UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

PUEBLO OF ACOMA PLAINTIFF, v. **NORRIS COCHRAN**, in his official capacity as Acting Secretary, U.S. Department of Health & Human Services **DEPARTMENT OF HEALTH AND HUMAN SERVICES** **ELIZABETH FOWLER**, in her official capacity as Acting Director, Indian Health Service **INDIAN HEALTH SERVICE** DEFENDANTS.	Civil Action No. 21-253 **PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION AND STATEMENT OF POINTS OF LAW AND AUTHORITIES IN SUPPORT OF MOTION** **ORAL HEARING REQUESTED**

Plaintiff Acoma Pueblo, a federally-recognized tribe, respectfully moves this Court for a preliminary injunction pursuant to Fed. R. Civ. Pro. 65(a) and Local Civil Rule 65.1 enjoining Defendants and their officers, agents, servants, employees and attorneys and those in active

concert with them or in participation with them from closing the Acoma-Canoncito-Laguna Hospital ("ACL Hospital") and reducing the facility's current services to urgent care services on February 1, 2021 until Defendants can provide Congress with the evaluation and one year notice required by section 301(b) of the Indian Health Care Improvement Act, 25 U.S.C. §1631(b) and the determination required by Section 105(i) of the Indian Self-Determination and Education Assistance Act, 25 U.S.C. §5324(i).

Plaintiff further moves for a waiver of security required under Fed. R. Civ. Pro. 65(c), or for nominal security, on the grounds set forth in the accompanying Plaintiff's Statement of Points of Law and Authorities in Support of Motion for Temporary Restraining Order and Motion for Preliminary Injunction, that Defendants will suffer no irreparable harm from being enjoined from closing ACL Hospital and operating the facility as an urgent care center beginning February 1, 2021.

Defendants have not yet appeared in this action and thus have not designated counsel to represent them herein. As a result, plaintiff has not been able to confer with opposing counsel in accordance with Local Civil Rule 7(m). Notwithstanding the foregoing, on January 26, 2021, the undersigned reached out to multiple attorneys within the Office of General Counsel (OGC), Department of Health and Human Services, and on January 27, 2021, received a call from two attorneys with the OGC, Region VI, Neel Gandhi and Farrah White. The undersigned attorney Gregory Smith discussed with the HHS attorneys the motions for a temporary restraining order and for a preliminary injunction, as well as the complaint that the plaintiff would be filing. The HHS attorneys indicated that they were not in a position to negotiate anything, but that their client was attempting to identify alternatives to the closure that is the subject of this case. They indicated that they would confer further with their client and get back out to us. In a follow-up conversation, they still had not yet received guidance from their client.

I. Introduction

Plaintiff Pueblo of Acoma ("Tribe") seeks a temporary restraining order and a preliminary injunction restraining and enjoining Defendants the Indian Health Service ("IHS") from closing the Acoma-Canoncito-Laguna Hospital ("ACL Hospital") in the midst of a pandemic without first meeting its obligations to Congress and to the Tribe under Section 301(b) of the Indian Health Care Improvement Act, 25 U.S.C. §1631(b) and Section 105(i) of the Indian Self-Determination and Education Assistance Act ("ISDEAA"), 25 U.S.C. §5324(i). According to the IHS, it intends to cease operating ACL Hospital as a hospital on February 1, 2021 and instead begin operating the facility as an urgent care facility with limited hours and no capacity to provide inpatient or emergency room services. The reason for the closure provided by the IHS is that ACL Hospital will no longer have funding necessary to operate as a hospital after one of the other tribes served by the hospital, the Laguna Pueblo, enters into a contract with the IHS to operate its own program with funding previously allocated by the IHS to the ACL Hospital.

The IHS has a history of abruptly closing hospitals. In 1988, Congress sought to put an end to that practice by instituting the evaluation and notice requirements in Section 301(b) of the Indian Health Care Improvement Act ("IHCIA"), 25 U.S.C. § 1631(b). Section 301(b) requires the IHS to evaluate the impacts that closing the hospital would have on the population served and provide Congress with one year's notice before any proposed closure. In this case the IHS has taken the position that it need not first comply with the notice and evaluation requirements of Section 301(b)(1) because lack of funding has created a safety issue that allows the IHS to temporarily close the hospital under the temporary closure exception for safety reasons found in Section 301(b)(2).

IHS's position would circumvent the purpose of Section 301(b), which is to give Congress time to determine whether the hospital should be closed or not. The "safety issue" claimed is self-

inflicted because the IHS has determined not to allocate other funding to keep the hospital open during the one year congressional review period. The IHS seeks to create a loophole for itself, taking advantage of one of the limited exceptions Congress provided for temporary closure to escape the oversight that Congress has deemed necessary.

Closure of ACL Hospital will result in immediate, severe and irreparable harm to the Tribe. It will create an immediate increased burden on the Tribe's Emergency Services program requiring additional funds from the Tribe, and create a significant likelihood of harm to its members due to delayed or deferred treatment. The IHS could reallocate resources to keep the ACL Hospital open during a global pandemic, but has chosen not to—a choice it made with limited consultation or regard for the impact on Acoma. This is exactly the type of irresponsible action that Congress intended to prevent in Section 301(b) of the IHCIA. If IHS is allowed to abuse the statutory exceptions in this manner, it will be able to evade the 301(b) requirements whenever it wants and meaningful congressional oversight will be lost.

The IHS's proposal to close ACL Hospital is also inconsistent with its obligations to the Tribe under Section 105(i) of the Indian Self-Determination and Education Assistance Act ("ISDEAA"), which requires the IHS to ensure that the ACL Hospital funding and services will be maintained after the Laguna Pueblo takes its shares.

