Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	
California Rural Indian Health Board, Inc., and the Blue Lake Rancheria,	DATE: June 23, 1993
Appellants,	Docket No. C-93-013
- v. -	Decision No. CR273
Indian Health Service,	
Appellee.	

RECOMMENDED DECISION

By letters dated August 20, 1992 and September 17, 1992, the California Area Office of Appellee, Indian Health Service (IHS), declined a proposal for a contract submitted by Appellants, the Blue Lake Rancheria (Blue Lake) and California Rural Indian Health Board, Inc. (CRIHB), to provide health care services to members of Blue Lake. Blue Lake and CRIHB requested a hearing, and the case was assigned to me for a hearing and a recommended decision. I conducted a hearing in Sacramento, California, on February 17 and 18, 1993.[1]

[1] While IHS exchanged IHS Proposed Exhibit 37 prior to the hearing, it did not offer this document into evidence at the hearing. However, IHS did move to have this document admitted into evidence when it submitted its April 26, 1993 posthearing reply brief. Appellee's Posthearing Reply Brief at 13. By letter dated April 28, 1993, Blue Lake and CRIHB objected to IHS' belated motion to offer this document into evidence. Blue Lake and CRIHB contended that it "would be a gross injustice to admit this document into the record at this late date in the absence of any explanation by IHS for its tardiness and only after the Appellants have lost any opportunity to challenge it." Appellants' April 28, 1993 Objection at 2. I deny as untimely IHS' request to have IHS Proposed Exhibit 37 admitted into evidence.

The parties submitted posthearing briefs and reply briefs.

I have carefully considered the evidence of record, the parties' arguments, and the applicable law. I conclude that the contract declination was lawful. Therefore, I recommend that the declination be sustained.

ISSUE

The issue in this case is whether IHS lawfully declined Blue Lake and CRIHB's contract proposal.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

1. Blue Lake is a federally-recognized Indian tribe. Tr. at 290.[2]

2. Blue Lake has 34 members. Tr. at 235.

3. CRIHB is a tribal organization whose mission is to assist California Indian tribes in obtaining health care. Tr. at 556 - 57.

4. Trinity Rural Indian Health Project, Inc. (TRIHP), operates a federally-funded medical and dental clinic that provides health care to Indians. Stipulation at paragraphs 3 - 6, 7, 10; see Tribe Ex. 3.

5. The TRIHP clinic is located in Weaverville, California. Tribe Ex. 3, p. 1.

6. Weaverville, California, is approximately 90 miles from Blue Lake. Tr. at 207.

7. On June 19, 1992, Blue Lake and CRIHB submitted a proposal to IHS to contract for the provision of health services to the members of Blue Lake. IHS Ex. 1.

8. Under the proposal, health services would be provided by TRIHP (designated in the proposal as "Trinity Rural

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[2] I cite to the exhibits of Blue Lake and CRIHB as "Tribe Ex. (number), p. (page number)." I cite to IHS' exhibits as "IHS Ex. (number), p. (page number)." I cite to the parties' Stipulation of Facts as "Stipulation at paragraph (number)." I cite to the Transcript as "Tr. at (page)."

Indian Health Services, Weaverville, California," or "TRIHS"). IHS Ex. 1, p. 5.

9. As of June 19, 1992, IHS and CRIHB had a contract to administer a comprehensive health care program for eligible Indians, which included members of Blue Lake. IHS Ex. 2, p. 1.

10. Pursuant to the contract in effect on June 19, 1992, CRIHB provided comprehensive health care services to the members of Blue Lake through a subcontract with United Indian Health Service Inc. (UIHS). IHS Ex. 2, p. 1.

11. The clinics operated by UIHS are located approximately 15 - 20 miles from Blue Lake. IHS Ex. 2, p. 1; Tr. at 207.

12. Both TRIHP and UIHS have been approved by IHS to provide health services to Indians. See Findings 4, 10.

13. The health services which UIHS provides at its clinics include physicians' services provided by three board-certified family practitioners. Tr. at 453; see IHS Ex. 10, p. 1.

14. The health services which UIHS provides at its clinics include a full-time dental clinic which offers a full service dental program, including basic care, orthodontia, oral surgery, and endodontics. IHS Ex. 10, p.2; Tr. at 454 - 455.

15. The health services which UIHS provides at its clinics include mental health services staffed by five providers of care. Tr. at 455; see IHS Ex. 10, p. 2.

16. UIHS operates a separate substance abuse program, United Indian Lodge, for the treatment of alcohol and other substance abuse. IHS Ex. 10, p.3; Tr. at 455.

17. UIHS' staff includes two public health nurses who, among other things, operate a diabetes program. Tr. at 456.

18. UIHS operates specialty clinics, including an allergy clinic and a podiatry clinic. Tr. at 456 - 457.

19. UIHS provides vision services at its clinics, which include the services of an ophthalmologist, two optometrists, and an optician. IHS Ex. 10, p. 2.

20. The TRIHP clinic's primary full-time health care provider is a physician's assistant. Tr. at 503; IHS Ex. 2, p. 1.

21. In California, a physician's assistant is a health care provider who is licensed to provide health care under the supervision of a physician. Tr. at 504.

22. Patients who visit the TRIHP clinic, and who, in the judgment of the staff physician assistant, need to see a physician are referred to physicians who practice in the vicinity of the TRIHP clinic. Tr. at 518 - 519.

23. TRIHP facilitates visits to specialists for its patients by assisting patients with their transportation to the specialists' offices. Tr. at 520.

24. TRIHP does not provide its patients with an alcohol abuse treatment program. Tr. at 522.

25. TRIHP sometimes refers its patients who are in need of alcohol abuse treatment to UIHS. Tr. at 522.

26. Although the health care services provided by TRIHP meet IHS' criteria for contracting entities who provide health care, they are less comprehensive than are those that are provided by UIHS. Tr. at 512; Findings 13 - 25; see Finding 12.

