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GENERAL MEMORANDUM 17-030

Indian Health Service Fiscal Year 2017 Final Budget

On May 5, 2017, President Trump signed HR 244, the Consolidated Appropriations, FY 2017 Act (Act) which provides funding for federal agencies for the remaining five months of the fiscal year. Prior to this, only one full-year appropriations bill (Military Construction/Veterans) had been enacted. Consolidated Appropriations, FY 2017 is Public Law 115-31 and the accompanying House and Senate Committee reports are H. Rept. 114-632 and S. Rept. 114-281. An Explanatory Statement serves as the conference report. The bill language and the Explanatory Statement are published in the May 3, 2017, CONGRESSIONAL RECORD. In this Memorandum, we report on the final FY 2017 funding for the Indian Health Service (IHS) which is in Division G of the Act.

The Act halted federal agencies having to operate in FY 2017 under a Continuing Resolution, primarily at FY 2016 funding levels, as it represents a negotiated agreement among Congressional leaders.

The Explanatory Statement provides that "Report language contained in House Report 114-632 and Senate Report 114-281 providing specific guidance to agencies regarding the administration of appropriated funds and any corresponding reporting requirements carries the same emphasis as the language included in this explanatory statement and should be complied with unless specifically addressed to the contrary herein. This explanatory statement, while repeating some language for emphasis, is not intended to negate the language referred to above unless expressly provided herein."

Our General Memoranda 16-016 (February 20, 2016) and 16-051 (August 3, 2016) describe President Obama's proposed FY 2017 IHS budget and the House and Senate Committee recommendations, respectively.

The references to the "Administration's request" or "request" in this Memorandum refer to the Obama Administration's FY 2017 proposed budget for the IHS. We will report separately on the Trump Administration's FY 2018 proposed budget for the IHS.

IHS OVERALL FUNDING

FY 2016 Enacted	$4,807,589,000
FY 2017 Admin. Request	$5,185,015,000
FY 2017 Enacted	$5,039,886,000

The FY 2017 enacted amount is basically a split the between the House and Senate Committee recommendations. The House bill was $84.8 million higher than the Senate Committee recommendation. The House proposed considerably more for built-in costs and Purchased/Referred Care than the Senate Committee, while the Senate Committee placed more emphasis on behavioral health and Native youth initiatives and clinic leases than did the House.

Built-in Costs. In the Services account, the Act includes $59.5 million for built-in costs of which $13.2 million is for pay costs and $37.1 million for medical inflation. This represents 50 percent of the amount that the Administration requested for each of these categories. No funding is appropriated for population growth.

In the Facilities account, the Act includes $9.3 million for built-in costs, consisting of $1.2 million for pay costs and $8.1 million for inflation. In most instances the funding represents 50 percent of the amount the Administration requested for each of these categories. No funding is appropriated for population growth.

By comparison, the FY 2016 final IHS appropriation contained only $19.4 million for inflationary purposes (for a 1.3 percent pay increase.)

Staffing Packages. The Act provides $15,982,000 for staffing of newly-opened health facilities, and the Explanatory Statement notes that this is "the full amount based upon updated estimates provided to the Committees." Of that amount $14.3 million is in the Services account and $1.6 million is in the Facilities Account. The original request was for $33 million.

Advance Appropriations Report. The House Report asks for a Government Accountability Office (GAO) report and evaluation on the use of advance appropriations for healthcare programs across the federal government, and their application to the IHS:

> The Government Accountability Office is directed to report on the use of advance appropriations authority for healthcare programs across the Federal government, including problems encountered, any estimates of cost savings, and applications to the Indian Health Service. (H. Rept. 114-632, p. 89)

Full Funding Report. The House Report also directs IHS to provide a plan of what would be required to fully fund the Indian Health Care Improvement Act:

> It has been over five years since the permanent reauthorization of the Indian Health Care Improvement Act (IHCIA), yet many of the provisions in the law remain unfunded. Tribes have specifically requested that priority areas for funding focus on diabetes treatment and prevention, behavioral health, and health professions. The Committee directs the Service to provide, no later than 90 days after enactment of this Act, a detailed plan with specific dollar amounts identified to fully fund and implement the IHCIA.
> (H. Rept. 114-632, p. 89)

Grant Programs and CSC. Of note is that Congress addressed the issue of the IHS not paying contract support costs (CSC) on its grant programs: Domestic Violence Prevention; Substance Abuse and Suicide Prevention; Zero Suicide Initiative; after-care

pilot projects at Youth Regional Treatment Centers; funding for the improvement of third party collections at IHS and tribally-operated facilities; and accreditation emergencies. The language that IHS relies on to deny CSC for these programs is the phrase "Notwithstanding any other law," the funding for these programs "shall be allocated at the discretion of the Director." Congress dropped the "notwithstanding" phrase in the FY 2017 Act.

