whether the Secretarial amount was truly lower than the Tribe's proposed funding level so that the ground for declination was valid, an administrative

³ Admittedly, Lincoln deals with judicial review of agency allocations, whereas this case involves administrative review of such allocations. Nevertheless, it remains a fact that the agency is far better equipped than a reviewing official, whether from the judicial or executive branch, to deal with the many variables involved in the proper ordering of the agency's priorities. See Lincoln, 508 U.S. at 193. In the absence of restrictions on the agencies' discretion in the operative statute(s), the complicated balancing of a number of factors required to allocate a lump-sum appropriation is peculiarly within the agency's expertise and should not be second-guessed post hoc.

law judge must be able to scrutinize whether IHS' determination of the Secretarial amount in the declination letter is based upon an accurate reflection of the funds allocated at all organizational levels of HHS for the PFSA's in question

The judge is not bound to accept, without scrutiny, IHS prehearing representations, in the declination letter or elsewhere, of the funds so allocated, but must hold the Secretary to her burden of proving the accuracy of such representations at hearing. If this office does not have such jurisdiction, the ability of the Secretary, through hearings held by this office, to carry out her statutory and regulatory duty to independently review declinations based upon insufficient funds would be undermined.

II.

IHS Considered All Available Funds

IHS met its burden of showing that it considered all funds allocated at all organizational levels of HHS for the PFSA's in question. The tribe's blanket allegation that other funds were available but not considered is simply not supported by the evidence adduced.

Only three funds were identified by the Tribe as available but not considered by TAO: the IHS Director's Emergency Fund, the Management Initiative Fund, and the CHS Reserve Fund. None of these funds are, or were, available for the purpose of funding the PFSA's in question on a recurring basis.

The evidence shows that the Emergency Fund and Management Initiative Fund are sub-activities of the sub-activity "Hospitals and Clinics" (Tr. 1252-53, 1255, 1508). Each year the Director takes off the top of the Hospital and Clinics allocation approximately \$4,000,000 and \$1,900,000 for the Emergency Fund and Management Initiative Fund, respectively (Tr. 1234-39, 1254-55, 1265-68, 1281-83, 1474-75, 1489-90, 1922-23). The amount, use, and distribution of these funds is governed by IHS policy (see, e.g., Ex. W) reached through agreements between the IHS Director and advisory groups of tribal representatives (Tr. 1472-73, 1478-81, 1488, 1491-93, 1501-10).

The Emergency Fund, as the name implies, is used to fund non-recurring, emergency needs for funding, such as funding to continue service when a health care facility is destroyed by fire or to address an epidemic (Tr. 1235, 1470-73, 1488, 1496-97, 1502-03, 1923). The IHS Director's Office determines when an emergency situation exists that warrants a distribution of funds (Tr. 1205, 1471). The fund is used only rarely (Tr. 1236-37). Any monies remaining in the Emergency Fund at the end of the fiscal year are distributed as tribal shares to each of the 530 tribes on a pro rata basis in accordance with their user populations (Tr. 159-60, 164, 1237-40, 1472-73, 1488, 1492).

Pursuant to agreement with the tribal groups, the Management Initiative Fund is used to fund non-recurring funding needs for Management-type activities, such as consultations with tribes, special investigative studies, travel, lodging, and meals for tribal advisory groups, meetings, and compliance with settlements and orders of judicial proceedings (Tr. 1241-43, 1269-70, 1474-75, 1502-04, 1888-91). Any funds remaining in this fund at the end of the fiscal year, like those in the Emergency Fund, are distributed as tribal shares on a pro rata basis to each of the 530 tribes based on their user populations (Tr. 1241-43, 1267-68).

Similar to the Emergency Fund, the CHS Reserve Fund is administered at Headquarters to meet non-recurring, unanticipated needs for health services for which an Area program lacks sufficient funding (or expertise) (Tr. 1247-50, 1268; Ex. W, p. 62). Approximately \$1,400,000 is taken off the top of the CHS allocation for this fund (Tr. 1268). Monies remaining on August 15 of each fiscal year are distributed to the Areas for distribution to IHS and tribal programs (Tr. 1249).

The Tribe argues that use of the Emergency Fund to fund the Tribe's HMO program in FY 1997 is evidence that the fund, in fact, is available to fund the program and that such funding could be made recurring in subsequent years. This argument is not supported by the evidence.