27. Blue Lake and CRIHB submitted their contract proposal to IHS pursuant to the Indian Self-Determination Act (Act). 25 U.S.C. §§ 450 et seq.

28. Under the Act, the Secretary of the Department of Health and Human Services (Secretary) is directed to enter into contracts ("self-determination contracts") with Indian tribes, pursuant to tribal resolutions, to provide health care services to eligible Indians. 25 U.S.C. § 450f(a)(1).

29. Under the Act, the Secretary must approve a self-determination contract with an Indian tribe to provide health care unless she finds specifically that:

> a. the service to be rendered to the Indian beneficiaries of the particular program or function to be contracted will not be satisfactory;
>
> b. adequate protection of trust resources is not assured; or

> c. the proposed project or function to be contracted for cannot be properly completed or maintained by the proposed contract.

25 U.S.C. § 450f(a)(2).

30. By letters dated August 20, 1992 and September 17, 1992, IHS declined the contract proposal of Blue Lake and CRIHB. IHS Ex. 2 - 3.

31. IHS advised Blue Lake and CRIHB that it was declining the proposal because the distance of travel for Blue Lake members to the TRIHP clinic, as compared to the distance of travel for Blue Lake members to the UIHS clinics, the difficult accessibility of the TRIHP clinic, and the less comprehensive health care services provided by the TRIHP clinic as opposed to those provided by the UIHS clinics, would cause the services provided by TRIHP to be unsatisfactory to Blue Lake members. IHS Ex. 2, p. 1 - 2; IHS Ex. 3, p. 2 - 3.

32. In any case where the Secretary declines to enter into a self-determination contract, the Secretary must provide the tribal organization which proposed to enter into the contract with:

> a. a written statement, setting forth her objections to the proposed self-determination contract;
>
> b. assistance to overcome the objections to the proposed self-determination contract; and
>
> c. a hearing on the record, and an opportunity to appeal the Secretary's objections to the proposed self-determination contract, under such rules and regulations as the Secretary may promulgate.

25 U.S.C. § 450f(b).

33. In this case, IHS (as the Secretary's delegate) has the burden of proving, by a preponderance of the evidence, that the decision to decline the Blue Lake and CRIHB contract proposal satisfies one of the statutory grounds for declining a self-determination contract proposal. 5 U.S.C. §§ 554(a), 556; see 25 U.S.C. §§ 450f(a)(2), (b); 42 C.F.R. § 36.208(a)(3).

34. As used in the Act, the term "the service to be rendered to the Indian beneficiaries of the particular program or function to be contracted will not be

satisfactory" means that the services which are proposed to be contracted for cannot be provided in a practicable manner consistent with the objectives of the proposed self-determination contract, or with the Secretary's obligation to provide health care to eligible Indians. 25 U.S.C. § 450f(a)(2).

35. The services which Blue Lake and CRIHB proposed to contract for included providing, via a subcontract with TRIHP, direct patient care for the treatment and prevention of acute and chronic illness and/or injuries. IHS Ex. 1, p. 12.

36. The services which Blue Lake and CRIHB proposed to contract for included providing, via a subcontract with TRIHP, preventive care and care for acute and chronic conditions. The elements of the proposal included providing services for prenatal care, child and adult immunizations, health promotion, disease prevention, and supervision of chronic diseases such as diabetes, hypertension, and arthritis. IHS Ex. 1, p. 12.

37. Frequent monitoring of a patient's condition by trained medical personnel may be an important element of the treatment of chronic illnesses such as diabetes and hypertension, and in the early detection and treatment of diseases such as cancer. Tr. at 360 - 369; see IHS Ex. 28.

38. Patients who live substantial distances from their health care providers are less likely to seek routine or regular treatment from those providers than are patients who live close to their providers, due to the inconvenience created by the need for lengthy travel to obtain health care. Tr. at 340 - 342.

39. In this case, the substantial distance (approximately 90 miles) that Blue Lake members would have to travel in order to obtain care at the TRIHP clinic could serve as a barrier to their seeking routine or regular treatment for chronic illnesses such as diabetes and hypertension, and early detection and treatment of diseases such as cancer. Tr. at 375 - 376, Findings 37, 38.

40. Patients who must seek care from more than one provider in different locations in order to receive treatment for medical conditions are less likely to seek routine or regular treatment for their conditions, and to comply with prescribed treatment, than are patients who obtain care from one provider at a single location. Tr. at 348.

41. In this case, TRIHP's practice of referring patients to specialists at locations other than the TRIHP clinic could serve as a barrier to Blue Lake members seeking care for their medical conditions and complying with prescribed treatment. Tr. at 376 - 377, 401 - 402; Finding 40.

42. Other clinics (UIHS) located in closer proximity to Blue Lake than TRIHP provide more comprehensive health care than does TRIHP. Findings 5, 6, 11, 26.

43. It would not be practicable or consistent with the Secretary's obligation to provide health care to eligible Indians to provide health care to Blue Lake members at the TRIHP clinic, given the barriers to treatment which would result from having TRIHP as the subcontractor, and given further that UIHS can provide care without such barriers. Tr. at 401 - 402; Findings 37 - 42.

44. IHS proved by a preponderance of the evidence that the services to be provided pursuant to the Blue Lake and CRIHB contract proposal would not be satisfactory. Findings 34 - 43.

45. The deficiencies in the Blue Lake and CRIHB contract proposal which were identified by IHS could not be rectified with technical assistance.

46. IHS did not contravene its duty to provide Blue Lake and CRIHB with technical assistance to rectify the deficiencies in the Blue Lake and CRIHB contract proposal. See Finding 32.