For those reasons, IHS must not be allowed to close ACL Hospital unless and until it fully complies with its legal responsibilities under the IHCIA and the ISDEAA, and immediate relief is necessary to ensure it does not do so.

II. Statement of Facts

The Acoma-Cañoncito-Laguna (ACL) Hospital, which is part of the Acoma-Cañoncito-Laguna Service Unit of the Indian Health Service (IHS), opened in the 1970's and has been the primary provider of health care services to the Pueblo of Acoma, a federally recognized Indian

tribe, as well as the Pueblo of Laguna, ever since. *See* IHS Contractor, *ACL Hospital*, http://www.ihscontractor.com/acl-hospital.html#/ (last visited Jan. 27, 2021).

On December 31, 2019, the Wuhan Municipal Health Commission, China, reported a cluster of cases of pneumonia in Wuhan, Hubei Province. World Health Org., *Archived: WHO Timeline – COVID-19* (Apr. 27, 2020), https://www.who.int/news/item/27-04-2020-who-timeline---covid-19. This was the first official report of the emergence of a new, highly contagious virus, which became known as COVID-19. In January 2020, the first COVID-19 cases were identified in the United States. Ctrs. for Disease Control & Prevention, U.S. Dep't of Health & Human Servs., *Evidence for Limited Early Spread of COVID-19 Within the United States, January-February 2020*, 69 Mortality & Morbidity Weekly Report 680, 680 (June 5, 2020). On January 31, 2020, in response to growing concerns about COVID-19, President Trump declared a public health emergency under the Public Health Service Act. Nat'l Conference of State Legislatures, *President Trump Declares State of Emergency for COVID-19* (Mar. 25, 2020), https://www.ncsl.org/ncsl-in-dc/publications-and-resources/president-trump-declares-state-of-emergency-for-covid-19.aspx. Subsequently, on March 13, 2020, he issued two national emergency declarations under both the Stafford Act and the National Emergencies Act and invoked emergency powers via Executive Order under the Defense Production Act on March 18, 2020. *Id.*; *see also* Proclamation No. 9994, 85 Fed. Reg. 15,337, 15,337-38 (Mar. 13, 2020); Exec. Order No. 13,909, 85 Fed. Reg. 16227 (Mar. 18, 2020).

Beginning in early spring 2020, the entire medical profession was mobilized to address the worst pandemic the United States had experienced since the Spanish Flu of 1918. Dan Mangan & John Schoen, *Coronavirus cases: These states face biggest potential shortfalls in hospital ICU beds*, CNBC (Apr. 6, 2020), https://www.cnbc.com/2020/04/06/coronavirus-cases-states-with-biggest-hospital-bed-shortfalls.html. Medical experts sounded the alarm that the pandemic would

increase in severity in the fall and winter seasons and urged that every effort be made to expand hospital capacity, both for COVID-19 patients, as well as for patients with other conditions requiring hospitalization. Olivia Goldhill, *'People are going to die': Hospitals in half of the states are facing a massive staffing shortage as COVID-19 surges*, STAT News (Nov. 19, 2020), https://www.statnews.com/2020/11/19/covid19-hospitals-in-half-the-states-facing-massive-staffing-shortage/.

In February 2020, the Albuquerque Area Indian Health Service (AAIHS) office received a letter of intent to contract from the Laguna Health Corporation (LHC), which proposed to withdraw the Pueblo of Laguna's funding shares from the ACL Hospital in accordance with Title I of the Indian Self-Determination and Education Assistance Act (ISDEAA) for the purpose of establishing a day-time clinic at Laguna, approximately 15-20 miles from the hospital. Ex. A. at 4,5. This letter of intent was followed by a Title I contract proposal on July 1, 2020. Ex. A. Six weeks later, on August 11, 2020, the AAIHS held its initial consultation meeting with the Pueblo of Acoma to inform them of its intent to enter into the contract and that, as a result, the IHS would be dramatically reducing services at the ACL hospital. Ex. A, 2.

In September 2020, following up on the August 11th meeting, the AAIHS provided the Pueblo of Acoma with a one-page proposal which outlined major reductions in service and involved closing the ACL hospital and replacing it with an urgent care facility with limited operating hours. Ex. A, 1. As discussed further below, the proposal violated Section 301(b) of the Indian Health Care Improvement Act (mandating that Congress be afforded a one-year advance notice of the closure of a hospital or portion thereof and requiring a detailed report on the impact of that closure) and Section 105(i) of the ISDEAA, 25 U.S.C. 5324(i) (requiring that the Secretary ensure that any division of a program serving one or more tribes must be conducted in consultation with all affected tribes, and may not limit or reduce the funding for program service

non-contracting tribes).

The proposal stated that the ACL hospital had 135 full time employees (including 7 Public Health Service Commissioned Officers) and 64 vacancies. Ex. B. The document indicated that the removal of Laguna's share would require a reduction in staff of 76. Ex. B. The document stated the IHS's intent to replace the 24-hour hospital with primary care and urgent care that would be provided Monday through Friday, from 8 a.m. to 4:30 p.m., with no week-end hours. Ex. B. In addition to the reduction in hours, it expressly stated the IHS would discontinue the following services:

- Emergency Room
- Inpatient Services
- Women's Services
- Optometry
- Podiatry
- Pediatrics

Ex. B. In addition, the pharmacy would no longer be able to provide over-the-counter drugs, nor would it be able to support Pueblo of Acoma and Pueblo of Laguna EMS with medications. Ex. B. Additionally, the facility would no longer provide anticoagulation and Hepatitis C treatment, and there would be no outside prescriptions and no curbside services. Ex. B. The dental program would no longer be able to provide dentures. Ex. B.

The IHS formally approved Laguna's proposed Title I contract on September 29, 2020. Ex. C. Laguna had initially proposed to receive its shares effective October 1, 2020, but it became evident in September that Laguna was not ready to open its facility so the final negotiated date for the withdrawal of the shares was set for February 1, 2021. Ex. D. In January 2021, Laguna informed the IHS that it needed an additional 30-days before it could open its clinic.