Use of the Emergency Fund to fund the Tribe's ISDA contract proposal would violate the policy and agreement between the Director and the tribal advisory groups to use the funds only for non-recurring, emergency needs and then distribute any unused funds to all tribes on a pro rata basis (Tr. 1472). As previously mentioned, the supplemental funding in FY 1997 was provided on a non-recurring, emergency basis as a stop-gap measure to insure continuity of health care for the Tribe while affording TAO more time to resolve the recurring need for additional funding. The Director expected that TAO would avert any future emergency need for funding by such means as negotiating or soliciting a new scope of health care services within recurring resources prior to the November 30, 1997, expiration of the HMO contract extension. Likewise, use of the Management Initiative Fund to fund the Tribe's ISDA contract proposal would violate the policy and agreement between the Director and the tribal advisory groups to use the fund only for non-recurring, management-type needs and then distribute any unused funds to all tribes on a pro rata basis (Tr. 1480-81, 1502-04).

If either the Emergency Fund, the Management Initiative Fund, or the CHS Reserve Fund were used to increase the amount awarded to the Tribe under the ISDA, that amount could not be reduced in subsequent years, except under very limited circumstances. See 25 U.S.C. § 450j-1(b). IHS would be forced to take funding from some other tribe or program to continue funding the Tribe's ISDA contract at the increased level while still maintaining the Emergency Fund at \$4,000,000, the Management Initiative Fund at \$1,900,000, and the CHS Reserve Fund at \$1,400,000.

Such a reallocation of funding cannot be forced upon IHS. Those funds are, and were, unavailable for distribution to the Tribe under the ISDA. They are not funds which the Secretary would have otherwise provided to the Tribe for such recurring funding.

As evidenced by the Director's actions in FY 1997, a shortfall in funding may be treated as an emergency justifying reliance upon the Emergency Fund until other measures are taken to address the shortfall. In future years, if the Congressional reopening of enrollment results in extraordinary increases in the Tribe's user population which creates another such emergency, the Director has discretion to rely upon the Emergency Fund again, to lobby Congress for additional funding, to negotiate or solicit a new scope of health care services within recurring resources, or to take other action.

While IHS considered all available funding sources, questions remain as to what is the precise Secretarial amount from those sources and whether allocation of the monies from those sources to the potential beneficiaries, including the Tribe, is subject to an equitable standard.

III.

The Determinations of the Secretarial Amounts Must Be Made Pursuant to Criteria Which Are Rationally Aimed at an Equitable Distribution of Funds to Potential Beneficiaries

The Tribe cites various authorities and pieces of evidence in support of the proposition that IHS has a duty to provide equitable health care funding to the Tribe. One of those authorities, Rincon Band of Mission Indians v. Harris, 618 F.2d 569 (9th Cir. 1980), contains the holding that "IHS has a 'continuing obligation under the Snyder Act to distribute rationally and equitably all of the available Program funds.'" Id. at 573 (quoting Rincon Mission Band of Indians v. Califano, 464 F.Supp. 934, 937 (N.D. Cal. 1979)). The Tribe concludes that the determination of the Secretarial amount for the ISDA contract is an allocation of funds which must be, but was not, equitable.

IHS contends that the continued vitality of the Rincon holding is suspect in light of the Supreme Court's holding in Lincoln. That holding is distinguishable from the Rincon holding in that the former involved discontinuation of a program (the allocation of funds among programs) while the latter pertained to the standards or criteria for allocating funds to those potentially eligible to receive them under a particular program.

The Rincon holding was based upon another Supreme Court case, Morton v. Ruiz, 415 U.S. 199 (1974), in which the Supreme Court outlined the general principles for the allocation of funds under the Snyder Act. 618 F.2d at 572. Under Rincon, if funding is inadequate to provide for the needs of all eligible beneficiaries,

it would be incumbent upon the [administering agency] to develop an eligibility standard to deal with this problem, and the standard, if rational and proper, might leave some of the class otherwise encompassed by the appropriation without benefits. But in such a case the agency must, at a minimum let the standard be generally known so as to assure that it is being applied consistently and so as to avoid both the reality and the appearance of arbitrary denial of benefits to potential beneficiaries.

