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Advance Appropriations for the Indian Health Service: Issues and Options for Congress

March 11, 2020

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SUMMARY

R46265

March 11, 2020

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Advance Appropriations for the Indian Health Service: Issues and Options for Congress

The Indian Health Service (IHS) within the Department of Health and Human Services (HHS) is the lead federal agency charged with improving the health of American Indians and Alaska Natives. In FY2019, IHS provided health care to approximately 2.6 million eligible American Indians/Alaska Natives through a system of programs and facilities located on or near Indian reservations, and through contractors in certain urban areas.

Current IHS Funding: Continuing Resolutions and Shutdowns

IHS is the only major federal provider of health care that is solely funded through regular appropriations on an annual basis. Other federal health care providers, such as the Veterans Health Administration (Department of Veterans Affairs, (VA)), receive the majority of their funding through advance appropriations, and a number of health programs, including Medicare and Medicaid, receive mandatory funding, which is controlled outside of appropriations acts. Since FY1997, IHS has once (in FY2006) received full-year appropriations by the start of the fiscal year. As a consequence, IHS activities generally have been funded for a portion of each year under a continuing resolution (CR). Receiving its funding under a CR has limited the activities that IHS can undertake, in part because IHS can only expend funds for the duration of a CR, which prohibits the agency from making longer-term, potentially cost-saving purchases. In addition, most of IHS's services are provided by Indian tribes under contracts with the federal government. Under a CR, these contracts can be issued only for the duration of the CR and must be reissued for each subsequent CR (or when full-year appropriations are enacted). This can be a time-consuming process for both IHS and the tribes, which may divert resources from other needed activities.

In addition to the challenges associated with receiving funding through a continuing resolution, there are instances when funding for IHS (and other agencies) has lapsed due to an absence of funding under regular or continuing appropriations. In these cases, agencies typically initiate a partial shutdown of services, unless they meet an exception that requires the services to continue, such as the protection of life or property. The majority of IHS services qualify for this exception. As such, even without appropriations, IHS continues to provide health services—doing so with unpaid providers and the related hurdles of restocking supplies, among other concerns. The use of regular appropriations to fund IHS has created a number of challenges for the agency, which have been the subject of several congressional hearings, as well as a 2018 report from the Government Accountability Office (GAO).

Potential IHS Funding: Advance Appropriations

In response to the funding challenges faced by IHS, some have proposed providing the agency with advance appropriations. Doing so would make funds available at the start of a fiscal year that comes *after* the fiscal year for which that appropriations act was enacted. For example, an advance appropriation in an FY2021 appropriations act would provide budget authority that would become available at the start of FY2022 (or later). Advance appropriations could help ensure that full-year funding is available at the start of the fiscal year, and that IHS is not subject to a funding lapse or a temporary appropriation. Such funding might pose certain operational challenges to the agency and budget process concerns to Congress. Since 2014, legislation has been introduced in each Congress that would authorize advance appropriations for IHS; these proposals have not advanced beyond the committees.

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Introduction

The Indian Health Service (IHS) within the Department of Health and Human Services (HHS) is the lead federal agency charged with improving the health of American Indians and Alaska Natives. IHS derives its primary authority from the Indian Health Care Improvement Act (IHCIA).[1] In FY2019, IHS provided health care to approximately 2.6 million eligible American Indians/Alaska Natives through a system of programs and facilities located on or near Indian reservations, and through contractors in certain urban areas.[2] IHS provides services to members of 573 federally recognized tribes.[3] It provides services either directly or through facilities and programs operated by Indian tribes or tribal organizations through self-determination contracts and self-governance compacts authorized in the Indian Self-Determination and Education Assistance Act (ISDEAA).[4] IHS also provides services to urban Indians through grants or contracts to Urban Indian Organizations.

