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January 11, 2021

GENERAL MEMORANDUM 21-001

FY 2021 Enacted Indian Health Service Appropriations;
SDPI Extended Through September 30, 2023

On December 27, 2020, President Trump signed the Consolidated Appropriations Act, 2021 into law (P.L. 116-260, "the Act"). This massive legislation includes federal discretionary funding for FY 2021, as well as additional provisions for COVID-19 relief and extensions of key programs, such as the Special Diabetes Program for Indians (SDPI). In this Memorandum we report on highlights of the final FY 2021 enacted appropriations for the Indian Health Service (IHS).

The IHS FY 2021 final appropriations bill is sparse, providing a $189 million increase over FY 2020 enacted and $57 million below the President's budget request. The total FY 2021 IHS appropriation is $6.2 billion. Services funding was decreased a total of $13 million (transfer of 105(*l*) lease costs described below) from FY 2020 and Facilities funding is increased by $6 million. *See* Appendix A for full funding details.

IHS OVERALL FUNDING

FY 2020 Enacted	$6,047,094
FY 2021 Administration Request	$6,293,568
FY 2021 House	$6,492,191
FY 2021 Senate Committee (draft)	$6,210,198
FY 2021 Enacted	**$6,236,279**

One key area of policy change concerns 105(*l*) leases which were added to a new "indefinite appropriations account" (discussed in detail below). In addition, the Contract Support Costs (CSC) appropriation allows IHS to apply any unspent CSC as an offset to the following years CSC requirement, reducing its payment (more information provided below). The Act also provides additional funding and instructions for Electronic Health Records (EHR) and continues funding for accreditation emergencies.

- You can find the full text of the Act here. (IHS appropriations start on page 342)
- You can find the text of the Joint Explanatory Statement accompanying the Act here. (IHS specific language starts on page 77).
- The Joint Explanatory Statement also adopted the House Committee Report by reference. You can find the House Report 116-448 here. (IHS specific language starts on page 124).

Detailed Discussion of FY 2021 Appropriations for Indian Health Service

Policy Issues:

105(l) leases – A separate indefinite appropriations for tribal leases under section 105(l) of the Indian Self-Determination and Education Assistance Act (ISDEAA) provides at "such sums as may be necessary" which are available through September 30, 2022. The estimated need is $101 million.

The Act specifies that the initial term of a lease must begin no earlier than the date of receipt of the lease proposal, thus rejecting the House provision opposed by tribes that lease proposals had to be submitted within the first 8 months of the fiscal year.

An earlier House bill had proposed further restrictions, such as denying funding for any proposal received during the final 120 days of the fiscal year, but Tribes opposed these and they were dropped in the final version. The Act directs Interior and IHS to consult with tribes during FY 2021 on "how to implement a consistent and transparent process for the payment of such leases." The Title IV General Provisions of the Interior Appropriations Division of the Act reads:

> "Sec. 431.(a) Notwithstanding any other provision of law, in the case of any lease under section 105(l) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 5324(l), the initial lease term shall commence no earlier than the date of receipt of the lease proposal.
>
> (b) The Secretaries of the Interior and Health and Human Services shall, jointly or separately, during fiscal year 2021 consult with tribes and tribal organizations through public solicitation and other means regarding the requirements for leases under section 105(l) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 5324(l) on how to implement a consistent and transparent process for the payment of such leases."

The Joint Explanatory Statement also directs the agencies to engage in "meaningful dialogue" with each other and with Tribes "to coalesce around a process to develop policy guidance." The Committees specifically direct the agencies to consult with Tribes "regarding agency regulations and policies that determine the amount of space and other standards necessary to carry out federal programs under a section 105(*l*) lease, and to ensure that such regulations and policies are consistent, transparent and clearly communicated to affected Tribes."

Contract Support Costs – As with 105(*l*) leases, Contract Support Costs (CSC) are their own account funded at "such sums as may be necessary" which has been the case since FY 2016. The estimate for FY 2021 is $916 million, an increase of $96 million over the FY 2020 level. Unfortunately, the bill contains a provision, which

last appeared in the FY 2017 Consolidated Appropriations Act that allows IHS to apply any unspent CSC as an offset to the following years CSC requirement, reducing its payment. Under this provision, if a Tribe spent all of its IHS direct dollars, but not all of its CSC, IHS could apply the unspent CSC as an offset to the following year's CSC requirement, reducing its payment.