415 U.S. at 230-31.

As noted in Rincon, Ruiz requires IHS to establish and to consistently apply a reasonable standard for the allocation of its limited health services and facilities budget. 618 F.2d at 572. Because the Supreme Court stressed prevention of arbitrary denials of benefits, the court in Rincon reasonably inferred that the Supreme Court also intended that the agency develop criteria for distribution that are rationally aimed at an equitable division of its funds. Id. This inference was found consistent with a previous holding that Ruiz stands for the principle that our government has an overriding duty of fairness when dealing with Indians. Id. (citing Fox v. Morton, 505 F.2d 254, 255 (9th Cir. 1974)). While Lincoln holds that the Snyder Act contains no meaningful standard for adjudging the agency's exercise of discretion in allocating funds among programs, this holding is not inconsistent with the holding in Ruiz and its extrapolation in Rincon so as to require the development of criteria rationally aimed at an equitable division of funds to potential beneficiaries of whatever programs IHS chooses to fund under the Act.

IHS attempts to distinguish Rincon upon the basis that it "involved a challenge under the Snyder Act . . . , not the [ISDA]" (IHS posthearing reply brief, p. 2). IHS argues that the ISDA contains no standards to apply to the determination of the amount which the Secretary would have otherwise provided:

The determination is not what the Secretary "should" provide because section 106(a)(1) does not provide any set standard for how much a tribe should receive based on a hypothetical future need. The ISDA is simply a contracting statute. The purpose of ISDA is to permit a tribe to assume a program which IHS is currently administering at the level of funds currently associated with the program. ISDA is not intended to address a myriad of other issues related to equity or standards for funding. Rather, its purpose is merely to identify the amount to which a tribe is entitled based on what the IHS is spending at the time the proposal is received.

(IHS's opening posthearing brief, p. 43). IHS concludes that the Interior Board of Indian Appeals (which referred the case to this office for recommended decision) is not a court of general jurisdiction and has no authority to review a Snyder Act claim.

Although all ISDA appeals are filed with the Board, this office acts on behalf of the HHS secretary, and not the Board, in holding a hearing and issuing a recommended decision for those cases relating to HHS action. See 25 C.F.R. § 900.165(b); 61 Fed. Reg. 32482, 32496, 32528 (June 24, 1996). Consequently, the jurisdiction of the Board is irrelevant.

More importantly, the ISDA directive to provide funding not less than the Secretary would have otherwise provided necessarily implicates consideration of the laws governing the provision of those funds in the absence of an ISDA contract proposal. That law includes the judicially recognized requirement (Rincon) under the Snyder Act that the allocation of funds should be made pursuant to criteria which are rationally aimed at an equitable distribution of the funds to potential beneficiaries.

In other words, the ISDA is not a self-funding statute, but a statute that gives tribes the means for contracting for services that are otherwise available from IHS pursuant to its allocations and expenditures under the Snyder Act and the IHCA. Native American Center of Recovery v. IHS, DAB No. C-93-083 (Decision, November 12, 1993). Thus, the standards governing funding allocations under those statutes must pertain to the Secretary's determination of the amount which she otherwise would have provided.

It follows that a legitimate issue for review is whether IHS' determination of the amount the Secretary would have otherwise provided was made pursuant to criteria which are rationally aimed at an equitable distribution of the funds to potential beneficiaries, i.e., all tribes receiving IHS health care services or funding for the PFSA's at issue.

IV.

Are the Criteria Rationally Aimed at an Equitable Distribution of Funds?

The issue of whether the criteria applied by IHS are rationally aimed at an equitable distribution of health care services comes into play with respect to the disputes over whether the Secretarial amounts were properly determined for CHS and the Tribe's headquarters share.

A.

CHS Funding

For CHS, the Tribe proposed funding of \$9,721,263, comprised of the following amounts: \$9,343,277 for the HMO, \$151,528 for other CHS services to be paid on a fee-for-service basis, \$185,178 for dental service, \$32,655 for patient advocate PFSA's, and \$50,453 for home health service PFSA's (Ex. A; Ex. B, pp. 3-7; Ex. HH). IHS determined that the Secretarial amount for CHS was much less: \$4,313,836 (Ex. HH).

The Tribe argues that a rational and equitable distribution must provide sufficient funding to cover the monthly premiums for each Tribal member eligible to participate in the HMO program, with no reduction in the present benefit package. In support of this argument, the Tribe asserts:

The denial of HMO benefits to some Pasqua Yaqui members would be neither rational nor proper in this situation. . . . Because the benefits received under the HMO are similar to those received by the other tribe in the TAO and because there is no viable alternative to the HMO that would allow rationing of services among all eligible Yaqui members, there is no "rational" or "proper" way for the IHS to distribute care among Tribal members other than to fully fund the HMO until an alternative is available. Thus, . . . adequate funding to provide HMO coverage for all eligible Yaqui is the only equitable and rational solution in this situation.