47. IHS lawfully declined the Blue Lake and CRIHB contract proposal.

ANALYSIS

The parties do not dispute the central facts of this case. Blue Lake is a federally-recognized Indian tribe of 34 members. CRIHB is a tribal organization which assists California Indians in obtaining health care. On June 19, 1992, Blue Lake and CRIHB applied to IHS for a contract to provide health care to Blue Lake members. The elements of the proposal included treatment for both acute and chronic medical conditions. They included preventive and ongoing treatment for conditions such as diabetes, hypertension, and arthritis. Blue Lake and CRIHB proposed that the health services to be delivered under the contract would be provided by a subcontract with TRIHP, which operates a clinic in Weaverville, California, approximately 90 miles from Blue Lake. TRIHP

had previously subcontracted under IHS contracts to provide health services for California Indians, although not for Blue Lake's members. There is no allegation that TRIHP has been deficient in providing such services.

Prior to June 19, 1992, Blue Lake's members were provided health care through an IHS contract with CRIHB and a subcontract with UIHS, which operates clinics about 15 - 20 miles from Blue Lake. UIHS offers a broader and more comprehensive range of health services than does TRIHP. UIHS offers comprehensive medical care at its clinics, including the services of three board-certified family practitioners. It also operates a full-time dental clinic which provides basic and specialized dental care including oral surgery, an ophthalmology program, a mental health program, and a substance abuse treatment facility. By contrast, TRIHP is staffed principally by a physician's assistant who is licensed in California to provide medical care under the supervision of a physician. TRIHP refers its patients to physicians, including specialists, when the physician's assistant determines that a higher level of care is required than that which he can provide.

IHS declined the June 19, 1992 Blue Lake and CRIHB contract proposal. It concluded that the services proposed to be rendered to Blue Lake members would not be satisfactory. IHS based its determination on the finding that the distance between Blue Lake and the TRIHP clinic would discourage Blue Lake members from seeking treatment there. IHS found also that the relatively fragmented care provided to patients by TRIHP -- consisting of referral of patients to outside medical practitioners when such care is indicated -- might create an additional barrier to Blue Lake members obtaining treatment at TRIHP. In declining the proposal, IHS contrasted these findings with its conclusion that UIHS offered Blue Lake members treatment without the barriers to treatment which it found would exist if TRIHP were the subcontracting entity.

Blue Lake and CRIHB made their contract proposal pursuant to the Act, 25 U.S.C. §§ 450 et seq. Section 450f of the Act directs the Secretary to enter into a contract, upon the request of an Indian tribe or tribal organization, to conduct and administer programs, including programs designed to provide health care to eligible Indians.[3]

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[3] The Act applies specifically to the Secretaries of Health and Human Service and Interior. 25 U.S.C. § 450b(i).

The Secretary may decline to enter into a proposed contract only upon grounds enumerated in the Act. 25 U.S.C. § 450f(a)(2). Among those enumerated grounds, and the statutory basis for declination relied upon by IHS which is at issue in this case, is that provided by section 450f(a)(2)(A) of the Act:

> [T]he service to be rendered to the Indian beneficiaries of the particular program or function to be contracted will not be satisfactory; . . . .

The issue in this case, therefore, is whether IHS' declination of the Blue Lake and CRIHB contract proposal comports with the statutory basis for declination relied on by IHS.

1. IHS has the burden of proving by a preponderance of the evidence that the declination was lawful.

The Act requires, at 25 U.S.C. § 450f(b)(3), that in the case of a contract proposal declination, the Secretary must offer the affected tribal organization a hearing on the record at which the tribal organization may appeal the grounds for declination. The Act is silent as to the parties' respective burdens of proof in such a hearing. I conclude that IHS has the burden of proving that its contract declination is justified and that it satisfies its burden of proof by showing that its declination is supported by a preponderance of the evidence.

The parties agree that IHS bears the burden of proof in a contract declination hearing. IHS' regulations repose the burden of proof on IHS in declination cases. 42 C.F.R. § 36.208(a)(3). IHS asserts that its burden in a declination case is to prove by a preponderance of the evidence that the declination comports with a statutory criterion for declination. Blue Lake and CRIHB argue that IHS' burden is greater than a preponderance of the evidence. They assert that IHS' burden in a declination case is to prove by clear and convincing evidence that the declination is justified. Appellants' Posthearing Reply Brief at 14.

This case involves a hearing on the record, which is governed by section 5 of the Administrative Procedure Act (APA). It states that:

> This section applies . . . in every case of adjudication required by statute to be determined on the record after opportunity for an agency hearing . . . .

5 U.S.C. § 554(a); see 25 U.S.C. § 450f(b)(3).

The standard of proof in APA-governed proceedings is preponderance of the evidence, absent a congressional declaration to the contrary. Steadman v. SEC, 101 S. Ct. 999, 1005 (1981). Thus, where a statute does not enunciate a standard of proof, as is the case here, and where hearings held pursuant to that statute are APA-governed hearings, the party which is the proponent of a rule or order (here, IHS) must prove its case by a preponderance of the evidence.

Blue Lake and CRIHB, citing the Act's legislative history, asserts that the Act enunciates a higher standard of proof than preponderance of the evidence. The history cited by Blue Lake and CRIHB consists of language in the report of the Senate Indian Affairs Committee, which was issued in conjunction with 1988 amendments to the Act. The committee stated that, in declination proceedings:

> The burden of proof for declination is on the Secretary to clearly demonstrate that a tribe is unable to operate the proposed program or function.

S. Rep. No. 274, 100th Cong., 1st Sess. 24, reprinted in 1987 U.S.C.C.A.N. 2620, 2643.

I do not find the Act, when read with the APA, to be ambiguous as to the parties' respective burdens of proof. Therefore, it is unnecessary to consult the Act's legislative history in order to decide how it is to be applied. Johnson v. Carter, 983 F.2d 1316 (4th Cir. 1993). Furthermore, I do not agree with Blue Lake and CRIHB's suggestion that this excerpt from the Act's legislative history signals congressional intent to impose on IHS in declination proceedings a higher standard of proof than the APA standard of preponderance of the evidence.