Lewis Aff., Ex. E, ¶ 5.

On October 26, 2020, the Acting Director of the ACL hospital informed the Pueblo of Acoma that 13 medical professionals had resigned and a substantial additional number announced that they would be retiring or taking jobs elsewhere. Lewis Aff. Ex. E, ¶ 4. As a result, the IHS said the emergency room and urgent care would no longer be open 24 hours per day. Lewis Aff. Ex. E, ¶ 4. Instead, these facilities would be open 14 hours per day (eventually the emergency room was closed) and no further patients would be admitted to inpatient services. Lewis Aff. Ex. E, ¶ 4. Months before the official date upon which the Laguna shares would be removed (February 1, 2021), the hospital was downsized to a day-time only urgent care clinic. Lewis Aff. Ex. E, ¶¶ 4-5.

In response to a question by Senators Heinrich and Udall and Representative Small about how the IHS intended to comply with its requirements under Section 301(b), the IHS attempted to explain its position as follows:

> The IHS has *not* indicated that it believes the 1-year notification to Congress described by Section 301(b) of the Indian Health Care Improvement Act (25 U.S.C. § 163l (b)(l)) does not apply in this situation. As a result of the significant reduction of resources available to the Federal program, the IHS believes that it will be necessary to permanently transform or re-design the ACLSU Hospital and is preparing a closure report. The Secretary will submit a report to Congress as required by section 1631(b)(l). Additionally, in a letter to the Pueblo of Acoma dated September 17, 2020, the IHS stated that it is preparing a closure report for the Secretary to submit to Congress.
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> In the meantime, the IHS is aware that 25 U.S.C. § 163l (b)(2) provides that the requirements of section 1631(b)(1) "shall not apply to any *temporary* closure of a facility or of any portion of a facility if such closure is necessary for medical, environmental, or safety reasons." *See* 25 U.S.C. § 1631(b)(2) (emphasis added). Because the LHC contracted for the Pueblo of Laguna's portion of programs and associated Tribal shares (funds) of the ACLSU Hospital, the resulting reduction of funding available to the Federal program may render the continued safe operation of inpatient and emergency departments at the ACLSU Hospital unfeasible. Thus, the IHS may be required to *temporarily suspend* services in the impacted departments during the 1-year notification period if the IHS cannot safely provide the services with the new funding level. Any such stoppages would be: 1) only

> temporary; and 2) necessary for medical, environmental, or safety reasons, until the permanent closure report requirement is met.

Ex. A, 3. In short, the IHS position was that it recognizes it needs to comply with the congressional notification and evaluation requirement of Section 301(b), but that it can delay doing so until *after* the ACL Hospital is closed by characterizing the closure as "temporary" and necessary to address a safety issue created by the IHS's failure to allocate additional funds to the facility after the Laguna Pueblo takes its shares.

The facility operated in this diminished capacity until January 1, 2021, when the IHS reestablished the facility as a hospital with emergency room and 24-hour operations. Lewis Aff. Ex. E, ¶ 5. However, the IHS only committed to maintaining the restored hours and services until January 31, 2021. Lewis Aff. Ex. E, ¶ 5. Upon the withdrawal of Laguna's shares effective February 1, 2021, the IHS has said that the ACL Hospital will again be closed and operated instead as a day-time only urgent care clinic. *See* Lewis Aff. Ex. E, ¶ 5.

The Laguna Pueblo has denied that it was ever asked by the IHS to delay taking its shares and further denied that it was advised that the removal of the shares would result in the closure of the 24-hour hospital, upon which Laguna tribal members also rely. Ex. F.

American Indians and Alaska Natives ("AI/AN"), including the Native communities served by the ACL hospital, suffer from diseases in much higher numbers than the U.S. population as a whole. Prior to the pandemic, AI/AN causes of death exceed the U.S. rate by:

- 5.5 times the rate for tuberculosis;
- 4.7 times the rate for chronic liver disease and cirrhosis;
- 3.1 times the rate for diabetes;
- 1.4 times the rate for pneumonia and influenza; and
- 1.0 times the rate for chronic lower respiratory diseases.

> The IHS acknowledges the health disparities in Indian Country:
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> > The American Indian and Alaska Native people have long experienced lower health status when compared with other Americans. Lower life expectancy and the disproportionate disease burden exist perhaps because of inadequate education, disproportionate poverty, discrimination in the delivery of health services, and cultural differences. These are broad quality of life issues rooted in economic adversity and poor social conditions. . . . .
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> > . . . .
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> > American Indians and Alaska Natives born today have a life expectancy that is 5.5 years less than the U.S. all races population (73.0 years to 78.5 years, respectively). American Indians and Alaska Natives continue to die at higher rates than other Americans in many categories, including chronic liver disease and cirrhosis, diabetes mellitus, unintentional injuries, assault/homicide, intentional self harm/suicide, and chronic lower respiratory diseases.

Indian Health Serv., *Fact Sheets, Disparities*, https://www.ihs.gov/newsroom/factsheets/disparities (last updated Oct. 2019).

These health disparities have contributed to severe COVID-19 illness and death rates among the AI/AN population. Based on the most recent data, COVID-19 mortality among AI/ANs is significantly higher than that of other populations, particularly non-Hispanic Whites. Ctrs. for Disease Control & Prevention, U.S. Dep't of Health & Human Servs., *COVID-19 Mortality Among American Indian and Alaska Native Persons – 14 States, January—June 2020*, 69 Mortality & Morbidity Weekly Report 1853, 1853 (Dec. 11, 2020). For example, "the cumulative incidence of laboratory-confirmed COVID-19 cases among AI/AN persons was 3.5 times that among White persons," and "[a]mong persons aged 20–29 years, 30–39 years, and 40–49 years, the COVID-19 mortality rates among AI/AN were 10.5, 11.6, and 8.2 times, respectively, those among White persons." *Id; see also Letter of Gov. MLG to Pres. Biden*, Exh., L.