(Tribe's posthearing reply brief, pp. 16-17).

The premises of this argument are (1) that the Tribe has been receiving a health care package that is similar to that received by TON, (2) that this similarity shows that the Tribe has been receiving a health care package that is similar, but not superior, to that received by the average tribe, and (3) that if the Tribe's HMO benefit package were reduced, its package would be no longer similar but inferior to that of the average tribe and thus would be inequitable. Premises (2) and (3) are not born out by the facts and premise (1) is in need of qualification.

The evidence shows that the Tribe's HMO health care package is, at worst, an average package of services and that its access to those services is well above average. While its package is similar to TON's health care package, there was no testimony that TON's benefit package is an average benefits package. There was testimony from Dr. Austin that the Tribe's package is comparable to the majority of tribes but his testimony was countered by that of Mr. Wiggins who stated that it was more like the packages of tribes with newer and better funded facilities.

The primary measure used by IHS to determine whether the distribution of health care services is equitable is per capita funding based on user populations. As calculated by Mr. Wiggins, the Tribe's FY 1998 per capita funding level of \$1,960.00 (Ex. II; Tr. 58) is more than \$600 above the FY 1998 average per capita funding level of \$1,328.00 for all tribes (Tr. 107-08). However, the FY 1998 figures include approximately \$2,000,000 in additional funds allocated to the Tribe's program in FY 1998, after issuance of the declination letter. At the time of the declination letter, without the additional \$2,000,000 (or approximately \$490 per each of the 4,069 Tribal users), the Tribe's funding would still have been above average.

Other IHS measures of equity include the outpatient usage rate per user and the inpatient usage rate per 1,000 users, which indicate health care access and utilization levels. Significantly,

both the Tribe's outpatient and inpatient usage rates are well above average and substantially higher than those of TON (Tr. 67-74; Ex. JJ, KK).

These figures are consistent with Ms. Guerra's testimony that the Tribe's access to services may be better than that of TON because some of TON's services are subject to rationing and deferral. As the Tribe has repeatedly acknowledged, its HMO services, unlike other CHS services received by other tribes, are not subject to rationing or deferral (Tribe's opening posthearing brief, p. 23 n.6; Tribe's posthearing reply brief, pp. 8, 16).

The Tribe promotes sufficient funding to maintain the same level of services for all its existing and reasonably anticipated future members in FY 1998. The record strongly suggests that this method would not necessarily achieve equity but would provide the Tribe with better than average access to at least an average package of services.

The Tribe concedes that "[t]his case would have a very different complexion if the HMO members were receiving service levels superior to that provided to similarly-situated tribal members, but the evidence shows that that is simply not the case." (Tribe's opening posthearing brief, p. 23) To the contrary, the evidence does show that the Tribe is receiving superior service in that it is receiving much better than average access to at least an average package of services.

The Tribe criticizes the outpatient and inpatient utilization rates for failing to include a measure of overall healthiness of particular tribal or area populations. It references the possible effect of high rates of diabetes in the Tribe's area on utilization rates in the area, but neglects to mention the evidence that utilization rates in other areas are affected by high rates of other health problems (Tr. 188-89, 209). More importantly, two work groups with tribal and IHS participation have examined utilization of user population figures as a basis for funding allocations and have recommended to the IHS Director adoption or continuation of the present allocation system based upon user populations (Ex. H). They specifically rejected use of a health status measure for a variety of cogent reasons, and the Tribal Co-Chair of one of those groups was the Tribe's representative, Mr. Ramirez (Ex. H, p. 13).

The Tribe also attacks IHS' per capita funding comparisons as being simplistic. Because IHS was responsible for choosing the unique HMO delivery system for the Tribe, it argues that any applicable definition of equity in this instance must measure what comes out of the system and not simply what goes into the system. Certainly, in an ideal world, IHS would gauge equity by a direct measure of the quality of care provided to each tribe. However, the Tribe has not identified such a measure and it is difficult to conceive of one that could reliably, effectively, and efficiently measure something so inherently difficult to measure.