The excerpt from the Act's legislative history relied on by Blue Lake and CRIHB does not state or imply that the standard of proof in hearings held pursuant to the Act is higher than preponderance of the evidence. A requirement that a fact be demonstrated clearly is not at all inconsistent with the requirement that a fact be proven by a preponderance of the evidence.

Furthermore, the legislative history makes it clear that Congress intended that proceedings conducted pursuant to the Act be conducted under standards embodied in the APA,

including the APA standard of proof. The Senate Indian Affairs Committee report states, on the same page as that which is relied on by Blue Lake and CRIHB:

> The intent of the Indian Self-Determination Act is to assure that a tribal organization receives a hearing 'on the record' in accordance with the requirements of the Administrative Procedures Act.

S. Rep. No. 274, 100th Cong., 1st Sess. 24, reprinted in 1987 U.S.C.C.A.N. 2620, 2643.

Blue Lake and CRIHB suggest also that a higher standard of proof than preponderance of the evidence is implicit in the Act itself, which articulates a congressional policy favoring contracts with tribes. According to Blue Lake and CRIHB, the Act creates a strong presumption in favor of self-determination proposals. Therefore, declinations of such proposals ought to be justified by a higher level of proof than preponderance of the evidence.

At the center of Blue Lake and CRIHB's argument is their contention that Congress intended that the Secretary pay great deference to Indian tribes' decisions in selecting health care providers with whom to contract. Therefore, according to Blue Lake and CRIHB, the Act should be read in a way which makes it very difficult for the Secretary to justify declining a contract proposal. Blue Lake and CRIHB argue that:

> [I]n this case [Appellants] have the right to make their own health care decisions and choose where to receive their health care, . . . and that IHS acts in a 'colonialistic' way by telling Indians what they are supposed to do, rather than working in partnership.

Appellants' Posthearing Brief at 18 (citations to the record omitted).

I agree with CRIHB and Blue Lake that the Act directs the Secretary to contract with tribes in all but enumerated circumstances. However, the preferences stated in the Act do not rise to an entitlement in the face of circumstances where facts justifying declination exist. Rather than creating an absolute right of tribes to contract, the Act balances a congressional policy in favor of self-determination contracts against the Secretary's continuing duty to provide health care to Indians and to assure that their welfare is protected. A preponderance of the evidence standard of proof in

declination cases is consistent with a policy favoring self-determination contracts which requires the Secretary to justify declinations of contract proposals.

The Act does not require the Secretary to enter into contracts which are not in the best interest of Indians. What the Act does require is that contracts be approved unless they fall within the statutory grounds for declination. In other words, Congress has defined those circumstances in which contracts may not be in the best interest of Indians and has instructed the Secretary to approve proposals unless they fall within the defined circumstances. However, Congress has not expressed a policy that it should be difficult for the Secretary to justify declining to enter into contracts where facts exist which show that proposals fall within one of the statutory grounds for contract declination.

2. The reasons which IHS stated for declining the Blue Lake and CRIHB contract proposal are consistent with the Act and with implementing regulations.

a. The Act

Blue Lake and CRIHB observe that the statutory term "[T]he service to be rendered to the Indian beneficiaries of the particular program or function to be contracted will not be satisfactory" was not defined by Congress. Therefore, according to Blue Lake and CRIHB, the Secretary is obliged to adopt regulations defining the term before it can be relied on as justification for declining a contract proposal. Blue Lake and CRIHB argue further that the Secretary has not defined the term, either in regulations or in published policy statements. It follows, they assert, that IHS could not decline the June 19, 1992 contract proposal based on the language of the Act. Blue Lake and CRIHB recognize that there is a correlation between distance and utilization of health care. They recognize also the "obvious medical importance" of comprehensive care. Appellants' Posthearing Reply Brief at 17. Nevertheless, they argue that IHS could not rely on these specific reasons to find the proposal to be unsatisfactory, because these factors are not established as a basis for declination in the Act, in regulations, or in policy statements.

IHS responds to this argument by asserting that Congress intended contract declination disputes to be resolved on a case-by-case basis, through administrative hearings. Therefore, according to IHS, the hearing process substitutes for regulations and formal policy declarations.

Formal rulemaking is not a prerequisite to action by an administrative agency, so long as that agency proceeds in accordance with ascertainable standards and explains its reasoning for applying those standards. Patchogue Nursing Center v. Bowen, 797 F.2d 1137, 1143 (2d Cir. 1986); Holmes v. New York City Housing Authority, 398 F.2d 262, 265 (2d Cir. 1968). Agency action in conformity with ascertainable standards does not constitute unlawful uncontrolled exercise of discretion by that agency. Id.[4]

I do not agree with Blue Lake and CRIHB's contention that IHS cannot apply the statutory standard for declination to this case, absent regulations or policies which refine the meaning of the Act. The Act contains ascertainable standards by which contract proposals can be evaluated. The objective and neutral criterion for declination contained in 25 U.S.C. § 450f(a)(2)(A) does not require further definition by the Secretary in the form of regulations or policies, because it is in and of itself an ascertainable standard for declination which permits declination determinations to be made and appealed.

Congress did not define what it meant when it permitted the Secretary to decline a contract proposal on the ground that "[T]he service to be rendered to the Indian beneficiaries of the particular program or function to be contracted will not be satisfactory." 25 U.S.C. § 450f(a)(2)(A). However, the meaning of this part of the Act is apparent, both from the language itself, and from its context within the Act. This section directs IHS to decline a contract proposal where IHS can demonstrate that the services which are proposed to be contracted for cannot be provided in a practicable manner consistent with the objectives of the proposed self-determination contract, or with the Secretary's obligation to provide health care to eligible Indians.