CONTRACT SUPPORT COSTS

FY 2016 Enacted	*Such sums as may be necessary*
FY 2017 Admin. Request	*Such sums as may be necessary*
FY 2017 Enacted	*Such sums as may be necessary*

The Act, consistent with the Administration's request, continues Contract Support Costs (CSC) in FY 2017 at "such sums as necessary" and maintains CSC in its own separate account.

The Act, consistent with the request of many tribes and tribal organizations, does not repeat the CSC language which was in the FY 2016 appropriations act that could be read to deny the carryover authority granted by the Indian Self-Determination and Education Assistance Act. Thus the Act does **not** contain this FY 2016 provision: "amounts obligated but not expended by a tribe or tribal organization for contract support costs for such agreements for the current fiscal year shall be applied to contract support costs otherwise due for such agreements for subsequent fiscal years."

The Act states:

> For payments to tribes and tribal organizations for contract support costs associated with Indian Self-Determination and Education Assistance Act agreements with the Indian Health Service for fiscal year 2017, such sums as may be necessary: *Provided*, That notwithstanding any other provision of law, no amounts made available under this heading shall be available for transfer to another budget account.

Senate Report Language:

> The Committee has continued language from fiscal year 2016 establishing an indefinite appropriation for contract support costs estimated to be $800,000,000, which is an increase of $82,030,000 above the fiscal year 2016 level. The Committee has modified language to delete a provision that contradicted certain provisions of the Indian Self-Determination and Education Assistance Act. (S. Rept. 114-281, pp. 90-91)

House Report Language:

> The Committee recommends an indefinite appropriation estimated to be $800,000,000 for contract support costs incurred by the agency as required by law, $82,030,000 above the fiscal year 2016 enacted level.
>
> The recommendation continues bill language making available for two years such sums as are necessary to meet the Federal government's full legal obligation, and prohibiting the transfer of funds to any other account for any other purpose. Language addressing

contract funds that go unspent in a given fiscal year is discontinued. (H. Rept. 114-632, p. 90)

Finally, the Act continues prior language in the General Provisions section:

> *Contract Support Costs, Prior Year Limitation*
> *Sec. 405.* Sections 405 and 406 of division F of the Consolidated and Further Continuing Appropriations Act, 2015 (Public Law 113-235) shall continue in effect in fiscal year 2017.
>
> *Contract Support Costs, Fiscal Year 2017 Limitation*
> *Sec. 406.* Amounts provided by this Act for fiscal year 2017 under headings "Department of Health and Human Services, Indian Health Service, Contract Support Costs" and "Department of the Interior, Bureau of Indian Affairs and Bureau of Indian Education, Contract Support Costs" are the only amounts available for contract support costs arising out of self-determination or self-governance contracts, grants, compacts, or annual funding agreements for fiscal year 2017 with the Bureau of Indian Affairs or the Indian Health Service: *Provided*, That such amounts provided by this Act are not available for payment of claims for contract support costs for prior years, or for repayment of payments for settlement or judgments awarding contract support costs for prior years.

FUNDING FOR INDIAN HEALTH SERVICES

FY 2016 Enacted	$3,566,387,000
FY 2017 Admin. Request	$3,815,109,000
FY 2017 Enacted	$3,694,482,000

HOSPITALS AND CLINICS

FY 2016 Enacted	$1,857,225,000
FY 2017 Admin. Request	$1,979,998,000
FY 2017 Enacted	$1,935,178,000

Tribal Clinic Leases. The Act provides $11 million ($9 million above the FY 2016 enacted level) as requested by the Administration to supplement funds for tribal clinic leases, of which $2 million is transferred from Direct Operations. The Senate report notes that the funds are particularly for Village Built Clinics. The Act reads:

> Provided further, that, of the funds provided, $11,000,000 shall remain available until expended to supplement funds available for operational costs at tribal clinics operated under an Indian Self-Determination and Education Assistance Act compact or contract where health care is delivered in space acquired through a full service lease, which is not eligible for maintenance and improvement and equipment funds from the Indian Health Service.

