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Gila River Indian Community and
Gila River Health Care

THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF ARIZONA

GILA RIVER INDIAN COMMUNITY, a federally-recognized Indian tribe; and GILA RIVER HEALTH CARE CORPORATION, a wholly-owned and subordinate entity of the Gila River Indian Community, Plaintiffs, v. UNITED STATES DEPARTMENT OF VETERANS AFFAIRS; and ROBERT A. McDONALD, Secretary, United States Department of Veterans Affairs, Defendants.	No. **COMPLAINT**

In 2010, the Patient Protection and Affordable Care Act ("ACA") was enacted. One goal of the ACA was to improve health care access and delivery for Native Americans. A provision in the ACA allows Indian tribes to be reimbursed for health care provided to

veterans and states:

> The Service, Indian tribe, or tribal organization shall be reimbursed by the Department of Veterans Affairs or the Department of Defense (as the case may be) where services are provided through the Service, an Indian tribe, or a tribal organization to beneficiaries eligible for services from either such Department, notwithstanding any other provision of law.

25 U.S.C. § 1645(c). This law provides that, if an Indian tribe or tribal organization provides health care services to an individual who is otherwise eligible for care from the VA, the VA must reimburse the Indian tribe or tribal organization for the services provided. Despite this plain and mandatory language directing the Department of Veterans Affairs ("VA") to reimburse Indian tribes and tribal organizations for health care services provided to veterans, the VA refuses to do so unless Indian tribes and tribal organizations agree to conditions well beyond the plain language of the law and which reduce the reimbursements that Indian tribes are entitled to under the law.

Because of the VA's refusal to follow the law, Plaintiffs Gila River Indian Community and Gila River Health Care Corporation make and file this Complaint against Defendants and allege as follows:

THE PARTIES

1. Plaintiff, Gila River Indian Community (the "Community"), is a federally-recognized Indian tribe with its headquarters in Sacaton, Arizona and occupies the Gila River Indian Reservation on lands located in Pinal and Maricopa Counties in Arizona.

2. Plaintiff, Gila River Health Care Corporation ("GRHC"), is a wholly-owned and subordinate tribal entity of the Community, and has been designated responsibility as a tribal organization in providing health care services pursuant to the Indian Self-Determination and Education Assistance Act ("ISDEAA").

3. Defendant, United States Department of Veterans Affairs ("VA"), is an executive agency, department, or instrumentality of the United States government.

4. Defendant, Robert A. McDonald, is the Secretary of the United States Department of Veterans Affairs (the "Secretary"), and has the overall responsibility for carrying out functions, duties and responsibilities of the VA, including the provision of reimbursements for health care services in accordance with 25 U.S.C. § 1645(c). His office is located in Washington, D.C. and he is sued in his official capacity.

5. As used throughout this Complaint (and unless context commands otherwise), the terms "Secretary" and "VA" are used interchangeably.

6. As used in this Complaint (and unless the context commands otherwise), the terms "Community" and "GRHC" are used collectively.

JURISDICTION AND VENUE

7. This action includes claims for mandamus, injunctive and declaratory relief, and violations of federal statutory duties to compel the VA to pay medical expenses for eligible veteran care as required by 25 U.S.C. § 1645(c).

8. The Court has jurisdiction over this action pursuant to 28 U.S.C. § 1331 (federal question), 28 U.S.C. § 1361 (original jurisdiction over mandamus actions to compel an agency to perform its duties), and 28 U.S.C. § 1362 (original jurisdiction over actions brought by Indian tribes under the Constitution, laws or treaties of the United States).

9. The Court is authorized to grant declaratory judgment and further relief pursuant to 28 U.S.C. §§ 2201 and 2202.

10. Judicial review of the VA's administrative actions is authorized pursuant to Chapter 7 of the Administrative Procedures Act (the "APA"), 5 U.S.C. §§ 701-706.

11. Venue is proper under 28 U.S.C. §§ 1391(b)(2), 1391(e) and 5 U.S.C. § 703 because a substantial part of the events giving rise to the claim occurred in this District and also because the Community's tribal headquarters are located in this District.