It is inevitable that the closure of the ACL hospital during a pandemic would do irreparable harm to the public health in Acoma and the surrounding communities. Just from a

mental health standpoint, the added strain of arranging for new doctors and travelling, typically at least one hour or more, in the middle of a pandemic takes a terrible toll on the Acoma community; however, there is also more specific harm. Shalini Ramachandran, *A Hidden Cost of Covid: Shrinking Mental-Health Services*, Wall Street J. (Oct. 9, 2020), https://www.wsj.com/articles/a-hidden-cost-of-covid-shrinking-mental-health-services-11602255729.

Because of the closure, the Acoma EMS department has become the primary care service for the Pueblo of Acoma and is stretched to its limit, not only responding to the usual needs of the community, but also responding to COVID-19 calls, and now calls that formerly would have been handled by the ACL hospital. Lewis Aff. Ex. E, ¶ 6. The Acoma EMS program is operated by the Tribe under a Title I contract with the IHS. The IHS provides some funding for the program, but the Tribe supplements that funding with its own funds. The Tribe had to significantly increase the funding it allocated to the EMS program after the temporary closure of the Hospital this fall. Lewis Aff. Ex. E, ¶ 8. Nevertheless, the EMS program is still overwhelmed. Acoma EMS spends an extraordinary amount of time transporting patients to hospitals in Albuquerque, a two-hour roundtrip. Lewis Aff. Ex. E, ¶ 6. Because of this, it is almost impossible for Acoma EMS to provide adequate emergency care to the Acoma community, and therefore to protect the public health of its citizens. Lewis Aff. Ex. E, ¶ 6.

Tragically, the closure of the ACL hospital contributed to the death of an Acoma citizen who was not able to be reached by Acoma Emergency Medical Service (EMS) in a timely manner because it was addressing needs precipitated by the closure. Lewis Aff. Ex. E, ¶ 7. On November 1, 2020, an Acoma member suffered a heart attack in his home on the reservation. Lewis Aff. Ex. E, ¶ 7. Because Acoma EMS services were transporting another patient, they were not immediately available to respond, requiring the Laguna EMS to be the first responder, even though they are located nearly 20 miles farther away. Lewis Aff. Ex. E, ¶ 7. The patient, who

tested positive for COVID-19, passed away before he could be transported to a hospital. Critical time was lost while Laguna scrambled its EMS to serve a patient at Acoma. Lewis Aff. Ex. E, ¶ 7. This death is directly traceable to the adverse impact on healthcare at Acoma as a result of the closure of the ACL hospital. Lewis Aff. Ex. E, ¶ 7.

The *New York Times* reported on a patient who had to be taken to two separate hospitals before he could receive treatment for multiple fractures in both his legs because the ACL Hospital was closed. Mark Walker, *Native Americans Reliant on Hospital Feel Abandoned by U.S. During Pandemic*, (Jan. 3, 2021), https://www.nytimes.com/2021/01/03/us/politics/indian-health-service-hospital.html. The patient had to be driven 45 minutes to a hospital in Grants, New Mexico and an additional hour to a hospital in Albuquerque, New Mexico after the hospital in Grants misdiagnosed him. *Id.* The inability of the ACL hospital to treat this individual resulted in nearly two hours of driving to find appropriate care for two broken legs. *Id.* Multiple times, on a daily basis, Acoma and other community members, who formerly had a short drive to the ACL hospital, now must drive an hour to Albuquerque to receive adequate care, even if they are experiencing severe symptoms of one sort or another. Lewis Aff. Ex. E, ¶ 9.

The IHS has funds available to keep the ACL hospital open during the pandemic and the one-year notice period. Ex. G. Specifically, the IHS has its regular annual appropriations, as well Area and Headquarters funds including the Director's emergency fund at its disposal and has not explained why those funds could not be used. Ex. G. In addition, in 2020 Congress provided the IHS with billions in supplemental funding to prepare for, prevent and respond to the coronavirus pandemic. In the Coronavirus Aid, Relief, and Economic Security Act (CARES Act), Pub. L. No. 116–136, Congress set aside $1.032 billion for the IHS and tribally operated facilities, as well as $175 billion in a Provider Relief Fund for health care providers generally. HHS designated a minimum of $500 million of that $175 billion for IHS and tribal facilities, while also allowing

IHS and tribal facilities access to the remainder of the Provider Relief Funds on the same basis as other health care providers. U.S. Dep't of Health & Human Servs., *CARES Act Provider Relief Fund: General Information*, https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/general-information/index.html, (last visited Jan. 27, 2021). While some of the these funds were specifically designated by Congress or allocated by the IHS for tribally operated facilities, the IHS retained hundreds of millions of dollars from these two sources of funding for direct service facilities like ACL Hospital. In Dear Tribal Leader letters sent on April 3 and April 23, 2020 the IHS explained that $570 million in CARES Act funds were being used to support direct service and tribally operated facilities. Exs. H & I. In its April 23, 2020 Dear Tribal Leader letter, the IHS explained that it was reserving $30 million "to address unanticipated needs in the near future." Ex. I.