Accreditation Emergencies. The Act includes significantly more funding than the original request, providing $29 million for accreditation emergencies. Of that amount $2 million is transferred from Direct Operations.

The Explanatory Statement explains:

> The Committees consider the loss or potential loss of a Medicare or Medicaid agreement with the Centers for Medicare and Medicaid Services (CMS) at any facility to be an accreditation emergency. The agreement includes a total of $29,000,000 for accreditation emergencies at an alarming number of facilities over the past year. Funds may be used for personnel or other expenses essential for sustaining operations of an affected service unit, including but not to exceed $4,000,000 for Purchased/Referred Care. These are not intended to be recurring base funds. The Director should reallocate the funds annually as necessary to ensure that agreements with CMS are reinstated, and to restore third-party collection shortfalls. Shortfalls should be calculated as described in the House report.

The House Report directs:

> Funds may be used for personnel or other expenses essential for sustaining operations of an affected service unit, but these are not intended to be recurring base funds. The Director should reallocate the funds as necessary to ensure that agreements with CMS are reinstated, and to restore third-party collection shortfalls. Shortfalls should be calculated relative to a baseline, which should be the average of the collections in each of the two fiscal years preceding the year in which an agreement with CMS was terminated or put on notice of termination. (H. Rept. 114-632, p. 88)

Domestic Violence Initiative. The Act provides $4 million for this initiative.

Prescription Drug Monitoring Program. The Act provides $1 million to fund the creation of a multi-state prescription drug monitoring program authorized by Section 196 of the Indian Health Care Improvement Act.

DENTAL SERVICES

FY 2016 Enacted	$178,286,000
FY 2017 Admin. Request	$186,829,000
FY 2017 Enacted	$182,597,000

Of the total amount, $3.9 million is for built-in costs and includes a transfer of $800,000 to Direct Operations "to backfill vacant dental health positions in headquarters." The Explanatory Statement urges the IHS to establish a centralized credentialing system.

Volunteer Dentists/Centralized Credentialing. Both the House and the Senate Committees expressed strong interest in IHS establishing a pilot project for a centralized credentialing system for volunteer dentists, similar to what the Department of Defense and Veterans Affairs have. The House Report directs the IHS to consult with those federal agencies and with private organizations to develop this pilot project. The Senate Report asks the IHS to

consult with federal agencies, private organizations and state dental organizations and work to establish a pilot project.

The House Report reads:

> The Committee understands that the geographic isolation of Indian tribes makes it difficult to attract and retain dentists and may limit access to care as tooth decay continues to be a problem. One way to help address access would be to allow volunteer dentists to treat patients who can provide important services that will improve access to oral health care. The Committee directs the Service to conduct a pilot project to explore establishing a centralized credentialing system to address workforce needs as well as volunteer providers similar to the Departments of Defense and Veterans Affairs who have centralized credentialing systems. The Committee directs the Service to consult with these agencies and private organizations to include the credentialing of dentists in a pilot program. (H. Rept. 114-632, p. 88)

The Senate Report reads:

> The Committee is concerned that tooth decay in Indian Country has reached epidemic proportions and notes that preschool children of American Indian and Alaska Natives have the highest level of tooth decay of any population group in the United States. The Committee understands that the geographic isolation of tribal health facilities makes it difficult to attract dentists to serve as providers and believes that one alternative to improve access to dental care is to allow volunteer dentists to treat patients. However, the Committee has heard reports that delays in getting approved healthcare providers credentialed to work at tribal or Indian Health Service facilities have resulted in candidates abandoning their efforts to volunteer because they could not be processed in a timely fashion. To address this problem, the Committee urges the Service to explore establishing a centralized credentialing system to encompass volunteer providers. The Departments of Defense and Veterans Affairs have centralized credentialing systems and the Committee believes that the Service should consult with those Departments, as well as private sector credential verification organizations and state dental associations, and work to establish a pilot project to test the feasibility of a centralized credentialing system. (S. Rept. 114-281, p. 90)

The House Committee also encourages the IHS "to coordinate with the Bureau of Indian Education (BIE) to integrate preventive dental care at schools within the BIE system" (H. Rept. 114-632, p. 88)

MENTAL HEALTH

FY 2016 Enacted	$ 82,100,000
FY 2017 Admin. Request	$111,143,000
FY 2017 Enacted	$ 94,080,000

The Act includes $6.9 million for a *Behavioral Health Integration Initiative* (the Administration's request and the Senate Committee bill recommended $21.4 million) and $3.6 million for the *Zero Suicide Initiative* (the same amount as requested). The

Administration's Budget Justification explains that funding would be available to tribes, tribal organizations, and urban Indian organizations to expand the behavioral health services to areas outside the traditional health care system. Funds could also be used for training, to hire behavioral health staff and for community-based programs.