Before addressing other criticisms of the Tribe, it is important to note that this office's function is not to attempt to conceive of possible better methods for IHS to carry out its discretionary allocations of funds. Because decisions allocating funds among tribes are based on

the exercise of discretion, this office should not substitute its judgment for that of IHS, but rather, should seek to ensure that proper consideration was given to all legal prerequisites to the exercise of that discretion and that the discretionary decision was reasonable or rational. See Ponca Tribe of Oklahoma v. Acting Anadarko Area Director, 22 IBIA 199, 203 (1992) (similar holding regarding review of funding allocation decisions made by the Bureau of Indian Affairs (BIA), U.S. Department of the Interior); see also Kaw Nation v. Anadarko Area Director, 24 IBIA 21, 30 (1993) (also pertaining to BIA funding allocations). The legal prerequisites in this case are that the Secretary provide funding in the amount that she would have otherwise provided and that the criteria by which IHS determined the Secretarial amount must be rationally aimed at an equitable distribution of funds to all of the potential beneficiaries (approximately 530 tribes).

The Tribe argues that reliance on the user population funding formula to distribute funds from the Indian Health Service appropriation does not result in equity because (1) its user population does not equal its HMO enrollment, (2) economies of scale will influence the effectiveness of each dollar spent, (3) the Tribe, unlike tribes receiving DS, does not have access to a particular alternative funding source, namely Medicare/Medicaid reimbursements which are received by DS facilities and then reinfused into the health care of the tribes using the DS facilities, (4) the formula does not account for funding for equipment or facilities and other indirect health care costs of providing DS to other tribes which are dispersed from sources other than the Indian Health Service appropriation but which are internalized costs included in the HMO capitated rate, and (5) the HMO internalizes other costs paid by IHS on behalf of the Tribe that are "externalized" for other tribes. None of these arguments withstands scrutiny.

The Tribe argues that it is illogical and inappropriate to rely upon user population figures to determine an equitable distribution of funds to a tribe utilizing an HMO because the HMO premiums must be prepaid for each HMO enrollee regardless of whether he or she has used the HMO services. However, as of June 1997, the difference between the HMO enrollment of 4,184 (Ex. LL) and the user population of 4,069 was relatively nominal.

Certainly, reliance upon user population figures may be misleading if funding is such that persons eligible to join the HMO are precluded from doing so, thus reducing the potential user population by a form of rationing. However, the potential user populations of other tribes may also be subject to reduction through the ongoing rationing of CHS services.

More importantly, there is no evidence that eligible persons have been excluded from the HMO because of inadequate funding. In the absence of such evidence, statistics based upon user populations provide a rational basis for determining what the eligible beneficiaries have actually been receiving and hence whether the distribution among them is equitable.

As noted by Mr. Wiggins, "It's my personal experience that [user population] is the best. It's the simplest measure and the broadest measure of who's actually using the system or obtaining services." (Tr. 55, 56).

The Tribe faults IHS for relying upon past user population figures when the Tribe's population and HMO enrollment are increasing at rates above the average two to three percent increase in user populations. The two work groups which examined utilization of user population figures to allocate funding recommended to the IHS Director adoption or continuation of the present allocation system based upon user populations, and the Tribe's representative co-chaired one of the groups (Ex. H).

As previously noted, the tribes wanted a stable base for determining tribal shares and user population, which grows on average at only two to three percent per year, fit the bill. The Tribe has presented no evidence contradicting IHS' evidence that user population is generally a stable base for apportioning funding to all the tribes.

Further, Mr. Wiggins expounded that IHS needed to use baseline data that was available for all tribes (Tr. 178). Past user population figures were available for all tribes, whereas present or near current tribal enrollment data was not so available (id.).

This does not mean that the ongoing and projected unusually large increases in user population are insignificant or should be ignored. However, to say that IHS should have based the Tribe's Secretarial amount on projections of user population or HMO enrollment is to say that IHS should do the same for all tribes, as IHS is duty bound to consistently apply the same criteria with respect to all tribes to avoid the reality or the appearance of arbitrariness. See Ruiz, 415 U.S. at 230-31; see also Rincon 619 F.2d at 572.

Such a system would invite unfairness, inconsistency, and chaos. Among other drawbacks, projections are necessarily fraught with uncertainty and easily subject to manipulation. It would be difficult to avoid the reality or the appearance of arbitrariness if projections were used.

Where, as here, funding is inadequate to provide for the needs of all eligible beneficiaries, the criteria, if rational and proper, might leave some of the class otherwise encompassed by an appropriation less well off than others in the class. See Ruiz, 415 U.S. at 230-31. For the criteria to be rational and proper, it is not necessary that their application result in an equal division of funds or an equal or full satisfaction of health care needs overall or in any particular case. Rather, the focus is on whether IHS consistently and objectively applied known criteria rationally aimed at an overall fair distribution of health care services. See id.; Rincon 618 F.2d at 572.