In late December, Congress made an additional $790 million in funding for the IHS in the Coronavirus Response and Relief Supplemental Appropriations Act, (Pub. L. No. 116-260). As described in a January 15, 2021 Dear Tribal Leader Letter, those funds are to be used "to support COVID-19 testing, contact tracing, containment, mitigation and related activities for monitoring and suppressing COVID-19 in American Indian and Alaska Native (AIAN) communities."). Ex. J. The letter outlines the following distribution:

- $550 million: to IHS Federal health programs and THPs, using existing distribution methodologies for program increases in Hospitals and Health Clinics, Purchased/Referred Care, Alcohol and Substance Abuse, Mental Health, Community Health Representatives, and Public Health Nursing.
- $50 million: Urban Indian Organizations
- $190 million to purchase COVID-19 tests, test kits, testing supplies, therapeutics, and related personal protective equipment through the IHS National Supply

Service Center.

Ex. J.

III. The Tribe is entitled to a Preliminary Injunction

"A preliminary injunction is 'an extraordinary remedy that may only be awarded upon a clear showing that the plaintiff is entitled to such relief.'" *Sherely v. Sebelius*, 644 F.3d 388, 392 (D.C. Cir. 2011) (quoting *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 22 (2008)). In order to obtain a preliminary injunction, a plaintiff "must establish [1] that he is likely to succeed on the merits, [2] that he is likely to suffer irreparable harm in the absence of preliminary relief, [3] that the balance of equities tips in his favor, and [4] that an injunction is in the public interest." *Winter*, 555 U.S. at 20. The balance of equities and the public interest factors "merge when relief is sought against the government." *Seeger v. United States Dep't of Def.*, 306 F. Supp. 3d 265, 291 (D.D.C. 2018) (citing *United States Ass'n of Reptile Keepers, Inc. v. Jewell*, 103 F. Supp. 3d 133, 163 (D.D.C. 2015) (citing *Nken v. Holder*, 556 U.S. 418, 435 (2009))). In addition, "[t]he standard for obtaining injunctive relief through either a temporary restraining order or a preliminary injunction" is the same four-factor test. *Gomez v. Kelly*, 237 F. Supp. 3d 13, 14 (D.D.C. 2017); *Hall v. Johnson*, 599 F. Supp. 2d 1, 3 n.2 (D.D.C. 2009) ("The same standard applies to both temporary restraining orders and to preliminary injunctions."). Upon an examination of these factors, the Tribe is clearly entitled to the relief it seeks.

A. <u>The Tribe is Likely to Succeed on the Merits.</u>

The IHS is not permitted to close the ACL hospital until it meets its statutory obligations under Section 301(b) of the Indian Health Care Improvement Act ("IHCIA") and Section 105(i) of the Indian Self-Determination and Education Assistance Act ("ISDEAA"). Because the IHS has made it clear that it intends to close the ACL Hospital without first meeting those requirements, the Tribe is likely to succeed on the merits.

i. *The IHS is in Violation of Section 301(b) of the IHCIA*

Section 301(b) of the IHCIA requires the IHS to provide Congress with notice and an evaluation that addresses seven specific factors set out in the statute at least one year before it may close a hospital or any portion thereof. 25 U.S.C. § 1631(b). Section 301(b) provides that:

> (1) ***Notwithstanding any provision of law*** other than this subsection, no Service hospital or outpatient health care facility of the Service, or any portion of such a hospital or facility, may be closed if the Secretary has not submitted to the Congress at least 1 year prior to the date such hospital or facility (or portion thereof) is proposed to be closed an evaluation of the impact of such proposed closure which specifies, in addition to other considerations—
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> (A) the accessibility of alternative health care resources for the population served by such hospital or facility;
> (B) the cost effectiveness of such closure;
> (C) the quality of health care to be provided to the population served by such hospital or facility after such closure;
> (D) the availability of contract health care funds to maintain existing levels of service;
> (E) the views of the Indian tribes served by such hospital or facility concerning such closure;
> (F) the level of utilization of such hospital or facility by all eligible Indians; and
> (G) the distance between such hospital or facility and the nearest operating Service hospital.

25 U.S.C. § 1631(b)(1) (emphasis added). The IHS is authorized to *temporarily* close a hospital before meeting these requirements, but only if the closure is necessary for "medical, environmental, or safety reasons." 25 U.S.C. § 1631(b)(2).

The IHS has not provided Congress with the evaluation required by the statute regarding the impact closing ACL hospital would have on the population it serves, nor has it provided Congress with the requisite one year notice of its intent to close the Hospital. As a result, the IHS is in violation of Section 301(b) of the IHCIA.

The IHS has attempted to justify the planned closure because it says it will no longer have the funds available to maintain ACL as a hospital once the Pueblo of Laguna takes its shares and associated funding on February 1, 2021. This reduction in funding, the IHS argues, will create a

safety issue that justifies the IHS to "temporarily" close under the temporary closure exception in Section 301(b)(2) before it is required to provide Congress with the evaluation and one year notice required by Section 301(b)(1). This self-serving interpretation of the law is contrary to the plain language of Section 301(b) and Congress's intent.

First, Section 301(b) applies "notwithstanding any other provision of law," and that includes all of ISDEAA. As a result, Section 301(b) applies to prevent the IHS from closing the hospital without first conducting the requisite evaluation and one year's notice to Congress regardless of whether the IHS enters into a Title I Contract with the Pueblo of Laguna. While the Pueblo of Laguna still has the right to contract for its shares under Title I of the ISDEAA, the result of that contract cannot be the closure of ACL Hospital before Congress is given a chance to act. Section 301(b) of the IHCIA prevents the IHS from closing the hospital until its conditions are met "notwithstanding any other provision of law."