GENERAL ALLEGATIONS

a. Health care is provided to Native and non-Native Veterans through the Community and GRHC

12. The Community and GRHC provide certain health care services through a compact of self-governance with the United States Indian Health Service ("IHS"), dated October 1, 2002, under Title V of the ISDEAA (the "Compact"), and through separate funding agreements negotiated between the Community and IHS on an annual or multi-year basis (a "Funding Agreement").

13. Through its wholly-owned entity, GRHC, the Community provides a broad range of "direct services" care that can be provided by GRHC staff at GRHC facilities and contract health services (also referred to as purchase/referred care) ("CHS" or "PRC") when referral to an outside provider is medically necessary and other criteria are met.

14. While direct services care and PRC services are primarily provided to Native American patients of GRHC, eligibility for both types of services provided through GRHC can include certain care to individuals who are not Native Americans ("non-Natives").

15. For example, Section 813 of the Indian Health Care Improvement Act, as added by the ACA, specifically allows the Community and GRHC to provide direct care services to a broad range of non-Natives on a fee for service basis.

16. Eligibility for direct care services and PRC services has also long been extended to non-Natives based on certain care or relationships, for example, including care for a non-Native woman pregnant with an eligible Native's child, certain other care for spouses and children of an eligible Native, stabilization of those in need of emergency care, and care for the prevention of communicable diseases (see, e.g., 25 U.S.C. § 1680c).

17. The Community and GRHC further provide such direct and PRC health care services to both Native and non-Native veterans even if they are entitled to coverage or eligibility through the VA as well.

b. Tribal Health Care Resources are underfunded

18. Federal budgets for both direct care services and PRC services have historically been underfunded.

19. The underfunding of tribal health care and the adverse impact on Native American populations has been long recognized by the United States and Congress and documented in studies conducted by government bodies including the United States General Accountability Office (the "GAO"). See, e.g., GAO-05-789 (report on health care services not available to Native Americans); GAO-11-767 (report on estimating unfunded contract health services); GAO-14-57 (report on opportunities to improve contract health services); GAO-13-553 (report on expanded options for Native Americans under PPACA).

20. Congress has taken several steps over the years to alleviate the underfunded health care burden on Native American populations. For example, under the Indian Health Care Improvement Act ("IHCIA"), 25 U.S.C. § 1621e, Congress enacted a statutory framework to enhance the ability of tribal health programs to secure third party reimbursements for the cost of health services otherwise covered through a tribal health program.

21. In 1999, a federal "payor of last resort" ("PLR") regulation, 42 CFR § 136.61, was adopted to confirm that Indian Health Services would pay secondary to other programs and private insurance "notwithstanding any State or local law to the contrary".

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c. ACA strengthens Tribal PLR rights and specifically calls for reimbursements from VA

22. On March 23, 2010, the ACA was signed into law, making several statutory reforms designed to improve the level of care and health services available to Native Americans.

23. One of the key ACA changes was the enactment of a statutory PLR rule, that not only confirmed that tribal health programs would pay behind other programs, notwithstanding state or local law to the contrary, but confirmed that tribal PLR rights also superseded federal law to the contrary.

24. Effective March 23, 2010, 25 U.S.C. § 1623(b) provides in part as follows:

> Health programs operated by . . . Indian tribes [or] tribal organizations . . . shall be the payer of last resort for services provided by such Service, tribes, or organizations to individuals eligible for services through such programs, notwithstanding any Federal, State, or local law to the contrary.

(emphasis added).

25. Another key ACA change was designed to specifically remove any doubt that tribal health programs pay secondary to the VA.

26. Effective March 23, 2010, 25 U.S.C. § 1645(c) was enacted to promote flexibility and choice to Native American veterans in deciding where they elect to receive their health care by specifically requiring the VA to reimburse Indian tribes or tribal organizations for veterans who receive care through a tribal health program in lieu of seeking care through the VA.

27. 25 U.S.C. § 1645(c) provides in part as follows:

> The Service, Indian tribe, or tribal organization shall be reimbursed by the Department of Veterans Affairs or the Department of Defense (as the case may be) where services are provided through the Service, an Indian tribe, or a tribal organization to beneficiaries eligible for services from either such Department, notwithstanding any other provision of law.