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[4] IHS' contention that rulemaking is unnecessary here because Congress intended disputes over declination to be adjudicated on a case-by-case basis begs the question of whether ascertainable standards exist to govern IHS' declination determinations. Uncontrolled exercise of discretion by an agency is impermissible, whether it is exercised through administrative adjudication or via some other process. What is significant here is not that declination disputes are adjudicated, but that they are adjudicated pursuant to ascertainable standards existing in the Act.

A purpose of the Act is to enable Indian tribes and tribal organizations to provide to their members services which Congress had previously instructed the Secretary to provide to Indians. The Act requires the Secretary to execute contracts for such services where tribal organizations make proposals that serve to carry out functions and activities previously vested in the Secretary. Those functions and activities have always imposed a duty on the Secretary to dispense resources in a practicable manner, consistent with the best interests of the Indian beneficiaries of those resources. In contracting for services, Indian tribes and tribal organizations must be held to the same standards of accountability for resources that the Secretary would be held to had she dispensed those resources directly. The Act does not give tribes carte blanche to contract for services where they cannot provide those services in a practicable manner, or where those services will not be provided in a way which is consistent with those duties and obligations vested previously in the Secretary. In deciding whether to accept or decline a contract proposal, the Secretary (or her delegate, IHS) must balance the statutory right of Indian tribes to contract for services against her continuing duty to protect Indians' welfare by assuring that those services are provided practicably and effectively.

The declination standard embodied in 25 U.S.C. § 450f(a)(2)(A) is an objective and neutral standard. See Environmental Defense Fund v. Ruckelshaus, 439 F.2d 584, 597 - 98 (D.C. Cir. 1971). It imposes on the Secretary the duty to evaluate contract proposals by deciding whether the proposals will accomplish practicably the objectives of the proposed contracts in a manner consistent with the Secretary's obligation to provide health care to Indians. That is not uncontrolled discretion to decline contract proposals. The section cannot be read to permit IHS to second-guess tribal organizations in order to decide whether their members would be "satisfied" by the services proposed to be contracted for. Nor can this section be read to permit IHS officials to decide subjectively whether they personally like or dislike the services which are proposed to be contracted for. Either interpretation would give IHS uncontrolled discretion to decline contract proposals.

The reasons that IHS articulated for declining Blue Lake and CRIHB's June 19, 1992 proposal are consistent with the declination criteria contained in 25 U.S.C. § 450f(a)(2)(A) and with the requirement that IHS explain why the proposal did not conform to the standards

contained in the Act. IHS concluded that the services proposed to be contracted for would not be satisfactory because of problems related to the distance Blue Lake members would have to travel to TRIHP to receive health care, the accessibility of the TRIHP clinic to Blue Lake members, and the relatively less comprehensive services offered by TRIHP, when compared with those offered by UIHS. IHS Ex. 2, p. 1 - 2; IHS Ex. 3, p. 2 - 3. These reasons relate directly to the practicability of the Blue Lake and CRIHB contract proposal. IHS explained adequately its reasons for applying the standards contained in the Act in declining the Blue Lake and CRIHB contract proposal. Patchogue Nursing Center, 797 F. 2d at 1143. The reasons given by IHS for declining the proposal explain why IHS concluded that the services which were within the proposal's scope -- including treatment for acute and chronic conditions, and preventive care -- could not be provided in a practicable manner pursuant to the proposal.

b. Regulations

Blue Lake and CRIHB argue that the contract declination failed to comply with regulations governing IHS contract declinations and is therefore defective. They contend that the regulations spell out limited grounds for declining contracts. According to Blue Lake and CRIHB, accessibility of services and lack of comprehensiveness of services are not among the bases for declination identified by the regulations and cannot be relied on by IHS, even if they conform to a statutory ground for declination. Blue Lake and CRIHB base their argument on their interpretation of 42 C.F.R. § 36.208, which establishes criteria for IHS evaluations of contract proposals. They contend that the regulation specifically states the grounds IHS may use to justify a declination and precludes IHS from relying on any grounds not specifically stated.

Subpart (a)(1) of this regulation provides that IHS will evaluate a contract proposal to determine if the services proposed to be rendered will be satisfactory. This language essentially tracks the language of 25 U.S.C. § 450f(a)(2)(A). Subpart (b) of the regulation lists the factors which IHS will consider in determining whether a proposal is deficient under subpart (a). These factors are: (1) equipment, buildings and facilities; (2) bookkeeping and accounting procedures; (3) substantive knowledge of the program to be contracted; (4) community support; (5) adequacy of trained personnel; and (6) other necessary components of contract performance.

Factor (6) is the factor cited by IHS as the supporting factor under the regulation for its determination to decline the Blue Lake and CRIHB proposal, and none of the other factors are at issue here. Blue Lake and CRIHB observe that this factor itself contains four subdivisions. These are:

> (i) The contractor's proposal must demonstrate the capacity to meet minimum health program and professional standards established by IHS . . .
>
> (ii) The contractor's proposal will be evaluated to determine the contractor's ability to meet the Uniform Administrative Standards . . .
>
> (iii) The ability of the contractor to carry out the contract in accordance with IHS policy, the applicable regulations of this part, and the Act.
>
> (iv) No other components shall be prescribed as a basis for declination unless such components are added to the regulations in this subpart by revision or amendment of regulations.

Blue Lake and CRIHB assert that accessibility and lack of comprehensiveness of services are not recited as permissible grounds to decline a contract anywhere in subdivisions (i) through (iii). They assert furthermore, that subdivision (iv) precludes using any finding as a basis for declination unless that finding is stated specifically in the regulations. Therefore, according to Blue Lake and CRIHB, the grounds relied on by IHS for declining the contract proposal are invalid whatever their merits, and cannot be relied on by IHS.

