



Legislative Action Alert

Congress Seals Massive Spending/Stimulus Deal

Includes 3-year Extension of SDPI, FY 2021 Appropriations, and Significant Tribal Health Provisions

December 21, 2020

\$2.5 Trillion Spending and COVID-19 Stimulus Deal Reached - Congress Now in Mad Dash Towards Passage

Background

After months of impasse in negotiations, and at the 11th hour, Congress clinched a bipartisan and bicameral deal on a roughly \$900 billion COVID-19 pandemic stimulus bill. The package is attached to a massive \$1.4 trillion Fiscal Year (FY) 2021 omnibus appropriations package - which includes all twelve appropriations bills including the Interior, Environment, and Related Agencies bill that funds the Indian Health Service (IHS).

Alongside the stimulus and appropriations package are a slue of year-end policy riders including tax extenders, clean energy provisions, education provisions, and comprise legislation to address surprise medical billing. The surprise billing package provides the federal cost savings to pay for a 3-year extension of the Special Diabetes Program for Indians (SDPI). The information below summarizes the key Tribal health provisions in the 5,593 page behemoth year-end package.

The House of Representatives is set to vote on the colossal package late this evening (Monday), which will be followed by swift consideration in the U.S. Senate. Both chambers have agreed to move as quickly as possible to pass the package today, although votes may slip into the early morning hours of Tuesday, December 22.

Yesterday, Sunday December 20, Congress passed a one-day continuing resolution (CR) while lawmakers hammered out the remaining text on the stimulus package. But given the massive size of the proposal, it may take Congress several days to finish enrolling and printing the bill, and preparing it for submission to the President's Desk. As a result, Congress decided to include an additional 7-day CR to ensure government funding did not expire while lawmakers and staff took the final administrative and procedural steps towards passing the gigantic year-end package.

To read the full legislative text of the entire year-end package [click here](#)

- Division G: FY 2021 Interior, Environment & Related Agencies Appropriations
- Division H: FY 2021 Labor-Health and Human Services Appropriations
- Division M-N: COVID-19 Response & Relief Supplemental Appropriations Act
- Division BB: Surprise Billing legislation and SDP/SDPI reauthorization

For a section-by-section on the stimulus package, [click here](#)

For the Explanatory Statement (Report) for FY 2021 Interior, [click here](#)

For the Explanatory Statement (Report) for FY 2021 LHHS, [click here](#)

Special Diabetes Program for Indians

After 15 months of short-term extensions - equaling six in total - Congress has finally reached an agreement on long-term reauthorization of the Special Diabetes Program for Indians (SDPI). As a result of a bipartisan and bicameral agreement on surprise medical billing, **Congress was able to secure the cost savings to pay for a three-year extension of SDPI** - through the end of FY 2023. This keeps SDPI on the same timeline as other "health extenders" including the Special Diabetes Program (which funds Type 1 diabetes research), funding for Community Health Centers, Teaching Health Centers, and other health programs.

Unfortunately, the reauthorization does not include an increase in funding for SDPI long sought by the Tribes and NIHB. Instead, it maintains SDPI funding at \$150 million annually - the same level since 2004. Tribes and NIHB submitted countless letters alongside national partner organizations urging an increase to SDPI to \$200 million annually. While bipartisan legislation was introduced to achieve this goal, it did not make it into the final package. Relatedly, the SDPI reauthorization does not include a critical legislative amendment to permit Tribes and Tribal organizations to receive SDPI awards pursuant to Title I contracting or Title V compacting agreements under the Indian Self-Determination and Education Assistance Act (ISDEAA). NIHB remains committed to securing these changes in the 117th Congress in close collaboration with the incoming Biden-Harris Administration.

Surprise Medical Billing

On Friday December 11, the four congressional committees that had been spent nearly two years working on a legislative solution to address surprise medical billing - the House Energy and Commerce Committee; Senate Health, Education, Labor, and Pensions Committee (HELP); House Ways and Means Committee; and House Education and Labor Committee - finally announced a bipartisan, bicameral deal.

The deal holds patients harmless of surprise medical bills in both emergency and non-emergency situations - including from air ambulance providers - by only requiring that patients be liable for the *in-network* costs of their care. The new law would require providers and insurers to negotiate a payment for the remaining portions of the bill (which used to be sent to patients as "surprise" bills prior to this legislation) within 30 days. If insurers and providers can't arrive at an agreement within 30 days, the dispute goes to a neutral third-party arbiter who is required to consider the median in-network reimbursement rate, the training level of the provider, and other factors.

In a win for hospitals and providers that was secured over the past week, the arbiter cannot consider the Medicare or Medicaid payment rate as a viable option for reimbursement. In addition, insurers are required to

submit reports on prescription drug and medical costs to the federal government. NIHB was able to secure language ensuring that the existing protections for American Indians and Alaska Natives (AI/ANs) against surprise billing under the Indian Health Care Improvement Act, and the requirement that inpatient hospitals accept Medicare-Like Rates as payment in full under Purchased/Referred Care (PRC) agreements be maintained.

