National Indian Health Board

Submitted via e-mail to: consultation@ihs.gov

April 26, 2019

RADM Michael D. Weahkee, MBA, MHSA
Assistant Surgeon General, U.S. Public Health Service
Principal Deputy Director
Indian Health Service
5600 Fishers Lane, Mail Stop: 08E86
Rockville, MD 20857
ATTN: FY 2019 Funding for ISDEAA 105(*l*) Leases

RE: FY 2019 Funding for ISDEAA 105(l) Leases

Dear Rear Admiral Weahkee,

On behalf of the National Indian Health Board, I write to respond to the Dear Tribal Leader Letter ("DTLL")[1] issued by the Indian Health Service ("IHS") on March 12, 2019, requesting feedback from Tribal representatives on short-term and long-term funding ideas for leases under section 105(*l*) of the Indian Self-Determination and Education Assistance Act ("ISDEAA"). As held in Maniilaq Association v. Burwell, 170 F. Supp. 3d 243 (D.D.C. 2016), the IHS is required under ISDEAA, section105(*l*) to enter into a lease upon the request of any Tribe or Tribal organization furnishing a Tribally leased or owned facility in support of programs, services, functions, and activities carried out under its ISDEAA contract or compact. Section 105(*l*) mandates compensation of leasing and other "reasonable expenses," when Tribal facilities are used to operate IHS programs under the ISDEAA.

Established in 1972, the National Indian Health Board ("NIHB") is an inter-Tribal organization that advocates on behalf of Tribal governments for the provision of quality health care to all American Indians and Alaska Natives ("AI/ANs"). The NIHB is governed by a Board of Directors consisting of a representative from each of the twelve Indian Health Service ("IHS") Areas. Each Area Health Board elects a representative to sit on the NIHB Board of Directors. In areas where there is no Area Health Board, Tribal governments choose a representative who communicates policy information and concerns of the Tribes in that area with the NIHB. Whether Tribes operate their entire health care program through contracts or compacts with IHS under Public Law 93-638, the ISDEAA, or continue to also rely on IHS for delivery of some, or even most, of their health care, the NIHB is their advocate.

[1] HHS, Dear Tribal Leader Letter (Mar. 12, 2019), https://www.ihs.gov/newsroom/includes/themes/responsive2017/display_objects/documents/2019_Letters/DTLL_DUIOLL_ISDEAA_03122019.pdf.

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Background

Historically, the IHS has not provided fair and reasonable payment for health facilities built by Tribes for the provision of health services authorized within negotiated contracts and compacts. The recent successful challenge against IHS in Maniilaq confirms this legacy. As of March 13, 2019, the IHS has received proposals from Tribes and Tribal organizations for FY 2019, totaling approximately $42 million. In addition to the initial $5 million IHS identified that may be used for 105(*l*) leases, IHS received $25 million in FY 2019 appropriations for a total of $30 million, with a remaining need of $12 million for these lease costs. Despite the $25 million increase in FY 2019 appropriations, IHS anticipates having to reprogram additional funds, as it did in FY 2018. Last year, IHS plugged the gap by transferring funds for inflation increases from a variety of Services budget lines, as detailed in Figure 1 of the enclosure to the DTLL. This resulted in depriving these programs of much-needed increases, and thus is not the solution for solving long-term funding discrepancies.

With an additional six months left in this fiscal year for IHS to receive lease proposals for FY 2019, Tribal leaders participating in recent IHS Budget Formulation meetings agreed unanimously to request $138 million additional funds for FY 2021 for Section 105(*l*) leases, and to add a separate line item under the binding obligations for Congressional indefinite appropriation.[2]

Long-Term Solutions for Funding 105(*l*) Leases

In the long term, the best solution is to establish a separate, indefinite appropriation for 105(*l*) lease compensation like that for contract support costs (CSCs). That would ensure full funding of lease costs while protecting program funding from the annual threat of reprogramming. While utilizing better mechanisms to anticipate the needs of Tribes would be ideal, an indefinite appropriation would save IHS and Congress from the impossible task of identifying the specific amounts needed in a given year to fully fund 105(*l*) leases.

The NIHB adamantly opposes any "solution" that would involve amending the ISDEAA to remove or limit section 105(*l*). For example, the Administration's FY 2018 and FY 2019 budgets included proposed appropriations act language that would have effectively nullified section 105(*l*) by making all lease compensation discretionary. IHS should drop this improper request to amend substantive law through an appropriations bill—which Congress has rejected for two years in a row—and should not seek to amend the ISDEAA through other means. Removing or limiting 105(*l*) would be extremely disruptive to Tribal health providers that have come to rely on this much-needed source of facilities funding. Instead, IHS should work with Tribes and Congress on a final solution that ensures lease funding meets the projected increase in need without chipping away at IHS programs.

[2] NIHB, IHS: The National Tribal Budget Formulation Workgroup's Recommendations on the Indian Health Service Fiscal Year 2021 Budget (Apr. 2019), https://www.nihb.org/docs/04242019/307871_NIHB%20IHS%20Budget%20Book_WEB.PDF.

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We appreciate the opportunity to provide input on this important matter. Should you have any questions about NIHB's comments as set forth in this letter, please contact Devin Delrow, NIHB's Director of Policy, at ddelrow@nihb.org.

Best regards,

Victoria Kitcheyan

Victoria Kitcheyan,
Chair, National Indian Health Board

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