Blue Lake and CRIHB read 42 C.F.R. § 36.208 too narrowly. The regulation is broadly worded to permit IHS to decline a contract proposal for any reason which complies with standards ascertainable in the Act. It provides expressly that IHS may decline a contract proposal based on the conclusion that the contractor is unable to comply with the requirements of the Act. 42 C.F.R. § 36.208(b)(6)(iii). When that subsection is read with 42 C.F.R. § 36.208(a)(1), it is plain that the regulations contemplate denials of proposals based on IHS' conclusion that the proposals would not provide services which will be satisfactory, in accordance with 25 U.S.C. § 450f(a)(2)(A).

It is true that the regulation does not spell out all of the reasons which IHS might adduce for finding a proposal to be deficient under the Act. The regulation does not recite as grounds for declination of contract proposals problems created by accessibility of health clinics or the comprehensiveness of their services. But that is not a bar to IHS citing reasons for declining a proposal which conform to the standards contained in the Act. As I find above, the Act itself contains ascertainable standards by which contracts may be evaluated, and there is no statutory requirement that the Secretary spell out in regulations the grounds for declination with any greater specificity than is provided by the neutral principles for declination stated in the Act. The regulation refers parties to the standards contained in the Act and advises them that their ability to comply with those standards will be evaluated in determining whether to approve or decline contract proposals.

The recitation in 42 C.F.R. § 36.208(b)(6)(iv) that no other components shall be prescribed as a basis for declination unless such components are added to the regulation does not preclude IHS from using the rationale it relied on as a basis for declining Blue Lake and CRIHB's contract proposal. As I hold above, the regulation subsumes as declination standards the criteria contained in the Act itself. Inasmuch as the rationale relied on by IHS for declining the proposal comports with the criteria contained in the Act, it does not constitute an "other component" outside of the present regulation.

Blue Lake and CRIHB argue also that the regulation, to the extent it enunciates a basis for declining their proposal, may be ultra vires the Act. They observe that the contract review factors set forth in 42 C.F.R. § 36.208(b)(6) are essentially identical to language originally in the Act, at 25 U.S.C. § 450f, which was deleted by Congress in 1988. They contend that this deletion mandated the Secretary and IHS to cease using the factors in 42 C.F.R. § 36.208(b)(6) as criteria for reviewing contract proposals.

It is unnecessary for me to decide Congress' intent in enacting the 1988 revisions to the Act. The provision of the regulation which is at issue here, 42 C.F.R. § 36.208(b)(6)(iii), refers parties to the criteria for declination that are contained in the Act. Thus, it merely restates IHS' duty to evaluate proposals pursuant to whatever declination criteria are contained in the Act as of the time the proposals are submitted to IHS. Even if this section were null and void as Blue Lake and CRIHB contend, IHS' statutory duty to evaluate proposals

pursuant to the Act would be unaffected. Moreover, Congress did not delete from the Act the subsection which directs the Secretary to decline contract proposals which are intended to provide services which will not be satisfactory.[5]

3. The reasons which IHS stated for declining the Blue Lake and CRIHB contract proposal are supported by the preponderance of the evidence.

IHS proved by a preponderance of the evidence that the distance between Blue Lake and TRIHP's clinic, coupled with the relatively fragmented treatment offered by TRIHP, serve to create barriers to Blue Lake members seeking treatment from TRIHP. These barriers to treatment are such as to make impracticable the rendering of services contemplated by the proposal and would be inconsistent with the Secretary's duty to assure that health care is provided to eligible Indians. IHS proved further that the impracticability of the Blue Lake and CRIHB proposal is particularly evident when the services offered by TRIHP to Blue Lake members are compared with the services offered by UIHS. The latter enterprise offers more comprehensive services than those offered by TRIHP and at a much closer distance to Blue Lake's members than the TRIHP clinic.

IHS offered the persuasive and essentially unrebutted testimony of a medical expert, John S. Yao, M.D., to support its rationale for declining the proposal. Dr. Yao is a board-certified internist who currently serves as the chief medical officer of IHS' California Area Office. Tr. at 336 - 38. Dr. Yao testified that, in this case, the distance between Blue Lake and TRIHP, approximately 90 miles, creates a barrier to treatment. This barrier is more evident in light of the fact that the distance between the Blue Lake and UIHS clinics is only 15 - 20 miles. Dr. Yao testified that it is a well-established tenet of public health that the distance that patients have to travel to receive medical care affects

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[5] Furthermore, it does not appear that I would have the authority to declare the regulation to be ultra vires the Act, in any event. My authority to hear and decide cases is delegated by the Secretary. The regulations which govern hearings under the Act do not confer authority on me to declare the regulations to be ultra vires the Act. 42 C.F.R. § 36.208.

the frequency with which they utilize that care.[6] The barriers to treatment caused by distances between patients and their providers may discourage patients from seeking routine care for chronic conditions, or from seeking preventive care. The dangers associated with failure to seek care may include exacerbation of relatively asymptomatic conditions, such as diabetes and hypertension, or the untreated progression of conditions such as cancer, which are treatable in their early stages but which become less treatable and more dangerous to the lives of patients as they progress.

Also, Dr. Yao testified persuasively that patients tend to be discouraged from seeking care when their treatment for a particular condition is fragmented -- that is, apportioned among a number of providers -- as opposed to being provided by a single provider who is qualified to treat all aspects of the patients' medical conditions. Dr. Yao contrasted TRIHP's practice of assigning patients to physicians in the vicinity of TRIHP, for aspects of their care which cannot be provided by TRIHP directly, with the centralized, and, in his opinion, more comprehensive services that are provided by UIHS. In Dr. Yao's opinion, the relatively fragmented care offered by TRIHP could pose barriers to Blue Lake members seeking treatment from TRIHP, especially when compared with the more centralized and, hence, more comprehensive care offered by UIHS. He summarized his concerns as follows:

> My concern is very clear. There's two very compelling reasons why this is unsatisfactory in my opinion because of the unsatisfactory medical services that will be rendered to Blue Lake Rancheria members, relating to the access of care as a barrier . . . .
>
> Like it or not, I think we have -- at least in my mind it's pretty clear that all things being equal, that is a barrier . . . .