The last work group to evaluate how headquarters shares should be determined, recommended in a report dated January 15, 1998, that user population (based upon the three most recent years for which data is available) continue to serve as the determinant (Ex. H). The Tribal Co-Chair of that group was the Tribe's representative, Mr. Ramirez (id.).

Nevertheless, IHS did and does have some obligation to address the unusually large increases in the Tribe's user population which are ongoing and nearly certain to continue because of the Congressional reopening of enrollment. That obligation stems, at least in part, from U.S.C. §§ 450f(b)(2), 450h(d), which impose upon IHS the duty to provide technical assistance to the Tribe to develop any new self-determination contract, to provide for the Tribe's assumption of the relevant PFSA's, and to overcome any IHS objections to approving the Tribe's proposal by developing modifications to the proposal or otherwise.

IHS' actions in FY 1997 and FY 1998 are the type of actions which would serve to meet IHS' obligation to provide technical assistance. IHS treated the shortfall in funding for the Tribe in FY 1997 as an emergency justifying the use of the Emergency Fund. It also assisted the Tribe in its successful efforts to lobby Congress for additional funding and then allocated the funding in FY 1999.

When faced with unusual ongoing or near certain future increases in user population, IHS, at a minimum, should advise the tribe proposing to contract regarding its options, such as lobbying Congress for additional appropriations or petitioning the IHS Director for an allocation from the Emergency Fund. Until the large increases in the user population are reflected in the available data used to calculate "user population," the situation is certainly akin to experiencing an epidemic or some other emergency justifying the use of the Emergency Fund or additional Congressional appropriations. However, those courses of action must be left to the discretion of the IHS Director and Congress.

The Tribe states that Mr. Wiggins acknowledged that economies of scale may affect the per capita amounts. Mr. Wiggins noted that the economics of scale would affect large and small tribes but not mid-sized tribes such as Pascua Yaqui (Tr. 87, 323, 316-319).

The Tribe correctly notes that Mr Wiggins did not include in his analysis other sources of health care resources such as Medicare and Medicaid. Mr. Wiggins stated that he measured only those funds which IHS controls, *i.e.*, the IHS appropriation (Tr. 327). If the Tribe desired to compare all sources of funding for health care, then it could have introduced such evidence.

The Tribe argues that Mr. Wiggins' calculations are flawed because he did not include the Indian Health Facilities appropriation of \$247,731,000 in calculating the average per capita funding for all tribes. He did not include these funds in his calculations because the majority of the facility funds are earmarked for specific construction projects (Tr. 322). The Tribe contends that HMO facility costs are reflected in the Tribe's per capita funding figure but that facility costs are not reflected in the average per capita funding figure for all tribes.

However, the facility funds excluded were limited mostly to funds allocated to specific IHS facility construction projects. To the extent that any provider of services, HMO or non-HMO, accounted for facility costs in the billed charges, then such costs are included in

Mr. Wiggins' analysis. The private provider bills which IHS pays under the CHS program undoubtedly accounted for such costs or the providers would go bankrupt.

Moreover, even if the per capita figures for all tribes were recalculated to include the facilities appropriation, the Tribes' funding would be above average for FY 1998 and approximately average at the time of issuance of the declination letter (see Tr. 315; Ex. II).

Without citing any evidence in the record, the Tribe argues that the costs of malpractice insurance affect the per capita rates. The Federal Tort Claims Act (FTCA), 28 U.S.C. § 2679, deems suits against Federal employees acting within the scope of their employment as suits against the United States. Thus, a Federal employee working for IHS need not purchase malpractice insurance and the average per capita ratio for all tribes reflects this advantage.

The Tribe erroneously asserts that the HMO provider does not enjoy such an advantage. Ms. Guerra testified that the HMO Southwest Catholic delivers health care through a subcontract with the El Rio Health Center (Tr. 30). Mr. Howard testified that the director of El Rio is the president of a group comprised of all "neighborhood health centers." (Tr. 1557). A "health center" is defined in section 330 of the Public Health Service Act, 42 U.S.C. § 254b(a), as "an entity that serves a population that is medically underserved. . . ." Employees of health centers and health center contractors that are physicians or other licensed health care practitioners are deemed Federal employees for the purpose of the Federal Tort Claims Act. 42 U.S.C. § 233(g)(1)(A). Thus, to the extent that the HMO subcontracts with a health center, it also enjoys the protections of FTCA coverage afforded such an entity.

