National Indian Health Board

December 17, 2015

CONGRESS UNVEILS FY 2016 OMNIBUS SPENDING AGREEMENT

Executive Summary

On December 16, 2015, the House and Senate Appropriations Committees unveiled its final FY 2016 spending bill (H.R. 2029). The bipartisan agreement is expected to pass Congress by the weekend in order to avoid a government shutdown. The large spending bill will provide $1.15 trillion in discretionary [1] appropriations to keep the federal government funded through September 30, 2016. This legislation contains annual discretionary appropriations for the Indian Health Service (IHS), Bureau of Indian Affairs (BIA) and the Bureau of Indian Education (BIE) and other federal programs at the Department of Health and Human Services (HHS) for Indian Health. Many of the health-related programs are unfortunately flat-funded or have nominal increases for FY 2016.

There were several policy riders added to the final legislation including repealing a ban on oil exports, and preserving a federal ban on funding research for gun violence. There are also provisions included to toughen visa requirements to guard against terrorism. Importantly, separate tax legislation also released this week would postpone the "Cadillac Tax" which taxes expensive health plans (and many self-insured Tribal plans) by two years until 2020.

For FY 2016, Congress has proposed **$ 4.8 billion for IHS,** which is an increase of $165 million (3.5%) over the FY 2015 enacted level and $295.4 million less than requested by the President. While important, this increase is nowhere near the $29.96 billion needed to fully fund the IHS. According to the House Appropriations Committee's summary of the legislation, much of the $1.7 billion increase to the Interior and Environment section of the omnibus (Division G) (where IHS and other Tribal programs are located) went to wild fire funding and the Payment in Lieu of Taxes program. You can view the entire 2,009-page bill here.

Within the $4.8 billion allocated to IHS, the bill designates $914 million (the same amount as FY 2015) for Purchased/Referred Care and $523.2 million for Facilities funding (an increase of $63 million from FY 2015). Table 1 below depicts individual spending allocations for individual IHS programs. The bill also contains full funding for Contract Support Costs (CSC) (estimated at $718 million) and creates a separate appropriation for CSC, meaning that "services" funds would not be used to pay the CSC obligation.

During the entire appropriations process, the National Indian Health Board (NIHB) worked closely with the House Appropriations Committee members and their staff. As part of this work, NIHB shared the FY 2016 IHS Tribal Budget Formulation Workgroup's Recommendations with the Committee. On March 25, 2015, NIHB Chairperson Lester Secatero testified before the House Appropriations Committee. You

[1] Discretionary spending is funding that Congress pass every year through the appropriations process. On the other hand "mandatory spending" is funding that is authorized as soon as Congress passes a law creating or renewing the program. Most of Indian Health Service funding is "discretionary." However, the Special Diabetes Program for Indians (SDPI) is "mandatory" spending. That program was not affected by the FY 20145 omnibus. For funding to continue for SDPI, it must be renewed by Congress before September 30, 2015.

can read the written testimony here. NIHB also sent a letter at the end of the year urging the committee to increase funding for IHS and other federal health programs for American Indians and Alaska Natives (AI/ANs). You can read that letter here.

In addition to IHS, there were several important provisions located in the Labor, HHS, and Education section of the omnibus (Division H) that will benefit the health of AI/ANs. This includes funding Tribal Behavioral Health Grants at $15 million for FY 2015 and allocating designed funding for the creation of a Tribal domestic violence hotline. More details are included below.

Indian Health Service

As noted above, the final spending agreement for FY 2016 includes $4.8 billion for IHS which is an increase of $165 million from last year. The Hospitals and Clinics line item, which represents the core of direct health care delivery for IHS, received a $20.4 million, an increase of 1% from the FY 2015 level. However, this is not enough to be keep up with medical inflation and other financial obligations. There is level funding for Purchased/Referred Care (PRC). The President requested an extra $70 million for PRC in FY 2016. Dental health programs also received an increase of $4.3 million in FY 2016. The budget agreement also adds an extra $1.13 million for Urban Indian Health programs, and "the recommendation includes bill language requiring a program strategic plan developed in consultation with urban Indians and the National Academy of Public Administration."

Youth Alcohol and Substance Abuse Treatment: As you may recall, the Administration requested an additional $25 million under the Generation Indigenous initiative for youth treatment for the Methamphetamine Suicide Prevention Initiative (MSPI) under the Alcohol and Substance Abuse line item. The FY 2016 appropriations agreement funds requested pay costs in addition to a **$10 million program increase for focus on Tribal youth.** This is in addition to an extra $15 million provided to the Substance Abuse and Mental Health Services Administration (SAMHSA) for Tribal Behavioral Health Grants.