(emphasis added).

28. The impact of these provisions (referred to herein as "Native Veteran Reimbursements Rights") is to allow Native American veterans the ability to choose where they receive their care based on quality of care factors, while ensuring that tribal budgets will not be drained when patients chose tribal services over care they could otherwise receive through the VA.

29. In recent years, this has become increasingly important for the Community and GRHC, as more patients, on information and belief, have elected to receive their care through GRHC as a result of being unable to secure timely appointments through the VA, and because the Phoenix VA in particular has been plagued by well-publicized health care scandals alleging poor quality of care and long waits for appointments.

d. The VA opposes and seeks to limit Native Veteran Reimbursement Rights

30. On information and belief, the VA was aware of the statutory proposal to strengthen Native Veteran Reimbursement Rights and opposed those reforms by lobbying against their adoption.

31. On information and belief, in their efforts to oppose enactment of Native Veteran Reimbursement Rights, the VA acknowledged its understanding that if these rights were enacted into law VA would be required to grant tribal health programs broad reimbursement rights, with regard to both direct and PRC health services.

32. Upon enactment of the statutory Native Veteran Reimbursement Rights, however, the VA did not commence reimbursements as directed in 25 U.S.C. § 1645(c) and failed to comply with the law.

33. Instead, on information and belief, VA withheld all tribal health program reimbursements pending its efforts to develop template reimbursement agreements (hereafter "template agreements") with the United States Indian Health Service ("IHS") to be used by VA with for both IHS and tribal health program reimbursements.

34. On information and belief, the VA worked with IHS to develop its template agreements without substantive consultation with any Indian tribal governments knowing, however, that its actions were intended to affect Indian tribal governments.

35. The VA efforts with IHS to develop template agreements did not, in any event, include any consultation with the Community or GRHC.

36. On information and belief, the VA sought to include provisions in its template agreements specifically designed to limit the scope of Native Veteran Reimbursement Rights beyond the statutory language of 25 U.S.C. § 1645(c).

37. Limitations to Native Veteran Reimbursement Rights sought by VA in its template agreements beyond the language of 25 U.S.C. § 1645(c) included, but were not limited to:

(a) No reimbursements would be made without VA's express agreement;

(b) Reimbursements, when agreed to by VA, would be limited to direct care services only;

(c) No reimbursements would be made for PRC services provided through a tribal health program;

(d) No reimbursements would be made for direct care services, if a tribe seeks to preserve its right to pursue reimbursement claims for PRC services (i.e., requiring tribes to give up reimbursement for PRC services in order to receive any reimbursement for direct care services);

(e) No reimbursements would be made for any services provided to non-Native veterans receiving care through a tribal health program; and

(f) No agreement (and no reimbursements) would be made by the VA unless the tribe agreed to allow the VA contracting officer to resolve any disputes over Native Veteran Reimbursement Rights.

38. On information and belief, IHS disagreed with the limitations that the VA was demanding with regard to veteran reimbursements (the "IHS-VA Dispute").

39. On information and belief, the IHS-VA Dispute was briefed for submission to the United States Department of Justice (the "DOJ").

40. On information and belief, the IHS-VA Dispute was not decided by the DOJ because VA and IHS leadership agreed to a resolution which, on information and belief, was designed to address inter-agency political concerns in addition to or in lieu of legal entitlement to reimbursements under the 25 U.S.C. § 1645(c) (the "Inter-Agency Agreement").

41. On information and belief, the Inter-Agency Agreement did not include consultation from any Indian tribal governments.

42. The Inter-Agency Agreement did not, in any event, include consultation with the Community or GRHC.

43. IHS, in either event, had no authority to compromise or limit tribal government, tribal organization, Community or GRHC reimbursement rights under 25 U.S.C. §§ 1645(c) or 1623(b).

e. The VA and IHS roll out template agreements limiting Native Veteran Reimbursement Rights

44. On or about December 6, 2012, almost three years after VA reimbursements were to have already begun under the ACA, IHS and VA announced a "national agreement" purporting to allow the VA to reimburse IHS for "direct care services".