COVID-19 Stimulus Package

After months of negotiations, Congress finally settled on a roughly \$900 billion compromise stimulus package in response to the ongoing COVID-19 pandemic. The package reauthorizes \$284 billion in loans under the Paycheck Protection Program (PPP); \$300 in weekly unemployment insurance for jobless workers through March 14, 2021; and \$600 stimulus checks for every adult making up to \$75,000 (\$150,000 for couples) including \$600 per child.

Since March of this year, NIHB submitted over twenty letters to Congress either independently or alongside national and regional Tribal organizations urging the inclusion of numerous critical Tribal health priorities to help prevent, mitigate, treat, and respond to a pandemic that has disproportionately impacted Tribal Nations and AI/AN communities. While the final package does not include the full scope of Tribal health policy priorities, it does include important wins outlined below.

Namely, the package includes a **\$210 million IHS, Tribal, and urban Indian (collectively I/T/U) set-aside in funding for vaccine distribution, administration, and other related needs**. Importantly, the section includes language authorizing awardees to use funds to reimburse costs associated with vaccine promotion, education, or any related expense incurred prior to enactment of the stimulus package. In addition, it outlines a **\$790 million I/T/U set-aside for COVID-19 testing, contact tracing, surveillance, and other needs**. Both set-asides include language authorizing transfer of funds to IHS for immediate distribution to Tribal programs.

Importantly, the package also includes a **minimum \$125 million I/T/U set-aside for mental and behavioral health needs** under the Substance Abuse and Mental Health Services Administration (SAMHSA). In a major victory, the package also includes **\$1 billion for Tribal broadband infrastructure development** under the National Telecommunications and Information Administration within the U.S. Department of Commerce. The stimulus package also sets-aside **\$800 million for Native American housing programs, and \$7 million for Tribal nutrition programs** under the Older Americans Act.

In another major win, the package **extends the deadline for expending CARES Act Coronavirus Relief Funds until December 31, 2021**. It also **authorizes the Secretary of Health and Human Services to extend Medicare waivers for use of telehealth until the end of 2021**.

Nevertheless, the final agreement does not include the \$1 billion in set-aside funds for the I/T/U under the Provider Relief Fund (PRF) that was initially outlined under the draft compromise package developed by a coalition of centrist lawmakers, including Senator Murkowski. That package had slated over \$30 billion in new funding for the PRF, while the final

agreement slashed that amount to only \$3 billion. However, the final package does include stronger language around the types of expenses and revenue losses that are compensable under the PRF, which was sought after by many Tribes.

FY 2021 Appropriations - Indian Health Service

The bipartisan, bicameral agreement funds the **Indian Health Service (IHS) at \$6.23 billion in FY 2021**, coming in at roughly \$189 million over the FY 2020 enacted level. As [NIHB previously reported](#), there was a significant gap between the House and Senate marks for IHS for FY 2021, with the House coming in at roughly \$281 million higher than the Senate. The final agreement is much closer to the Senate mark for IHS, which provided a lower increase for IHS overall above enacted.

The final agreement includes an **indefinite appropriation for 105(l) lease agreements at \$101 million**. Importantly, it gives IHS the authority to obligate the funds over two fiscal years - until the end of FY 2022. Tribes and NIHB vehemently opposed statutory restrictions on Tribal eligibility to enter into lease agreements, such as (but not limited to) any constraints based on the square footage of a Tribal health facility. The final appropriations package does NOT include any restrictions based on square footage, but does require that lease agreements "*...commence no earlier than the date of receipt of the lease proposal*". This would end the IHS practice of back-paying lease costs to the start of the fiscal year, which had contributed to the unpredictability of lease costs and issues in estimating future costs associated with the lease.

In the bill text, appropriators require the Secretary of Health and Human Services and the Secretary of interior to consult with Tribes and Tribal organizations on "*...how to implement a consistent and transparent process for the payment of such leases*." Similarly, under the Explanatory Statement for Interior, appropriators direct IHS and the Bureau of Indian Affairs to develop policy guidelines around lease costs and encourage both agencies to continue discussion around a permanent solution for 105(l) lease agreements, noting that court decisions under *Maniilaq* "*...appear to create an entitlement to compensation for 105(l) leases that is typically not funded under discretionary appropriations*."

Importantly, the Explanatory Statement also acknowledges that a very recent court case that litigated what constitutes "reasonable costs" under Section 105(l) of the Indian Self-Determination and Education Assistance Act, and directed both IHS and BIA to consult with Tribes and Tribal organizations "*...regarding agency regulations and policies that determine the amount of space and other standards necessary to carry out federal programs under a section 105(1) lease, and to ensure that such regulations and policies are consistent, transparent and clearly communicated to affected Tribes*."