The Tribe argues Mr. Wiggins' charts include contact support costs received and requested by the Tribe, but exclude these same costs for the tribes served directly by IHS. For an analysis to be valid, one must either include or exclude all administrative-type costs for calculating the per capitas for IHS and the Tribe.

In FY 1998, Congress provided \$168,000,000 to the IHS to distribute to all tribes for contract support costs. Department of the Interior and Related Agencies Appropriations, 1998, Pub. L. 105-83, 105th Cong., 1st Sess (1997). These "contract support appropriations" are used only for contracting and compacting tribes. Although not labeled "Contract support costs," IHS clearly has similar administrative-type costs for operating its health care program for directly-served tribes (Tr. 269). Mr. Wiggins decided to include all administrative-type costs rather than excluding such costs both for contracting and directly-served tribes. Mr. Wiggins was asked if he should not have backed out contract support costs "to be fair." He responded, "No, I would say the opposite it true." (Tr. 227). Thus, Mr. Wiggins included all administrative-type costs in his analysis for both Pascua Yaqui and for IHS (Exhibit YY).

The Tribe asserts that there are incentives inherent in an HMO that could increase HMO utilization for inexpensive preventative care. Mr. Wiggins testified that such an incentive is "not

limited to HMOs," but that IHS facilities have similar incentives (Tr. 198). He concluded that even after considering all arguments and all the hypothetical possibilities raised by the Tribe, the total funding of the Pascua Yaqui contract still would exceed the IHS average (Tr. 300).

In sum, while it is clear that IHS plans should have taken into account the increase in potential users created by the 1994-1997 open enrollment for the Tribe, it is not the function of this office to second guess the agency in its disbursement of funds. Here, IHS based its declination, in part, on the grounds that the monies requested in the Tribe's proposal were in excess of the amount the Secretary would have otherwise made available. IHS met its burden of proof as to this contention.

IHS clearly demonstrated that it properly followed its own policies and criteria for allocation of funds, developed in consultation with tribal representatives, and those policies and criteria are rationally aimed at an equitable distribution of health care services to all the tribes. Consequently, the IHS-determined Secretarial amount of \$4,313,836 for CHS is upheld as appropriate and the IHS properly declined to fund the Tribe's CHS proposal in excess of this amount

B.

Headquarters Share Funding

The Tribe also challenges the IHS-determined Secretarial amount of \$166,993 for its headquarters share. IHS relied upon the user population figure of 3,839 to calculate the Tribe's headquarters share. The Tribe takes issue with the use of this figure, arguing that it should have been at least as high as the 4,069 user population figure employed to calculate the other Secretarial amounts. To the extent, if any, that its challenge is based upon the allegation that the criteria used by IHS are not rationally aimed at an equitable distribution, it is rejected for the reasons set forth in Part A of this section.

Further, IHS established that the 3,839 figure is the correct figure. For headquarters shares purposes, its policy was and is to recompute the user population figures only every three to five years. It showed that the 3,839 figure derived from the most recent computation for that purpose in approximately FY 1995 and that recomputation was not at hand at the time of declination.

The 4,069 user population figure was calculated from more recent data for other purposes. It is not the applicable figure for determining headquarters shares.

In sum, IHS met its burden of clearly establishing that \$166,993 is the proper Secretarial amount for the Tribe's headquarters share.

V.

Facilities Support Funding

The Tribe also proposed to receive monies from TAO's Facility Support fund. That fund is used to support the operation and maintenance of buildings belonging to TON at San Xavier. Consequently, IHS correctly determined that those funds are not available to the Tribe as monies the Secretary would have otherwise provided to the Tribe.

VI.

Residuals

The Tribe argues that the residual amounts determined by IHS for "Administration & Management" and "Chief Medical Officer" are too high and therefore that the Secretarial amounts for those PFSA's should be higher. As explained below, a decision cannot be rendered on this issue, but the matter is remanded to IHS for further action.

25 U.S.C. §450f(a)(2)(E) recognizes that under an ISDA contract certain activities cannot be provided by the contracting tribe, but must be performed by the government. These activities are referred to as "inherently federal activities", "inherently governmental activities", or, in the governmental vernacular, "residual functions" (Exs. OO, PP).

Whether an activity is inherently governmental is a matter for agency determination and possible review by the Office of Personnel Management (Ex OO, 57 Fed. Reg. 45101). In the present case, there is no dispute as to which functions are inherently federal activities, but the amount of funding required to carry out those residual functions, expressed as the necessary number of full-time equivalent positions (FTEs), is contested.