45. In reality, IHS and tribal health programs were already entitled to reimbursements beginning March 23, 2010 from the VA in the absence of any agreement through the express language of 25 U.S.C. § 1645(c), and the Inter-Agency Agreement restricted, rather than expanded, Native Veteran Reimbursement Rights.

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46. On information and belief, the VA and IHS failed to inform tribal governments that the national agreement included provisions limiting statutory tribal reimbursement rights, and that IHS itself had previously submitted legal briefs to the DOJ in an effort to strike down many of the same key provisions included in the final Inter-Agency Agreement, including VA's insistence on limiting reimbursements to only direct care services.

47. On information and belief, approximately three years after the VA was required to have started reimbursements to tribal health programs under the ACA, the VA began a new publicity campaign seeking tribal health programs to "sign on" to the template agreement.

f. Template agreement negotiations with GRHC - Scope of Reimbursements

48. In February of 2013, the VA opened discussions with GRHC to enter into a template agreement for reimbursements under 25 U.S.C. § 1645(c).

49. The template agreement, however, included limitations not found in 25 U.S.C. § 1645(c) including, for example: (1) reimbursement was limited to prospective services rather than reimbursements based on the ACA effective date; (2) reimbursement was limited to direct care services only, and did not include PRC services; (3) reimbursement did not include non-Native veterans receiving care through GRHC; and (4) the agreement required GRHC to submit disputes with the VA for resolution by the VA's own contracting officer.

50. Moreover, the VA indicated that no reimbursements would be provided unless GRHC entered into the template agreement, despite the fact that 25 U.S.C. § 1645(c) mandated such reimbursements, and did not call for separate agreements at all.

51. Over the next approximately eight months, GRHC and the VA exchanged redlines of the template agreement and engaged in efforts to reach a compromise on the scope of reimbursements due under 25 U.S.C. § 1645(c).

52. Negotiations over changes to the scope of reimbursements to be provided under the template agreement culminated with a phone conference with VA representatives

and legal counsel, Dennis Foley, from the VA Office of General Counsel, on October 31, 2013, during which VA made it clear that the VA had already addressed the scope of reimbursements under 25 U.S.C. § 1645(c) in lengthy negotiations with IHS, and that a decision had already been made by the VA not to allow reimbursements other than for direct services.

53. At the October 31, 2013 meeting, VA legal counsel, Dennis Foley, confirmed that VA's position will not change unless it is required to change by the Department of Justice or unless the Community sued the federal government and prevailed in court.

54. Following the October 31, 2013 meeting, GRHC continued to request reconsideration on the scope of reimbursements, but VA rejected all such discussions.

g. Template agreement negotiations with GRHC - Reservation of Rights

55. After the VA made it clear that its administrative decision with regard to the scope of reimbursements available under 25 U.C.S. § 1645(c) was final, GRHC attempted to mitigate damages by securing an agreement limited to the direct service reimbursements already called for in the VA template agreement, but under a reservation of rights.

56. In November of 2013, the VA informed GRHC that such negotiations would have to be addressed to the General Counsel of the Department of Veterans Affairs (William A. Gunn) at the VA Central Office.

57. On or about December 5, 2013, GRHC submitted a request for reconsideration as instructed through the General Counsel of the Department of Veterans Affairs (William A. Gunn) at the VA Central Office.

58. Negotiations over whether the VA would agree to provide direct service reimbursements while allowing the Community to reserve its rights over non-agreed matters continued for the next year, and through VA's final rejection of a redline agreement on July 1, 2015.

h. Final Efforts at Government-to-Government Consultation.

59. In March of 2014, and while the VA General Counsel was considering GRHC's effort to mitigate, the Community sent a delegation to meet with VA leadership in Washington D.C. on a government-to-government basis under Executive Order 13175.

60. On or about May 1, 2014, the Community reached out to Arizona Senators John McCain and Jeff Flake an effort to encourage reconsideration of the agency's prior actions through government-to-government consultation.

61. GRHC also suggested a delegation meeting, including Congressional representatives, to be held at the Community's offices.