However, the typical reason Tribes do not spend their entire CSC funding is that program funding remains unspent and is also carried over, which the ISDEAA authorizes. In this scenario, the unspent CSC will be required to support the unspent program funding in the next year, so there should be no reduction in CSC funding. Still, it is not clear how IHS will administer this provision, and it could be read to require offsets to CSC funding for any amounts carried over from the previous year.

Electronic Health Records – The final bill provides $34.5 million for a new Electronic Health Records System[1] which is $82.5 million below the President's request. This funding would be used to replace the aging the Resource and Patient Management System (RPMS), which is currently reliant on support from the Veterans Administration's VistA system that is being phased out. The Explanatory Statement also notes that $65 million in FY 2020 supplemental funding was provided for this project through the CARES Act (P.L. 116-136).

The Act says the House and Senate Appropriations Committees must be consulted 90 days prior to IHS obligating funds for a new Health Information Technology Infrastructure system. It also says that IHS cannot obligate funds unless they submit a report to Congress within 120 days that lists Tribes who do not use the current RPMS system "along with cost estimates required for those Tribes to implement, maintain and make any necessary updates to these systems" (Joint Explanatory Statement, page 78). The Committee asked for a similar report in FY 2020, but given the escalation of this language to statutory text it is likely that IHS has not provided this report to the Committee.

The Act also provides for an additional $500,000 through the Dental Health line item for the electronic dental records (EDR) system. Congress also directs IHS to ensure that EDR funding is included in the larger EHR enhancement efforts.

Rejection of CHAP/CHR Consolidation – The final bill rejects the Administration's proposal to consolidate the Community Health Aide Program with the Community Health Representatives and Health Education programs.

Advance Appropriations – The Act and Joint Explanatory Statement are silent on the issue of Advance Appropriations for IHS which would provide funding for IHS a year

[1] the Senate had proposed $8 million and the House $61 million for this purpose

in advance so that IHS funding would not be at risk from government shut downs or short-term continuing resolutions. However, House Report 116-448, which was also adopted a part of this Act restates language from FY 2020 appropriations directing IHS to "examine its processes, determine needed changes and report back to the Committee within 180 days" (House Report 116-448, page 125).

Indian Health Services Funding

Hospitals and Clinics (H&C) **–** As discussed above, funding for 105(*l*) leases which had been in the Hospitals and Clinics account was transferred to a new indefinite account. Increases over FY 2020 under H&C are modest and include $1 million for Domestic Violence Prevention; $5 million for Tribal Epidemiology Centers; $5 million for the Hepatitis C and HIV initiative; $5 million for Alzheimer's; $5 million to improve maternal health; and $2 million for the existing Tribal dental health therapist training program in Alaska, Washington, Idaho, and Oregon. Funding for Accreditation Emergencies remains at $58 million.

Purchased and Referred Care – The final bill provides $975 million for Purchased and Referred Care, an $11 million increase, of which $5.8 million is for new tribes.

Direct Operations – The Act provides a $10 million increase for a total of $82.4 million. The increases are $4.9 million each for Quality and Oversight and for Management and Operations. In addition, $1 million is provided to conduct an infrastructure study for facilities run by urban Indian organizations.

Staffing of New Facilities – The Act provides $16.3 million for newly opened health facilities which is the full amount needed according to recent estimates.

Indian Health Facilities Funding

Overall, the Facilities account received a $6 million increase for total funding of $917.9 million. Most funding is continued at FY 2020 levels, or received a nominal increase. This includes $259.2 million for Health Care Facilities Construction, which is level with FY 2020. Within this amount is $10 million for Staff Quarters; $5 million for Green Infrastructure; and $25 million for Small Ambulatory Clinics. Sanitation Facilities Construction is funded at $96.6 million ($3 million above FY 2020). Maintenance and Improvement is funded at $169 million (level with FY 2020). Facilities and Environmental Health Support receives a $2 million increase and Equipment funding receives a $1 million increase from FY 2020.