The Director of IHS set up a workgroup to develop principles and methods to determine what the residuals would be in a 100% ISDA-contracted or compacted environment in which the tribes take over all health service contracts for an area (Ex. PP). TAO, following IHS policy, negotiated the number of FTE's for the residual functions with the three entities in the area, the Tribe, TON and the Urban Program. They did not come to a meeting of the minds. Because two of the three interested entities are not parties to the instant matter, I would be remiss in rendering recommended FTE's for the residual functions.

However, it is appropriate to direct IHS to determine the FTE's for the residual functions either through negotiations with, or issuance of an appealable decision to, all of the interested parties. Cf. Chitina Traditional Village Council v. Juneau Area Director, Bureau of Indian Affairs, 31 IBIA 100, 103-04 (1997) (upholding a declination of an ISDA contract proposal but remanding the matter with instructions to BIA to provide technical assistance in the form of a

determination of the appellant's service area/population either through negotiation or issuance of an appealable decision). This determination constitutes technical assistance which IHS is required to provide after a declination decision under 25 U.S.C. § § 450f(b)(2), 450h(d) and 25 C.F.R. § 900.30. IHS must make the required determination within 90 days of the date of this decision.

Conclusion

Based upon the foregoing, the declination letter, as subsequently modified to correct minor errors in the amounts approved (see addendum to this Recommended Decision), is upheld and the matter is remanded to IHS for determination of the FTE's for the residual functions either through negotiations with, or issuance of an appealable decision to, all of the interested parties within 90 days of the date of this decision.⁴

//original signed
Nicholas T. Kuzmack
Administrative Law Judge

⁴ Should the Tribe accept the partial approval of their proposal, they should be placed on the CSC priority list based upon a requested start date in FY 1998 and a proposal receipt date of July 21, 1997.

Pascua Yaqui Proposal (July 21, 1997)
and IHS Declination (October 20, 1997) with Corrections

A	B	C	D	E	F	G	H	I	J	K
Activities	July 21, 1997 Pascua Yaqui Proposal	October 20, 1997 Declination Letter	FY 1997 Tucson Area Allowance	FY 1997 Tucson Area Residual Amount	FY 1997 Tucson Area Allow. Subject to Tribal Shares	Encumbered Resources	Liquid Resources	Tribal Share Percentage	Pascua Yaqui Share of Liquid Resources	Pascua Yaqui 106(a)(1) Amount
		As Corrected on 12/15/97 Tables	(As of 9/30/97)	(As of 9/30/97)	(D - E)	(Computed from Residual & Encumbered Table)	(F - G)	(.1788 or 1.00)	(H x I)	(F x I)
Administration & Management	\$205,125	\$42,036	\$2,151,908	\$1,234,990	\$916,918	\$681,818	\$235,100	17.88%	\$42,036	\$163,945
Chief Medical Officer	\$78,528	\$16,435	\$254,796	\$162,876	\$91,921	\$0	\$91,921	17.88%	\$16,435	\$16,435
AIDS Coordinator	\$15,191	\$1,669	\$84,959	\$0	\$84,959	\$75,623	\$9,336	17.88%	\$1,669	\$15,191
Pascua Yaqui Health System Delivery	\$82,734	\$17,207	\$82,734	\$0	\$82,734	\$65,527	\$17,207	100.00%	\$17,207	\$82,734
Mental Health	\$50,453	\$34,563	\$50,453	\$0	\$50,453	\$15,890	\$34,563	100.00%	\$34,563	\$50,453
Social Services	\$25,024	\$0	\$151,626	\$0	\$151,626	\$0	\$151,626	0.00%	\$0	\$0
Alcohol/Sub- stance Abuse	\$186,015	\$45,226	\$531,548	\$0	\$531,548	\$278,604	\$252,944	17.88%	\$45,226	\$95,041
Facilities Support	\$22,627	\$0	\$126,550	\$0	\$126,550	\$0	\$126,550	0.00%	\$0	\$0
Total Area Program and Shares	\$665,697	\$157,137	\$3,434,574						\$157,137	\$423,799
Contract Health Services	\$9,721,263	\$3,571,336	\$4,313,836	\$0	\$4,313,836	\$742,500	\$3,571,336	100.00%	\$3,571,336	\$4,313,836
Headquarters Shares	\$166,993	\$77,079	\$166,993	\$0	\$166,993	\$89,914	\$77,079	100.00%	\$77,079	\$166,993
Totals as Corrected	\$10,553,953	\$3,805,552	\$7,915,403	\$1,397,866					\$3,805,552	\$4,904,628