ALCOHOL AND SUBSTANCE ABUSE

FY 2016 Enacted	$205,305,000
FY 2017 Admin. Request	$233,286,000
FY 2017 Enacted	$218,353,000

The Act includes $6.5 million for the Generation Indigenous Initiative (compares to $15 million request), $1.8 million for the youth pilot project, and $2 million for "grants or contacts with public or private institutions to provide alcohol or drug treatment services to Indians, including alcohol detoxification services".

Na' Nizhoozhi Center. The Explanatory Statement and the Senate Committee Report express concern for the Na' Nizhoozhi Center in Gallup, NM, which provides substance abuse services to members of many tribes and encourages the IHS to work with the Center and others to find a sustainable way to increase its capacity.

PURCHASED/REFERRED CARE

FY 2016 Enacted	$914,139,000
FY 2017 Admin. Request	$962,331,000
FY 2017 Enacted	$928,830,000

Of the total amount, $14.7 million is for built-in costs and $53 million for the Catastrophic Health Emergency Fund ($1.5 million over FY 2016).

The Explanatory Statement rejects the House Committee Report language which referenced a GAO report on the distribution of Purchased/Referred Care funds and which instructed how the increase was to be used.

The House Report comments on the use of federal facilities outside of the IHS system:

> The IHS is encouraged to evaluate the feasibility of entering into reimbursable agreements with Federal health facilities outside of the IHS system for patient referrals. Such agreements should be considered only when such referrals save costs and patient travel times relative to referrals to the nearest non-Federal health facilities, and when such referrals do not significantly increase patient wait times at such Federal facilities. (H. Rept. 114-632, pp. 88-89)

PUBLIC HEALTH NURSING

FY 2016 Enacted	$76,623,000
FY 2017 Admin. Request	$82,040,000
FY 2017 Enacted	$78,701,000

HEALTH EDUCATION

FY 2016 Enacted	$18,255,000
FY 2017 Admin. Request	$19,545,000
FY 2017 Enacted	$18,663,000

COMMUNITY HEALTH REPRESENTATIVES

FY 2016 Enacted	$58,906,000
FY 2017 Admin. Request	$62,428,000
FY 2017 Enacted	$60,325,000

HEPATITIS B and HAEMOPHILUS
IMMUNIZATION (Hib) PROGRAMS IN ALASKA

FY 2016 Enacted	$1,950,000
FY 2017 Admin. Request	$2,062,000
FY 2017 Enacted	$2,041,000

URBAN INDIAN HEALTH

FY 2016 Enacted	$44,741,000
FY 2017 Admin. Request	$48,157,000
FY 2017 Enacted	$47,678,000

Of the total, $1.8 million is for built-in costs and $1.13 million as requested to develop a strategic plan for the Urban Indian Health program in consultation with urban Indians and the National Academy of Public Administration. This effort was begun in FY 2016 with $1.1 million being appropriated for the development of a strategic plan.

The House Report encourages review and changing of authorizing statutes with the goal of providing Urban Indian organizations equitable reimbursement with IHS and tribal health programs:

> The recommendation includes $48,157,000 as requested for Urban Indian Health, $3,416,000 above the fiscal year 2016 enacted level. IHS should continue to include current services estimates for Urban Indian Health in future budget requests. The Committee recognizes that seven out of ten American Indian/Alaska Natives live in urban centers, according to the latest census data. Many of these individuals are, or are descendants of, individuals encouraged by the Federal government to move to urban centers during the termination and relocation era of the 1950s and 1960s, and are thus entitled to receive vital culturally appropriate health services from urban Indian organizations, just as they would have received health services from IHS-run and tribally-run facilities if they lived on or near a reservation. Unfortunately, urban Indian health organizations are struggling to recover their costs because they are not designated in relevant statutes as eligible providers on an equal par with IHS and Tribal Health Program facilities. The Committee urges the authorizing committees of jurisdiction to review these statutes and make any changes necessary for urban Indian organizations to

receive equitable reimbursement for the culturally appropriate services they provide to Native individuals, including Native veterans. (H. Rept. 114-632, p. 89)