Joint Venture Program – The Joint Explanatory Statement also directs IHS to establish "a more consistent application cycle of between three to five years for consideration of new joint venture projects." The Committees also note that IHS should select a specific number of awards and let non-selected applications apply during the next competitive cycle.

CONTINUING BILL LANGUAGE

The Act continues language from previously enacted bills, including the following:

Housing Allowances – Continues the provision that the IHS may provide to civilian medical personnel serving in IHS-operated hospitals housing allowances equivalent to those that would be provided to members of the Commissioned Corps of the Public Health Service serving in similar positions at such hospitals.

IDEA Data Collection Language – Continues the Bureau of Indian Affairs (BIA) authorization to collect data from the IHS and tribes regarding disabled children in order to assist with the implementation of the Individuals with Disabilities Education Act (IDEA).

Prohibition on Implementing Eligibility Regulations – Continues the prohibition on the implementation of the eligibility regulations, published September 16, 1987.

Services for Non-Indians – Continues the provision that allows the IHS and tribal facilities to extend health care services to non-Indians, subject to charges. The provision states:

> *"Provided,* That in accordance with the provisions of the Indian Health Care Improvement Act, non-Indian patients may be extended health care at all tribally administered or Indian Health Service facilities, subject to charges, and the proceeds along with funds recovered under the Federal Medical Care Recovery Act (42 U.S.C. 2651-2653) shall be credited to the account of the facility providing the service and shall be available without fiscal year limitation."

Assessments by HHS – Continues the provision which provides that no IHS funds may be used for any assessments or charges by the Department of Health and Human Services "unless identified in the budget justification and provided in this Act, or approved by the House and Senate Committees on Appropriations through the reprogramming process."

Limitation on No-Bid Contracts – Continues the provision regarding the use of no-bid contracts. The provision specifically exempts Indian Self-Determination agreements:

"Sec. 410. None of the funds appropriated or otherwise made available by this Act to executive branch agencies may be used to enter into any Federal contract unless such contract is entered into in accordance with the requirements of Chapter 33 of title 41 United States Code or chapter 137 of title 10, United States Code, and the Federal Acquisition Regulations, unless:

(1) Federal law specifically authorizes a contract to be entered into without regard for these requirements, including formula grants for States, or federally recognized Indian tribes; or

(2) Such contract is authorized by the Indian Self-Determination and Education and Assistance Act (Public Law 93-638, 25 U.S.C. 450 et seq.) or by any other Federal laws that specifically authorize a contract within an Indian tribe as defined in section 4(e) of that Act (25 U.S.C. 450b(e)); or

(3) Such contract was awarded prior to the date of enactment of this Act."

Use of Defaulted Funds – Continues the provision that allows funds collected on defaults from the Loan Repayment and Health Professions Scholarship programs to be used to make new awards under the Loan Repayment and Scholarship programs.

Posting of Reports – The Act contains a provision to allow the agencies to post requested reports on a public website after the House and Senate Appropriations Committees have reviewed for at least 45 days. The Joint Explanatory Statement requests several reports of interest, including a report on Advance Appropriations; a report on Tribes that currently maintain their own non-RPMS EHR system; and a report recruitment and retention barriers.

Other Provisions:

Special Diabetes Program for Indians – The Act separately includes a 3-year renewal for the Special Diabetes Program for Indians (SDPI) at current funding levels of $150 million per fiscal year. This means SDPI will now expire on September 30, 2023. Tribes had advocated for an increase in funding to $200 million per fiscal year. Legislation introduced in the Senate would have also allowed SDPI funding to be received through self-governance contracts and compacts, but the Act does not incorporate this proposal.

Conclusion

If you have any questions or would like additional information on any of issues raised in this report, please contact Karen Funk (kfunk@hobbsstraus.com or (202-822-8282) or Caitrin McCarron Shuy (cshuy@hobbsstraus.com or 202-822-8282).