62. On or about June 19, 2014, Senator John McCain sent a letter to the then Acting Director of the Department of Veterans Affairs, Sloan Gibson, requesting an update on reimbursements to the Community as required by 25 U.S.C. § 1645(c).

63. On or about September, 9, 2014, the Community and GRHC sent another delegation to a VA consultation meeting held in Albuquerque, New Mexico, and again urged the VA to consult with tribes on substantive changes to the template agreement, including the subject of PRC service reimbursements, pre-agreement reimbursements, and allowing tribes to receive direct service reimbursements without waiving other rights under 25 U.S.C. § 1645(c).

64. The Community has exhausted efforts at seeking reconsideration by the VA on the scope of services available for reimbursement under 25 U.S.C. § 1645(c), and on mitigation through a direct service reimbursement agreement, under a reservation of rights.

65. All Community efforts have been rejected, and from March 23, 2010 through the date of this Complaint, VA has provided no reimbursements to GRHC in violation of 25 U.S.C. § 1645(c).

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FIRST CAUSE OF ACTION

(Violation of 25 U.S.C. § 1645(c))

66. Plaintiffs incorporate all previous allegations of fact and law into this Cause of Action.

67. Under 25 U.S.C. § 1645(c), the VA is required to reimburse GRHC for all services provided through GRHC to any beneficiaries eligible for services from the VA.

68. The VA violated and continues to violate this statute by failing to provide reimbursements from the effective date of the ACA, March 23, 2010, forward.

69. The VA violated and continues to violate this statute by conditioning reimbursements on a separate agreement by VA.

70. The VA violated and continues to violate this statute by conditioning any reimbursements on the Community's agreement to terms and conditions not included in 25 U.S.C. § 1645(c).

71. The VA violated and continues to violate this statute by limiting reimbursements to Native American veterans.

72. The VA violated and continues to violate this statute by limiting reimbursements to direct care services only, and by excluding PRC services.

SECOND CAUSE OF ACTION

(Violation of 25 U.S.C. § 1623(b))

73. Plaintiffs incorporate all previous allegations of fact and law into this Cause of Action.

74. Under 25 U.S.C. § 1623(b), GRHC is a payor of last resort to VA, notwithstanding Federal law to the contrary.

1 75. The VA has violated this statute by forcing GRHC into a primary payer
2 position on all services for which VA has refused to provide reimbursements as set forth
3 herein.

4 **THIRD CAUSE OF ACTION**

5 **(Mandamus Relief)**

6 76. Plaintiffs incorporate all previous allegations of fact and law into this Cause of
7 Action.
8 77. Under 25 U.S.C. § 1645(c), the VA is required to perform a non-discretionary
9 duty owned to the Community.
10 78. Defendants have breached this duty by failing to reimburse Plaintiffs and no
11 other remedy is available.
12 79. The Community and GRHC are entitled to the entry of a writ of mandamus
13 compelling the VA to perform duties owed to the Community and GRHC.
14

15 **PRAYER FOR RELIEF**

16 WHEREFORE, Plaintiff Community prays for the following relief:
17 1. A declaration that VA has violated 25 U.S.C. §§ 1645(c) and 1623(b);
18 2. Injunctive and declaratory relief compelling VA to provide reimbursements for
19 all direct care and PRC services provided through GRHC to VA eligible veteran's from
20 March 23, 2010, through the date of judgment;
21 3. Injunctive and declaratory relief compelling VA to provide reimbursements for
22 all direct care and PRC services provided through GRHC to VA eligible veteran's from and
23 after the date of judgment; and
24 4. An award of the Community's costs, including full reasonable attorneys' fees
25 and litigation costs, as provided for in 28 U.S.C. § 2412, together with such other and further
26 relief as the interests of justice and equity may require.

1 Dated this 22nd day of March, 2016.
2
3 Respectfully submitted,
4 GILA RIVER INDIAN COMMUNITY
5
6 By *s/ Thomas L. Murphy*
Linus Everling, Esq.
7 Thomas Murphy, Esq.
8 -and-
9 YODER & LANGFORD, P.C.
10 Robert R. Yoder, Esq.
11 *Attorneys for Plaintiffs*
12 *Gila River Indian Community and*
Gila River Healthcare Corporation
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