INDIAN HEALTH PROFESSIONS

FY 2016 Enacted	$48,342,000
FY 2017 Admin. Request	$49,345,000
FY 2017 Enacted	$49,345,000

Programs funded under Indian Health Professions are: Health Professions Preparatory and Pre-Graduate Scholarships; Health Professions Scholarships; Extern Program; Loan Repayment Program; Quentin N. Burdick American Indians Into Nursing Program; Indians Into Medicine Program; and American Indians into Psychology. As requested by the Administration, the Act includes $36 million for the loan repayment program.

Health Administration. The Explanatory Statement rejects the House Committee proposal to change the definition of health professional to include health administration. However, the Statement urges IHS "to consider making health administrators a higher priority for loan repayments, in consultation with Tribes."

TRIBAL MANAGEMENT

FY 2016 Enacted	$2,442,000
FY 2017 Admin. Request	$2,488,000
FY 2017 Enacted	$2,465,000

Funding is for new and continuation grants for the purpose of evaluating the feasibility of contracting IHS programs, developing tribal management capabilities, and evaluating health services. Funding priorities are, in order: 1) tribes that have received federal recognition or restoration within the past five years; 2) tribes/tribal organizations that are addressing audit material weaknesses; and 3) all other tribes/tribal organizations.

IHS notes that in FY 2015, 88 percent of the funding awarded focused on Health Management Structure; 8 percent on Planning grants; and 4 percent on Evaluation studies.

DIRECT OPERATIONS

FY 2016 Enacted	$72,338,000
FY 2017 Admin. Request	$69,620,000
FY 2017 Enacted	$70,420,000

Of the total amount, $1.28 million is for built-in costs and transfers as noted elsewhere in this Memorandum. The IHS noted in its budget submission that 58.7 percent of the Direct Operations budget would go to Headquarters and 41.3 percent to the 12 Area Offices. Tribal Shares funding for Title I contracts and Title V compacts are also included.

SELF-GOVERNANCE

FY 2016 Enacted	$5,735,000
FY 2017 Admin. Request	$5,837,000
FY 2017 Enacted	$5,786,000

The Self-Governance budget supports implementation of the IHS Tribal Self-Governance Program including funding required for Tribal Shares; oversight of the IHS Director's Agency Lead Negotiators; technical assistance on tribal consultation activities; analysis of Indian Health Care Improvement Act new authorities; and funding to support the activities of the IHS Director's Tribal Self-Governance Advisory Committee.

The IHS notes in its FY 2018 budget justification that in FY 2016, $1.9 billion was transferred to tribes to support 89 ISDEAA Title V compacts and 115 funding agreements.

SPECIAL DIABETES PROGRAM FOR INDIANS

While the entitlement funding for the Special Diabetes Program for Indians (SDPI) is not part of the IHS appropriations process, tribes and tribal organizations routinely include support for this program in their testimony on IHS funding. SDPI is currently funded through FY 2017 at $150 million (see our General Memorandum 15-032 of April 17, 2015).

FUNDING FOR INDIAN HEALTH FACILITIES

FY 2016 Enacted	$523,232,000
FY 2017 Admin. Request	$569,906,000
FY 2017 Enacted	$545,424,000

Of the total amount $1.2 million is for pay costs and $8 million for inflation. Full funding is provided for inflation for Maintenance and Improvement and for Sanitation Facilities. Overall, inflation and pay costs are funded at about half of the requested amount.

MAINTENANCE AND IMPROVEMENT

FY 2016 Enacted	$73,614,000
FY 2017 Admin. Request	$76,981,000
FY 2017 Enacted	$75,745,000

As of October 1, 2015, the Backlog of Essential Maintenance, Alteration, and Repair is $473 million. Maintenance and Improvement (M&I) funds are provided to Area Offices for distribution to projects in their regions. Funding is for the following purposes: 1) routine maintenance; 2) M&I Projects to reduce the backlog of maintenance; 3) environmental compliance; and 4) demolition of vacant or obsolete health care facilities. Up to $500,000 is provided to the IHS for the demolition of federal buildings.