There is no lack of funding exception to the one year notice and evaluation requirements in Section 301(b). In fact, Congress considered and rejected including a funding exception when it enacted Section 301(b) in 1988. Congress enacted Section 301(b) because it was "concerned with the practice that has been followed in past years in which IHS facilities have been closed without notice to patients, without adequate preparation to assure that patients are advised of alternative health care providers, and without an evaluation of the impact a proposed closure may be expected to have." S. Rep. No. 100-508, at 16-17 (1988). While Congress recognized the need for an exception for temporary closures, there was some debate as to how broad the exception language should be. HHS expressed its view to the House Committee of jurisdiction that the provision needed a broad temporary closure exemption that would permit the IHS to temporarily close a facility or a portion of a facility for "good cause," which would have included medical or fiscal reasons. H.R. Rep. 99-94, pt. 2, at 44 (1985). However the language allowing

the IHS to temporarily close a facility or portion thereof for fiscal reasons was ultimately not adopted in Section 301(b).

The IHS cannot therefore cite a lack of funding as the basis for a safety issue authorizing it to "temporarily" close the hospital indefinitely. The IHS has refused to allocate funds at its disposal to keep the ACL Hospital open. That willful refusal cannot constitute a "safety issue." Such an interpretation would transform a limited statutory exception into a back door for the IHS to close any facility it chose not to allocate funding to. This is not what the plain language of Section 301(b) requires or what Congress intended.

In any event, the IHS has ample funds at its disposal to keep the hospital open during the requisite one year notice period. As an initial matter, the IHS has Area and Headquarters funds including the Director's emergency fund at its disposal and has not explained why those funds could not be used. Moreover, in 2020 Congress provided the IHS with billions in supplemental funding to prepare for, prevent and respond to the coronavirus pandemic. Congress set aside $1.032 billion for the IHS and tribally operated facilities in the Coronavirus, Aid, Relief and Economic Support ("CARES") Act (Pub. L. No. 116-136, Div. B, tit. VII, 134 Stat. 281, 550 (2020)), as well as $175 billion in a Provider Relief Fund for health care providers generally. HHS designated a minimum of $500 million of that $175 billion for IHS and tribal facilities, while also allowing IHS and tribal facilities the same access to the remainder of the Provider Relief Funds as other health care providers. Some of the funds received by the IHS were specifically designated for tribally operated facilities, but the IHS retained hundreds of millions of dollars from these two sources of funding for direct service facilities like ACL Hospital. In Dear Tribal Leader letters sent on April 3 and April 23, 2020 the IHS explained that $570 million in CARES Act funds were being used to support direct service and tribally operated facilities. Exs. H & I. In its April 23, 2020 Dear Tribal Leader letter, the IHS explained that it was reserving

"$30 million to address unanticipated needs in the near future." Ex. I.

At the end of last year, Congress provided the IHS with an additional $790 million in funding through the IHS COVID-19 relief package and FY 2021 omnibus appropriations legislation (Pub. L. No. 116-260, Div. M., tit. III). These funds must be used for "testing, contact tracing, surveillance, containment and mitigation," including "support for workforce," and are to be distributed at the discretion of the IHS Director. *Id.* In a January 15, 2021 Dear Tribal Leader letter, the IHS announced it would be allocating $550 million out of this additional funding to IHS Federal health programs and tribally operated programs. Ex. J.

The IHS thus has significant resources above and beyond its usual annual appropriation to keep ACL Hospital open in the near term. The IHS has explained that it cannot use these funds to keep the ACL Hospital open indefinitely because these funds are required by statute to be used to prevent, prepare for and respond to coronavirus. The Tribe does not dispute that fact, but does believe that the IHS can use these funds to keep the hospital open during the pandemic. HHS has taken a broad view of how CARES Act funding can be used. Its Provider Relief Fund FAQs state that the funds can be used for "diagnoses, testing or care for individuals with possible or actual cases of COVID-19." Ex. K, 8-9. The "HHS broadly views every patient as a possible case of COVID-19," Ex. K, 2, 4, & 9, thereby allowing these funds to be used for expenses incurred in caring for all patients. The HHS FAQs further provide that funds can be used "to expand or preserve care delivery." Ex. K, 10.

While the IHS undoubtedly has discretion in how it allocates its appropriated resources, *Lincoln v. Vigil*, 508 U.S. 182, 185 & 193 (1993), that discretion is constrained by Section 301(b) with regard to the closure of a hospital. In *Lincoln*, the Supreme Court held that the IHS was within its authority to close a Handicapped Indian Children's Program, which the agency created with funds from its lump sum appropriation. *Id.* at 193-94. The Court held the IHS's decision to

close the program was not judicially reviewable, because that decision was "committed to agency discretion by law" under 5 U.S.C. § 701(a)(2). *Id.* There was no statutory law, in the appropriation or otherwise, mandating creation of the program or governing its operation or termination. The Court held that where "Congress merely appropriates lump-sum amounts without statutorily restricting what can be done with those funds, a clear inference arises that it does not intend to impose legally binding restrictions." *Id.* at 192. The Court determined that a lump sum appropriation "reflects a congressional recognition that an agency must be allowed 'flexibility to shift . . . funds within a particular . . . appropriation account so that' the agency 'can make necessary adjustments for "unforeseen developments" and "changing requirements."'" *Id.* Because there was no law to apply to the IHS decision to end the program, the Court held the agency's decision was unreviewable under § 701(a)(2) of the APA.