Appendix A
Indian Health Service Funding FY 2021

	FY 2021						
	FY 2020 Enacted	FY 2021 Presbud	FY 2021 House	FY 2021 Senate (draft)	FY 2021 Enacted	Final FY 2021 vs. FY 20 Enacted	Final FY 2021 vs. Request
Services							
Hospitals & Health Clinics	$ 2,324,606	$ 2,432,384	$ 2,366,089	$ 2,246,048	$ 2,238,087	$ (86,519)	$ (194,297)
Electronic Health Record System	$ 8,000	$ 125,000	$ 61,000	$ 8,000	$ 34,500	$ 26,500	$ (90,500)
Dental Services	$ 210,590	$ 219,380	$ 222,027	$ 216,057	$ 214,687	$ 4,097	$ (4,693)
Mental Health	$ 108,933	$ 128,228	$ 132,740	$ 111,824	$ 115,107	$ 6,174	$ (13,121)
Alcohol & Substance Abuse	$ 245,603	$ 235,745	$ 259,937	$ 249,028	$ 251,360	$ 5,757	$ 15,615
Purchased /Referred Care	$ 964,819	$ 964,783	$ 1,011,933	$ 977,174	$ 975,856	$ 11,037	$ 11,073
Indian Healthcare Improvement Fund	$ 72,280	$ 72,280	$ 73,451	$ 72,999	$ 72,280	$ -	$ -
Total, Clinical Services	*$3,934,831*	*$4,177,800*	*$4,127,177*	*$3,881,130*	*$3,901,877*	*-$32,954*	*-$275,923*
Public Health Nursing	$ 91,984	$ 95,353	$ 96,251	$ 94,744	$ 92,736	$ 752	$ (2,617)
Health Education	$ 20,568	$ -	$ 20,807	$ 20,677	$ 21,034	$ 466	$ 21,034
Comm. Health Reps	$ 62,888	$ -	$ 63,151	$ 62,888	$ 62,892	$ 4	$ 62,892
Community Health	$ -	$ 44,109			$ -	$ -	$ (44,109)
Immunization AK	$ 2,127	$ 2,165	$ 2,174	$ 2,165	$ 2,127	$ -	$ (38)
Total, Preventive Health	*177,567*	*$141,627*	*$182,383*	*$180,474*	*$178,789*	*$1,222*	*$37,162*
Urban Health	$ 57,684	$ 49,636	$ 66,127	$ 59,314	$ 62,684	$ 5,000	$ 13,048
Indian Health Professions	$ 65,314	$ 51,683	$ 72,299	$ 65,314	$ 67,314	$ 2,000	$ 15,631
Tribal Management	$ 2,465	$ -	$ 2,477	$ 2,465	$ 2,465	$ -	$ 2,465
Direct Operations	$ 71,538	$ 81,480	$ 83,856	$ 71,582	$ 82,456	$ 10,918	$ 976
Self-Governance	$ 5,806	$ 4,887	$ 5,878	$ 5,806	$ 5,806	$ -	$ 919
Contract Support Cost							
Total, Other Services	*$ 202,807*	*$187,686*		*204,481*	*$ 220,725*	*$17,918*	*$33,039*
Total Services	**$ 4,315,205**	**$ 4,507,113**	**$ 4,540,197**	**$ 4,266,085**	**$ 4,301,391**	$ (13,814)	$ (205,722)
Contract Support Costs	$ 820,000	$ 916,000	$ 916,000	$ 916,000	$ 916,000	$ 96,000	$ -
105(l) Leases			$ 101,000	$ 101,000	$ 101,000		
Facilities							
Maintenance & Improvement	$ 168,952	$ 167,948	$ 171,284	$ 170,741	$ 168,952	$ -	$ 1,004
Sanitation Facilities Constr.	$ 193,577	$ 192,931	$ 196,265	$ 198,459	$ 196,577	$ 3,000	$ 3,646
Health Care Fac. Constr.	$ 259,290	$ 124,918	$ 262,763	$ 262,412	$ 259,290	$ -	$ 134,372
Facil. & Envir. Hlth Supp.	$ 261,983	$ 259,763	$ 270,707	$ 267,157	$ 263,982	$ 1,999	$ 4,219
Equipment	$ 28,087	$ 23,895	$ 33,975	$ 28,344	$ 29,087	$ 1,000	$ 5,192
Total Facilities	**911,889**	**769,455**	**934,994**	**927,113**	**917,888**	**5,999**	**148,433**
Total	**$6,047,094**	**$6,293,568**	**$6,492,191**	**$6,210,198**	**$6,236,279**	**$189,185**	**($57,289)**