Contract Support Costs: As you may recall, the National Indian Health Board and the Tribes have been requesting that Congress enact mandatory appropriations for Contract Support Costs (CSC) to ensure that services are not cut if the CSC obligations to Tribes are less than appropriated in a given year. The Administration proposed that Congress enact this change starting in FY 2017, and suggested that CSC be made mandatory through FY 2019. NIHB and Tribes supported making mandatory CSC permanent, starting in FY 2016. In the FY 2016 bill, CSC continues to be fully funded at $718 million (an increase of $55 million over FY 2015). The final budget Agreement included language designating CSC as a separate appropriation. Previously, CSC had been appropriated as part of the "services" appropriation. This separate appropriation for CSC means that funds for IHS services cannot be cut to meet CSC obligations. While this does not make CSC "mandatory" funding, it does prevent services being cut for the purposes of making CSC payments.

CMS Accreditation at IHS operated facilities in the Great Plains Region: Recently, several IHS-operated hospitals in the Great Plains region have faced the loss and potential loss of their ability to bill the Centers for Medicare and Medicaid Services (CMS) for services provided, due to deficiencies found during inspections. The Explanatory Statement for the FY 2016 spending agreement expresses deep concern over these actions, and adds an additional $2 million in "new, flexible funding" so that IHS "may take actions necessary to ensure that CMS accreditation status is reinstated and retained…" NIHB has been

carefully following the issues at these facilities and will continue to advocate for greatly improved health delivery services.

Table 1: FY 2016 Indian Health Service Funding
(Dollars in Thousands)

	Pres. Request	Enacted 2016	Amount Change from FY 2015	Percent Change from FY 2015	Enacted +/- President's request
Services					
Hospitals & Health Clinics	$ 1,936,323	$ 1,857,225	20,436	1.10%	-79,098
Dental Services	181,459	178,286	4,304	2.41%	-3,173
Mental Health	84,485	82,100	955	1.16%	-2,385
Alcohol & Substance Abuse	227,062	205,305	14,324	6.98%	-21,757
Purchased /Referred Care	984,475	914,139	0	0.00%	-70,336
Total, Clinical Services	*3,413,804*	*3,237,055*	*40,019*	1.24%	*-176,749*
Public Health Nursing	79,576	76,623	983	1.28%	-2,953
Health Education	19,136	18,255	229	1.25%	-881
Comm. Health Reps	62,363	58,906	437	0.74%	-3,457
Immunization AK	1,950	1,950	124	6.36%	0
Total, Preventive Health	*163,025*	*155,734*	*1,773*	1.14%	*-7,291*
Urban Health	43,604	44,741	1,137	2.54%	1,137
Indian Health Professions	48,342	48,342	0	0.00%	0
Tribal Management	2,442	2,442	0	0.00%	0
Direct Operations	68,338	72,338	4,273	5.91%	4,000
Self-Governance	5,735	5,735	8	0.14%	0
Contract Support Costs	717,970				
Total, Other Services	*886,431*	*173,598*	*-657,552*		
Total Services	**$ 4,463,260**	**$ 3,566,387**	**-615,760**		**$ (896,873)**
Contract Support Costs		**$ 717,970**	55,000	7.66%	717,970
Facilities					
Maintenance & Improvement	89,097	73,614	20,000	27.17%	-15,483
Sanitation Facilities Constr.	115,138	99,423	20,000	20.12%	-15,715
Health Care Fac. Constr.	185,048	105,048	20,000	19.04%	-80,000
Facil. & Envir. Hlth Supp.	226,870	222,610	2,998	1.35%	-4,260
Equipment	23,572	22,537	0	0.00%	-1,035
Total Facilities	639,725	**523,232**	**62,998**	12.04%	-116,493
Total	**$ 5,102,985**	**$ 4,807,589**	**$ 165,208**	**3.44%**	***$ (295,396)***

Division H – Labor, HHS, Education

Outside of IHS, there are several provisions that benefit AI/AN health. The Appropriations Committee included language in the explanatory statement accompanying the bill that notes that the House and Senate Committee reports (House Report 114-195 and Senate Report 114-74) passed earlier this year still stand unless otherwise indicated. Here is a summary of some of the key provisions for Indian Health in 2016.

Tribal Behavioral Health Grants and AI/AN Suicide Prevention: Tribal Behavioral Health Grants, Administered by the Substance Abuse and Mental Health Services Administration, are funded at **$15 million in FY 2016** (an increase of $10 million above FY 2015). These are competitive grants designed to target Tribal entities with the highest rates of suicide per capita over the last 10 years. These funds must be used for effective and promising strategies to address the problems of substance abuse and suicide, and to promote mental health and well-being among AI/AN young people. The **American Indian/ Alaska Native Suicide Prevention program is funded at $2.931 million**. The accompanying House report also contains language directing "SAMHSA to ensure that the activities conducted under the American Indian and Alaskan Native Suicide Prevention program are effectively coordinated with the Tribal Behavioral Health Grants (TBHG)…SAMHSA is directed to brief the [Appropriations] Committee regarding the criteria for grant awards. Following the award of the grants, SAMHSA is directed to provide a briefing within 120 days to review the progress made and any unforeseen challenges that arise."