The situation here is entirely different. As explained above, the IHCIA at 25 U.S.C. § 1631(b) prohibits the IHS, "***notwithstanding any other provision of law***," from closing any hospital or portion of a hospital without first complying with its requirements, which the IHS has not done here. The ISDEAA is an "other provision of law" and § 1631(b) is applicable here regardless of the ISDEAA. Thus, this situation differs from *Lincoln* because there is law to apply for judicial review of the IHS hospital closure decision at issue here. The D.C. Circuit in *Shawnee Tribe v. Mnuchin*, No. 20-5286, 2021 WL 28207 at *4 (Jan. 25, 2021), just held that *Lincoln* is distinguishable where there is law to apply to an agency decision regarding distribution of funds to Indian tribes under Title V of the CARES Act. The decision in *Shawnee Tribe* governs the issue of whether *Lincoln* should apply here.

ii. *The IHS is in violation of Section 105(i) of the ISDEAA*

Section 105(i) of the ISDEAA, 25 U.S.C. § 5324(i), requires the Secretary to ensure that any division of a program serving one or more tribes must be conducted in consultation with all

affected tribes, and may not limit or reduce the funding for any tribe served by the program. It provides, in relevant part:

> (1) If a self-determination contract requires the Secretary to divide the administration of a program that has previously been administered for the benefit of a greater number of tribes than are represented by the tribal organization that is a party to the contract, the Secretary shall take such action as may be necessary to ensure that services are provided to the tribes not served by a self-determination contract, including program redesign in consultation with the tribal organization and all affected tribes.
>
> (2) Nothing in this subchapter shall be construed to limit or reduce in any way the funding for any program, project, or activity serving a tribe under this or other applicable Federal law. Any tribe or tribal organization that alleges that a self-determination contract is in violation of this section may apply the provisions of section 5331 of this title.

25 U.S.C. § 5324(i). This provision of the law requires that when a program serves multiple tribes, and one of those tribes proposes to enter into a contract that would divide the program, the Secretary must ensure that services continue to be provided to the non-contracting tribe. This requires a divisibility analysis to be conducted in consultation with the affected tribes. Section 105(i)(2) (codified at 25 U.S.C. § 5324(i)(2)) prohibits the IHS from limiting or reducing the funding available to the programs serving the non-contracting tribes in any way.

The IHS has failed to meet its obligations under Section 105(i). While the IHS can provide this Court with a long list of conference calls where it discussed its plans with the Tribe, at no point did the IHS ever discuss whether or how the ACL program could be divided in a manner that (1) ensured continued hospital services would be provided to the Tribe and its members and (2) did not result in a reduction in funding to the program. Instead, IHS only provided the Tribe with a one-page summary of the hospital and other services that would no longer be provided at ACL Hospital due to lack of funding. Ex. B. It did not consult with the Tribe as to how the program could be divided in a way that ensured that services and funding would be maintained for the Tribe.

While the IHS certainly has an obligation to enter into contracts with tribes like the Pueblo of Laguna under Title I of the ISDEAA, Section 105(i) requires the IHS to ensure that entering into such contracts will not result in reduction in services or funding to the programs serving the non-contracting tribes. IHS has not done so here, and as a result the Tribe is likely to succeed on the merits.

B. The Tribe is Likely to Suffer Irreparable Harm

To demonstrate irreparable harm, the plaintiff must show that (1) the harm is certain and great, actual and not theoretical, and so imminent that there is a clear and present need for equitable relief to prevent irreparable harm and (2) the harm must be beyond remediation. *Open Commtys. All. v. Carson*, 286 F. Supp. 3d 148, 174 (D.D.C. 2017); *see e.g.*, *NAACP v. United States Postal Serv.*, No. 20-CV-2295, 2020 WL 5995032 at *12 (D.D.C. Oct. 10, 2020) (appeal filed); *TikTok Inc. v. Trump*, No. 1:20-CV-02658, 2020 WL 57636534 at *8 (D.D.C. Sept. 27, 2020); *see also Wis. Gas Co. v. FERC*, 758 F.2d 669, 674 (D.C. Cir. 1985). However, because "a preliminary injunction requires only a *likelihood* of irreparable injury, . . . Damocles's sword does not have to actually fall . . . before the court will issue an injunction," meaning that a party can show a likely injury even when the conduct for which they seek an injunction against has not yet been initiated or enforced. *See Open Commtys. All.*, 286 F. Supp. 3d at 175 (emphasis added) (citing *League of Women Voters of the United States v. Newby*, 838 F.3d 1, 8-9 (D.C. Cir. 2016).

This court has recently recognized that a high "risk of contracting COVID-19 and the resulting health complications, including the possibility of death, is the prototypical irreparable harm." *Banks v. Booth*, 459 F.Supp.3d 143, 159 (D.D.C. 2020) (citing *Harris v. Bd. of Supervisors, L.A. Cty.*, 366 F.3d 754, 766 (9th Cir. 2004)). While the *Banks* decision involved a failure to institute and implement adequate COVID-19 protocols not at issue here, the court noted that "[f]acing requests for preliminary injunctive relief, courts often find a showing of irreparable

harm where the movant's health is in imminent danger." *Id.* (citing *Al-Joudi v. Bush*, 406 F. Supp. 2d 13, 20 (D.D.C. 2005) (citing *Wilson v. Group Hosp. & Med. Servs., Inc.*, 791 F. Supp. 309, 314 (D.D.C. 1992) (granting preliminary injunction where cancer patient's "health and future remain[ed] in serious doubt" and insurance would not pay for life-saving treatment))). In doing so, it favorably cited a Ninth Circuit decision where the court found that a proposal to reduce the number of hospital beds available could result in irreparable harm from pain, infection, and possible death due to delayed treatment. *Id.* (citing *Harris v. Bd. of Supervisors, L.A. Cty.*, 366 F.3d 754, 766 (9th Cir. 2004)).

The IHS's proposal to downgrade services at ACL from a hospital with inpatient and emergency room services to an urgent care clinic with limited hours would create a similar likelihood of irreparable harm due to delayed treatment. As indicated above, American Indians suffer from pre-existing health disparities that have contributed to severe COVID-19 illness and death rates among the AI/AN population. "Among persons aged 20–29 years, 30–39 years, and 40–49 years, the COVID-19 mortality rates among AI/AN were 10.5, 11.6, and 8.2 times, respectively, those among White persons." Ctrs. for Disease Control & Prevention, U.S. Dep't of Health & Human Servs., *COVID-19 Mortality Among American Indian and Alaska Native Persons – 14 States, January—June 2020*, 69 Mortality & Morbidity Weekly Report 1853, 1853 (Dec. 11, 2020). Tragically, one of the Tribe's members died after being turned away from ACL Hospital when it was temporarily closed this fall, and others experienced harm in the form of delayed access to needed care. Lewis Aff. Ex. E, ¶ 7.