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[6] IHS introduced into evidence, over the objections of Blue Lake and CRIHB, several medical journal articles. See, e.g., IHS Ex. 19. I accepted these articles as evidence which tended to corroborate, and, hence, make credible Dr. Yao's expert opinion that distance and fragmentation of care may pose barriers to treatment. I did not accept the articles as direct evidence that the services which Blue Lake and CRIHB proposed to provide via a subcontract with TRIHP were unsatisfactory.

> Then the second thing is the comprehensive nature of the services . . .

Tr. at 402.

Dr. Yao concluded that having TRIHP as a subcontractor for Blue Lake members seemed to be particularly inappropriate in light of the proximity of UIHS' clinics to Blue Lake and the relatively more comprehensive services which UIHS offered, as compared with those offered by TRIHP.

I find Dr. Yao's testimony provides ample justification for IHS' declination of the Blue Lake and CRIHB contract proposal. The preponderance of the evidence is that the Blue Lake and CRIHB contract proposal would not provide services in a satisfactory matter, because the services sought to be provided would not be provided in a practicable manner. Using TRIHP as a subcontractor would frustrate the proposal's stated objectives of providing care for acute and chronic conditions, in addition to providing preventive care. Furthermore, the proposal is inconsistent with the Secretary's obligation to assure that Indians receive health care, because it creates barriers to the delivery of health care services and it is at cross purposes with the stated objectives of the proposal.

Blue Lake and CRIHB respond to this evidence with several arguments. They point to evidence showing that IHS currently funds other self-determination contracts in California which involve treatment facilities that are located substantial distances from the Indians who are served by these contracts. They point out that, in some instances, these contracts establish service areas in which Indians travel right past other IHS clinics to go to the clinic designated by the contract to serve them. From this evidence, they make two contentions. First, they argue that the evidence vitiates Dr. Yao's concern about the distance which Blue Lake members would have to travel to receive services under the Blue Lake and CRIHB proposal. Second, they contend that IHS should not be permitted to decline a proposal if, in fact, it has approved other proposals which embody similar barriers to treatment to those identified by IHS as existing in the Blue Lake and CRIHB proposal.

I am not persuaded that evidence showing that IHS funds other contracts involving long travel distances for treatment by eligible Indians (including contracts involving travel past other clinics) rebuts the conclusion that the Blue Lake and CRIHB proposal would

not provide services in a satisfactory manner. The issue in this case is whether the Blue Lake and CRIHB proposal creates unacceptable barriers to treatment, not whether IHS has approved other contracts which create unacceptable barriers to treatment. Therefore, what IHS may have done or not done in other cases says nothing about the problems which have been established to be inherent in this proposal. In evaluating a proposal pursuant to the Act, IHS must evaluate that proposal on its own merits. If it declines a proposal, it must do so on the merits of that proposal.

Furthermore, analysis of other contracts previously approved by IHS officials may prove, at most, that IHS officials may not always exercise perfect judgment in reviewing and approving contract proposals. But any judgment errors that IHS officials may make in reviewing contract proposals do not derogate from these officials' responsibility to review contract proposals pursuant to relevant statutory criteria. Otherwise, IHS would be held hostage to its errors and would be forced to approve contracts which repeat those errors. That would be inimical to the exercise of duties which the Act reposes in the Secretary.

Blue Lake and CRIHB argue that IHS' declination at bottom reflects only a preference for UIHS over TRIHP. They assert that both entities' clinics have been approved as providers by IHS. They note that there is no contention in this case that TRIHP's services are inadequate. According to Blue Lake and CRIHB, IHS' stated reasons for declining the proposal are merely a rationalization for IHS' preference of UIHS. Therefore, according to Blue Lake and CRIHB, the declination amounts to unsubstantiated second-guessing of Blue Lake in violation of the Act.

I would agree with this argument if the evidence showed only that UIHS provides more comprehensive care than does TRIHP, or if the evidence showed only that TRIHP's clinic is further away from Blue Lake than are the UIHS clinics. If the evidence were limited to that, then IHS' declination could be characterized as a subjective preference for "better" care. But, in fact, the evidence shows more than that. As is established by Dr. Yao's testimony, the problems associated with TRIHP's selection as a subcontractor amount to objective barriers to treatment which jeopardize the attainment of the health care goals stated in the Blue Lake and CRIHB proposal. In this case, IHS' "preference" for UIHS simply reflects the fact that the treatment barriers which are associated

with TRIHP, due to the locations of Blue Lake and TRIHP, do not exist with respect to UIHS.

Blue Lake and CRIHB contend additionally that Dr. Yao's testimony is flawed, because it rests on generalizations about how patients respond to barriers to treatment. Blue Lake and CRIHB assert that IHS made no effort to assess the individual needs and predilections of each of the 34 members of Blue Lake.

I do not find that IHS had a duty to survey the Blue Lake members in order to determine whether Blue Lake and CRIHB's proposal was satisfactory. Such an obligation is not reasonable and is not implicit in the declination criteria of the Act. IHS contracts with numerous tribes and tribal organizations, many of which have thousands of members. To require IHS to evaluate the needs of tribes' members on an individualized basis before deciding whether to approve or decline contract proposals would be to saddle it with an obligation with which it could never hope to comply.[7]

Blue Lake and CRIHB argue also that while TRIHP may refer its patients to outside physicians for treatment, when necessary, the working relationships which TRIHP has established with physicians are excellent and pose no meaningful problems for TRIHP's patients. It is undisputed that TRIHP has established excellent relations with local physicians and that IHS has not identified problems with its referrals. On the other hand, this does not derogate from Dr. Yao's opinion that fragmented treatment might discourage patients from seeking care or from continuing to obtain care on a regular basis. The issue is not whether TRIHP provides adequate care, which it plainly does, but whether TRIHP's practice of referring patients to outside providers might, when coupled with the long travel distance from Blue Lake to TRIHP, tend to discourage Blue Lake members from seeking care at TRIHP. On this point, I find Dr. Yao's testimony concerning the barriers created by TRIHP's choice as a subcontractor to be persuasive.