FACILITIES AND ENVIRONMENTAL HEALTH SUPPORT

FY 2016 Enacted	$222,610,000
FY 2017 Admin. Request	$233,858,000
FY 2017 Enacted	$226,950,000

MEDICAL EQUIPMENT

FY 2016 Enacted	$22,537,000
FY 2017 Admin. Request	$23,654,000
FY 2017 Enacted	$22,966,000

The Act continues language to provide up to $500,000 to purchase TRANSAM equipment from the Department of Defense and up to $2.7 million for the purchase of ambulances.

CONSTRUCTION

Construction of Sanitation Facilities

FY 2016 Enacted	$ 99,423,000
FY 2017 Admin. Request	$103,036,000
FY 2017 Enacted	$101,772,000

IHS projected in the FY 2017 budget justification that the funds would be distributed as follows: 1) $57 million for projects to serve new or like-new housing; 2) $43 million for projects to serve existing homes; 3) $2 million for projects such as studies, training, or other needs related to sanitation facilities construction; and 4) $1 million emergency projects. The IHS sanitation facilities construction funds cannot be used to provide sanitation facilities for HUD-built homes.

Construction of Health Care Facilities

FY 2016 Enacted	$105,048,000
FY 2017 Admin. Request	$132,377,000
FY 2017 Enacted	$117,991,000

The Act does not specify which projects will be funded. The Administration's request included funding for the Phoenix Northeast Health Center; Whiteriver Hospital; Rapid City Health Center; and Dikon Alternative Rural Health Center.

The Explanatory Statement addresses the need for a project-level funding distribution plan for healthcare facilities construction, and, consistent with House Report language, also calls for a gap analysis of the level of healthcare services across the IHS system:

> The Committees remain dedicated to providing access to health care for IHS patients across the system. The IHS is expected to aggressively work down the current Health Facilities Construction Priority System list as well as work with the Department and

> Tribes to examine alternative financing arrangements and meritorious regional demonstration projects authorized under the Indian Health Care Improvement Act that would effectively close the service gap. Within 60 days of enactment of this Act, the Service shall submit a spending plan to the Committees that details the project-level distribution of funds provided for healthcare facilities construction.
>
> The IHS has no defined benefit package and is not designed to be comparable to the private sector health system. IHS does not provide the same health services in each area. Health services provided to a community depend upon the facilities and services available in the local area, the facilities' financial and personnel resources (42 CFR 136.11(c)) and the needs of the service population. In order to determine whether IHS patients across the system have comparable access to healthcare, the IHS is directed to conduct and publish a gap analysis of the locations and capacities of patient health facilities relative to the IHS user population. The analysis should include: facilities within the IHS system, including facilities on the Health Facilities Construction Priority System list and the Joint Venture Construction Program list; and where possible facilities within private or other Federal health systems for which arrangements with IHS exist, or should exist, to see IHS patients.

The Senate report directs the IHS to work with the Southeast Alaska Regional Health Consortium "to formulate options for facilities upgrades and ultimately a replacement facility at Mt. Edgecombe in Sitka." (S. Rept. 114-281, p. 91)

Small Ambulatory Program Health Care Facilities. The Act includes $5 million for the Small Ambulatory Program which has not been funded since 2008.

The Senate Report notes: "this program is another critical tool for addressing facilities maintenance and construction backlogs throughout the nation. The Committee encourages the Service to give strong consideration to utilizing these new resources to assist with infrastructure improvements at remote sites such as Gambell and Savoonga on St. Lawrence Island, Alaska" (S. Rept. 114-281, p. 91). The Explanatory Statement echoes the Senate Report language.

New and Replacement Quarters. The Act includes $6 million for new and replacement quarters.

CONTINUING BILL LANGUAGE

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

IDEA Data Collection Language. Continued is the 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). The provision is:

> *Provided further,* That the Bureau of Indian Affairs may collect from the Indian Health Service and tribes and tribal organizations operating health facilities pursuant to Public Law 93-638 such individually identifiable health information relating to disabled children as may be necessary for the purpose of carrying out its functions under the Individuals with Disabilities Education Act. (20 U.S.C. 1400, et. seq.)

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

Services for Non-Indians. Continued is 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 DHHS. Continued is 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. Continued is the provision regarding the use of no-bid contracts. The provision specifically exempts Indian Self-Determination agreements:

> Sec. 411. 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. Continued is 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.

Please let us know if we may provide additional information or assistance regarding FY 2017 Indian Health Service appropriations.

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