In addition, as discussed above, closing ACL Hospital will shift the primary burden for emergency care to the Tribe's EMS program, which will be significantly strained, thereby reducing the Tribe's ability to protect the public's health within its jurisdiction. *New York v. Trump*, No. 20-CV-2340(EGS), 2020 WL 5763775, at *11 (D.D.C. Sept. 27, 2020) (federal

agency action that impedes efforts to protect the public health within their jurisdictions, including mitigating the spread of COVID-19, result in harm to government Plaintiffs), *order clarified*, No. 20-CV-2340(EGS), 2020 WL 6572675 (D.D.C. Oct. 22, 2020)

Absent a restraining order preventing the Defendants from closing ACL Hospital, the Tribe and its members will suffer immediate and irreparable harm due to service cuts. These harms cannot be remedied by money damages. In short, "the interests at stake are not merely economic interests in [an administrative scheme], but personal interests in life and health." *Cobell v. Norton*, 240 F.3d 1081, 1097 (D.C. Cir. 2001) (quoting *Pub. Citizen Health Research Grp. v. Auchter*, 702 F.2d 1150, 1156 (D.C. Cir.1983) (citation omitted)).

C. The Balance of the Equities Tip in Favor of the Tribe and an Injunction Would be in the Public Interest.

In contrast to the significant, irreparable injury that the Tribe and its members would suffer, Defendants would not suffer any injury as a result of a temporary restraining order or an injunction. The balance of harm thus tips sharply in the Tribe's favor. Restraining the Defendants by requiring them to maintain the status quo and keep the hospital in operation pending the resolution of this case does not burden them in any manner. As discussed above, Defendants can find and reprogram other funds to support the continued operation of ACL Hospital at its full capacity.

Granting temporary relief also serves the public interest. While there is "no public interest in the perpetuation of unlawful agency action," this court has previously found "a substantial public interest in having governmental agencies abide by the federal laws . . . that govern their existence and operations." *Open Commtys. All.*, 286 F. Supp. 3d at 179 (quoting *League of Women Voters*, 838 F.3d at 12). As set forth above, Section 301(b) of the IHCIA requires IHS to provide Congress with notice and an evaluation that takes into consideration several factors one

year prior to closing a hospital or facility or even a portion of a hospital or facility. 25 U.S.C. § 1631(b)(1). In addition, Section 105(i) of the ISDEAA prohibits the IHS from limiting or reducing funding for a tribe when IHS divides a program that serves more than one tribe, as the ACL program does here. Thus, IHS has failed to abide by the federal laws that "govern [its] existence and operations."

A restraining order would halt the Defendant's blatant attempt to ignore the basic requirements of Section 301(b) of the IHCIA and Section 105(i) of the ISDEAA. It would allow Congress the one year required by law to determine whether to maintain the hospital, including by increasing appropriations for the program. It would also preserve access to hospital services in a rural area not just for the IHS beneficiaries served by ACL Hospital, but for others as well. The ACL Hospital, like all other hospitals, are required to provide emergency services to everyone, Indians and non-Indians alike, under the Emergency Medical Treatment and Labor Act (Pub. L. No. 99-272, tit. IX, § 9121(b), 100 Stat. 164 (1986) (codified at 42 U.S.C. § 1395dd)). The requested relief would therefore serve the public interest by keeping a hospital open in an area that is being hard hit by the current pandemic and reducing the burden on other neighboring New Mexico hospitals which are already at capacity.

IV. The Tribe Should not be Required to Post a Bond

The decision whether to impose a bond as a requirement for a TRO is a matter of discretion for the court. *Temple Univ. v. White*, 941 F.2d 201, 219 (3d Cir. 1991) (a "strict reading" of the Fed. R. Civ. Pro. 65 bond requirement may be "inappropriate"); *Fed. Prescription Serv., Inc. v. Am. Pharm. Ass'n*, 636 F.2d 755, 759 (D.C. Cir. 1980) (district court may dispense with bond requirement where "restraint will do . . . 'no material damage'" to the defendant); *see also Navajo Health Found.-Sage Memorial Hosp. v. Burwell*, 100 F. Supp. 3d 1122, 1191 (D.N.M. 2015) (exercising court's wide discretion, court required no bond in case brought by

tribally-run health facility against IHS).

As discussed above, the Tribe will suffer irreparable harm if the action is not enjoined, while the Defendants will suffer no harm. Tribal funding has suffered greatly as a result of the pandemic and it should not be required to post a bond. Lewis Aff. Ex. E, ¶ 8. In response to the pandemic, in mid-March 2020 the Pueblo of Acoma closed its multi-million dollar casino, the principal source of tribal revenue, as well as most of its other enterprises, such as its Tourist Visitor center (http://www.casinovendors.com/article/new-mexico-tribal-casinos-will-be-closed-temporarily-234370/); these businesses remains closed as of the filing of this motion (https://www.skycity.com).

IV. Conclusion

The Tribe is entitled to a preliminary injunction pending resolution of this case.

Respectfully submitted,

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DATE: January 28, 2021

CERTIFICATE OF SERVICE

I hereby certify that on this 28 day of January, 2021, I electronically filed the forgoing Motion for Preliminary Injunction with the Clerk of the Court using the CM/ECF system which will send notification of such filing to all registered CM/ECF users.

In addition, I have caused a true and correct copy of Plaintiff's Motion, along with accompanying documents, and all pleadings and papers filed in the action to date to be sent by USPS overnight mail to the following:

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