While the appropriations package increases the IHS budget by roughly \$189 million overall, over half of the increase - 53% - goes towards the indefinite appropriation for 105(l) alone. Further, given the strict spending caps associated with the Interior budget for FY 2021, creation of the indefinite appropriation for 105(l) led appropriators to divert funds from other important line items. Unfortunately, this repeats the same issue that

existed prior to Congress establishing a separate account for 105(l) lease costs, wherein IHS was forced to reprogram millions from other line items in both FY 2018 and FY 2019 to remain current on lease agreement costs.

Specifically, Congress funds the **Hospitals and Health Clinics (H&HC) line item at \$2.238 billion for FY 2021** - roughly \$86 million below FY 2020 enacted, which was at \$2.324 billion. Within the line item, appropriators earmark \$5 million for maternal health needs, \$5 million for Alzheimer's prevention and treatment, \$5 million for Tribal Epidemiology Centers (TECs), and a **new \$5 million initiative on HIV and Hepatitis C**. Congress also sets aside \$2 million in the H&HC line item for the Tribal DHAT training programs in Washington, Oregon, Idaho, and Alaska.

The package also maintains \$5 million for nationalization of the Community Health Aide Program (CHAP), which is equal to the FY 2020 enacted level. Relatedly, the **Senate mark rejects the proposal from the President's Budget to consolidate funding for CHAP, Health Education, and Community Health Representatives (CHRs), instead opting to keep these funding line items separate, as the Tribes prefer**. The package also outlines small increases for Purchased/Referred Care, Alcohol & Substance Abuse, Mental Health, and other line items in the IHS budget.

FY 2020 IHS Enacted	FY 2021 IHS Final Bill
Overall.....\$6.04 billion	Overall..... \$6.23 billion
Hospitals/Clinics.....\$2.32 billion	Hospitals/Clinics.....\$2.23 billion
EHRs.....\$8 million	EHRs.....\$34.5 million
PRC.....\$964 million	PRC.....\$975 million
CHRs.....\$62.88 million	CHRs.....\$62.89 million
Alcohol & Substance.....\$245 million	Alcohol & Substance.....\$251 million
Sanitation Fac. Con.....\$193 million	Sanitation Fac. Con.....\$196 million
Facilities Account.....\$911 million	Facilities Account.....\$917 million

Funding for Important Tribal Programs Outside IHS

NIHB continues to strongly advocate for important Indian health programs funded under the Labor-Health and Human Services (LHHS) budget by agencies such as the Centers for Disease Control and Prevention (CDC) and the Substance Abuse and Mental Health Services Administration (SAMHSA). The majority of Tribally-specific programs remain level funded at their FY 2020 enacted levels, with a few slight increases to certain programs. For example, Congress maintains the **\$15 million set-aside under the Health Resources and Services Administration for placements of National Health Service Corps officers within IHS, Tribal and urban Indian facilities**.

Office of the Secretary

For the first time, Congress allocates a **\$1.5 million Tribal set-aside under the Minority HIV/AIDS Prevention and Treatment Program**. This is a big win that Tribes and NIHB had pushed for many years, and NIHB is pleased to see dedicated funding in both the LHHS and Interior budgets to address the disproportionate impacts of HIV/AIDS and Hepatitis C on AI/AN populations.

Centers for Disease Control and Prevention

Under CDC, the final appropriations package outlines a **\$1 million increase**

in funding for the Good Health and Wellness in Indian Country (GHWIC) program to \$22 million overall for FY 2021. Unfortunately, the final package does not include a separate \$150 million in Tribal funds for public health infrastructure and program development that was outlined the House LHHS appropriations bill. Given the significant challenges and gaps in Tribal public health infrastructure nationwide, NIHB is very disappointed that the final bill omits this crucial Tribal set-aside.

The final bill also outlines concerns with the Tribal Advisory Committee, noting in the explanatory statement that *"The agreement directs the Director, in consultation with the TAC, to develop written guidelines for each CDC center, institute, and office on best practices around delivery of Tribal technical assistance and consideration of unique Tribal public health needs. The goal of such guidelines should be the integration of Tribal communities and population needs into CDC programs. The Director shall report on the status of development of these written guidelines in the fiscal year 2022 Congressional Justification"*

Substance Abuse and Mental Health Services Administration

The agreement for SAMHSA provides slight increases to Tribal funds above FY 2020 enacted levels. For instance, the **Tribal Behavioral Health Grants are funded at \$41.5 million overall in FY 2021** (\$20.75 million for mental health and \$20.75 million for substance abuse). Similarly, Congress retains the **\$50 million Tribal set-aside in opioid response grants, but increases the medication-assisted treatment set aside to \$11 million.**

In addition, the American Indian/Alaska Native (AI/AN) **set-aside in Zero Suicide grants are increased to \$2.4 million**, while the **AI/AN Suicide Prevention Initiative is retained at \$2.931 million.**

For any questions regarding the final package, contact NIHB Director of Congressional Relations, Shervin Aazami, at saazami@nihb.org or Congressional Relations Associate, Erin Morris, at emorris@nihb.org

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