The evidence in this case proves that, given the barriers to treatment which would result from having TRIHP as the

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[7] IHS must approve or decline a contract proposal within 60 days after its receipt of the proposal. 42 C.F.R. § 36.213. IHS hardly could be expected to perform the kind of individualized review of Indians' needs and predilictions, suggested by Blue Lake and CRIHB, within 60 days.

subcontractor, and given further that UIHS can provide care without such barriers, there is no legitimate purpose for a contract in which TRIHP is the subcontractor. Thus, IHS' declination is not based simply on the barriers resulting from the proposed relationship with TRIHP, but on the relative inadequacy of TRIHP's services when compared with those offered by UIHS.

Finally, Blue Lake and CRIHB assert that any barriers to treatment which may be created by TRIHP's choice as a subcontractor to replace UIHS are essentially irrelevant, because IHS will continue to pay for the medical care of those Blue Lake members who might elect to patronize UIHS rather than TRIHP. Appellants' Posthearing Brief at 47 - 8. Thus, according to Blue Lake and CRIHB, the choice of TRIHP as subcontractor creates no meaningful barriers to treatment of Blue Lake members, because those Blue Lake members who are daunted by the distance to the TRIHP clinic or by the relatively less comprehensive services offered by TRIHP will opt to patronize UIHS or some other IHS-funded clinic.

This argument does not derogate from IHS' conclusion that the services proposed to be provided by TRIHP will not be satisfactory. Indeed, Blue Lake and CRIHB's admission that some Blue Lake members will continue to patronize UIHS supports the conclusion that there may be barriers to treatment of Blue Lake members at TRIHP's clinic.

Furthermore, if this assertion were accepted as a premise for requiring that the proposal be accepted, it would serve to make meaningless the statutory criteria for IHS to decline contract proposals. Under Blue Lake and CRIHB's theory, they could propose to subcontract with any IHS-approved clinic located anywhere in the United States, and IHS would have no choice but to accept the proposal. The services of any clinic with which Blue Lake and CRIHB proposed to subcontract could never be found to be unsatisfactory by IHS, because UIHS would exist as an alternative to whatever clinic with which Blue Lake and CRIHB chose to contract.

Congress would not have enacted declination criteria only to have them be read in a way which makes those criteria meaningless. IHS' policy of providing health care for eligible Indians at any IHS-approved facility they visit plainly inures to the benefit of individual Indians. But that does not derogate from IHS' statutory obligation to assure that contract proposals are evaluated on their merits and that they make sense. Here, the proposal of Blue Lake and CRIHB has been evaluated on its merits and

has been found to be deficient. The fact that Blue Lake members may resort to extracurricular treatment alternatives does not remediate the proposal's deficiencies.

4. IHS did not breach its duty to provide Blue Lake and CRIHB with technical assistance to cure deficiencies in their contract proposal.

Blue Lake and CRIHB contend that IHS was obligated to provide them with technical assistance to remedy any deficiencies observed in their contract proposal, prior to declining the proposal. They assert that IHS failed to offer or provide such assistance. They contend that, consequently, the declination is defective.

The Act provides that whenever the Secretary declines a proposal for a self-determination contract, she shall provide assistance to the tribal organization that submitted the proposal in order to overcome her stated objections. 25 U.S.C. § 450f(b)(2). Implementing regulations impose on IHS the duty to offer technical assistance to overcome deficiencies in contract proposals. 42 C.F.R. § 36.212(f).

There is no question that IHS did not offer technical assistance to Blue Lake and CRIHB to resolve the deficiencies in the proposal which IHS identified. However, I do not find that this is a failure which invalidates IHS' declination of the proposal. There is no technical assistance which IHS could have offered Blue Lake and CRIHB which would have overcome IHS' objections. The Act and regulations do not impose on IHS the duty to engage in exercises of futility.

No amount of technical assistance could reduce the distance or travel time between Blue Lake and TRIHP. Technical assistance would not overcome the fact that TRIHP is not organized to provide the comprehensive care that UIHS provides. Blue Lake and CRIHB assert that IHS should have discussed with them ways to facilitate transportation of Blue Lake members to TRIHP. But lack of transportation to TRIHP never was asserted by IHS to be a deficiency in the proposal. The issue never has been the availability of transportation to TRIHP, but rather, has always been the distance that Blue Lake members would have to travel to get to the TRIHP clinic and the time involved in the trip. That problem would not be overcome by increasing either the number of vehicles available to transport Blue Lake members, or the number of individuals who are available to drive Blue Lake members to TRIHP.

5. Blue Lake and TRIHP are not entitled to attorney fees under the Equal Access to Justice Act.

Blue Lake and TRIHP contend that they should be awarded attorney fees under the Equal Access to Justice Act (EAJA), 28 U.S.C. § 2412. A necessary premise to an award of fees to a party under EAJA is that it prevail in a civil action against the Secretary. 28 U.S.C. § 2412(d)(1)(A). Blue Lake and CRIHB have not prevailed in this case, inasmuch as I find IHS' declination of their proposal to be lawful. Therefore, they have demonstrated no basis to be awarded attorney fees under EAJA.

CONCLUSION

I conclude that IHS has shown by a preponderance of the evidence that its declination of the June 19, 1992 contract proposal of Blue Lake and CRIHB was lawful under the Act. Therefore, I recommend that the declination be sustained.

/s/

Steven T. Kessel
Administrative Law Judge