Tribal Epidemiology Centers (TECs): Tribal Epidemiology Centers (TECs) are critical to studying disease prevalence and prevention in Indian Country, but are severely underfunded. The FY 2016 House Appropriations report language requires the Centers for Disease Control and Prevention (CDC) to "to conduct a review and develop an action plan, in consultation with Indian Country…on actions CDC can undertake to address improved surveillance and measurable public health impacts in Tribal communities." This is a critical first step to ensuring that TECs receive additional support from CSC and could form the basis of establishing more funding for TECs in the future.

Definition of Indian in the Affordable Care Act: Language is included in the original House Committee report that would encourage the Administration to write regulations to "establish a consistent definition of an ''Indian'' for purposes of providing health benefits." The definitions included in several provisions of the Affordable Care Act are not consistent with those that IHS and CMS use to determine eligibility. Unfortunately, this language does not take the issue as far as Tribes would like to, in order to correct the Definition of Indian in the Affordable Care Act. NIHB will work with CMS and IHS to ensure that the regulation requested by Congress is finalized.

Minority AIDS Initiative: In FY 2016, the Appropriations Committee allocated **$53.9 million for the Minority AIDS Initiative** (SMAIF) (an increase of $1.6 million over FY 2015) which is managed through the office of the Secretary at HHS. Initially, the Senate's draft FY 2016 appropriations bill had eliminated this funding. NIHB and the Northwest Portland Area Indian Health Board sent a letter to the Appropriations Committee asking for these funds to be restored in the final FY 2016 appropriation. These funds are critical to Indian Country as they are the *only* funds that IHS uses to conduct HIV/AIDS related treatment and prevention. In FY 2015, the SMAIF provided $3.4 million to the IHS. IHS National HIV/AIDS Program coordinates and promotes HIV/AIDS prevention and treatment activities specific to AI/AN people as part of the agency's comprehensive public health approach. IHS provides clinical and administrative supports for primary care providers to successfully address these needs.

Other Government Programs affecting health care delivery for American Indians and Alaska Natives

Administration for Children and Families

- Head Start received **$9.1 billion**, which is $570 million above the FY 2015 level and $949 million below the President's request.

- Low Income Home Energy Assistance Program (LIHEAP) received **$3.39 billion,** which level with FY 2015 and the President's request
- Community Services Block Grant received **$715 million,** which is $41 million above the President's request and FY 2015 enacted amount.
- Native American Programs received **$50 million** in the FY 2016 agreement. This is equal to the FY 2015President's request and $3.4 million above the enacted level
- Childcare Development Block Grant received $2.76 billion in FY 2016 which is $326 million above FY 2015 and $44 million below the President's Request. According to a newly passed law, Tribes must receive at least 2% of this funding.
- Domestic Violence Prevention: The FY 2016 funding agreement contains an increase of **$3.7 million** for the Domestic Violence Hotline. One of the listed purposes for this is to create a Tribal-specific hotline.

Administration for Community Living – Administration on Aging

- Grants to Native Americans at the Administration on Aging were funded at **$31.16 million** in the FY 2016 agreement. This is $5 million over FY 2015 and $2 million above the President's Request.
    - This program provides grants to eligible Tribal organizations to promote the delivery of home and community-based supportive services, including nutrition services and support for family and informal caregivers, to Native American, Alaskan Native and Native Hawaiian elders.

Substance Abuse and Mental Health Services (SAMSHA)

- Tribal Behavioral Health Grants received **$15 million**
    - This is $10,000 more than the FY 2015 level of $5 million
- AI/AN Suicide Prevention Initiative received **$2.931 million,** which is equal to the FY 2015 level.
- Garrett Lee Smith Youth Suicide Prevention – State and Tribal Youth Suicide Prevention Grants received **$35.427 million** in the omnibus appropriations bill which is equal to the FY 2015 level

Centers for Disease Control and Prevention

- Overall the Centers for Disease Control and Prevention (CDC) would receive an increase of $300 million for a total of $7.2 billion in FY 2015. This includes $6.3 million in appropriated funds, and an additional $892.3 million from the Prevention and Public Health Fund.
- CDC funding includes **$70 million** to increase efforts to combat prescription drug overdose abuse.
- Injury Prevention and Control will receive an increase of **$65 million** from FY 2015, but $20 million less than the President requested
- Chronic Disease Prevention and Health Promotion will be funded at **$1.2 billion** in FY 2015 with $190 million targeted at diabetes and the National Diabetes Prevention Program.
    - Racial and Ethnic Approaches to Community Health (REACH) grants will receive **$50.95 million** in FY 2016. This is a $20.95 million increase from FY 2015 enacted levels.

If you'd like more information on FY 2016 Appropriations, please contact Caitrin Shuy at cshuy@nihb.org or (202) 507-4070.