IHS is funded through annual appropriations acts and, as a consequence, its activities require that interim funding be provided by a continuing resolution (CR) if regular appropriations are not enacted prior to the start of the fiscal year on October 1. IHS has received full-year appropriations by the start of the fiscal year once since FY1997 (in FY2006).[5] As a result, the agency has been funded by a CR at some point during nearly each of the past 20 fiscal years, which has created a number of challenges for IHS, given its role as a direct provider of health services. For instance, in testimony before the House Committee on Natural Resources, tribal witnesses reported that CRs inhibit tribes' ability to make up-front purchases (e.g., of medications) because there is no guarantee that the tribe will be reimbursed. Such delays mean that a tribe may incur higher costs because of this delay in spending. In addition, tribes have reported that CRs have harmed their relationships with vendors because they are unable to make payments on a timely basis. Moreover, tribes have noted that CRs can result in higher costs on commercial loans, due to a tribe's downgraded credit rating given uncertainty about whether it will have sufficient funds to make loan payments.[6]

On several occasions the IHS has experienced a lapse in appropriations. Generally, a lapse in funding requires the agency to initiate a partial shutdown of services, unless these services meet an exception requiring them to continue, such as the protection of life or property. Because the majority of IHS's services qualify for this exception, most of IHS's services continue during a

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[1] P.L. 94-437, as amended. 25 U.S.C. §§1601 et seq. and 42 U.S.C. §§1395qq and 1396j (and amending other sections). This act was permanently reauthorized as part of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended). See CRS Report R41630, *The Indian Health Care Improvement Act Reauthorization and Extension as Enacted by the ACA: Detailed Summary and Timeline*.

[2] For more information, see CRS Report R43330, *The Indian Health Service (IHS): An Overview*.

[3] U.S. Department of Health and Human Services (HHS), Indian Health Service (IHS), FY2020, "Justification of Estimates for Appropriations Committees," https://www.ihs.gov/budgetformulation/includes/themes/responsive2017/display_objects/documents/FY2020CongressionalJustification.pdf. Hereinafter, FY2020 CJ.

[4] P.L. 93-638; 25 U.S.C. §§450 et seq.

[5] IHS became an independent agency within the Department of Health and Human Services in 1987. Between 1955 (when the agency's functions were transferred from the Department of the Interior) until 1987, it was a Bureau as part of the Health Resources and Services Administration. See HHS, Health Resources and Services Administration, "History" https://www.hrsa.gov/about/history.html and discussion of the Indian Health Facilities Transfer Act of 1954 in CRS Report R43330, *The Indian Health Service (IHS): An Overview*.

[6] GAO, *Indian Health Service: Considerations Related to Providing Advance Appropriation Authority*, 18-652, September 13, 2018, https://www.gao.gov/products/GAO-18-652.

partial shutdown. However, in these instances, its providers are not paid and the tribes do not receive ISDEAA funds to maintain their health services.[7]

To address these funding issues, some have proposed providing IHS with advance appropriations, so that funding is available on a timeline different from the immediate federal fiscal year. These advance appropriations would provide funding in one fiscal year that would not be available for obligation until a subsequent fiscal year. The funding decision, therefore, would occur one or more fiscal year before funds are to be obligated.[8] Advance appropriations for the agency would be available at the start of the next fiscal year, regardless of whether the corresponding regular appropriations acts for that fiscal year had been enacted. For example, a FY2021 appropriations act could provide budget authority[9] for IHS that would become available at the start of FY2022. This method of providing advance appropriations for funding was first used in 1962 and is now used for a number of programs, including veterans' medical care accounts (since 2009)[10] and the Corporation for Public Broadcasting (since 1976). Programs receiving advance appropriations are listed in the President's annual budget request to Congress.[11]

Most federal programs that pay for health services are either not funded through the annual appropriations process (e.g., most of Medicare) or receive advance appropriations (e.g., Grants to States for Medicaid and some of the veterans' medical care accounts). As a result, the health services provided or paid for by either of these methods may continue across fiscal years without disruption. Depending on how funding is structured, advance appropriations might help IHS avoid the issues created by CRs and government shutdowns; however, such funding might pose certain operational challenges to the agency and budget process concerns to Congress.

This report provides an overview of different federal funding mechanisms used to fund health programs, along with relevant congressional budget enforcement issues associated with advance appropriations. It then provides specific information about IHS funding and the effects that providing funding under the regular annual appropriations cycle has had on IHS's operations. The report concludes with a discussion of the challenges that both Congress and IHS may face in providing and implementing advance appropriations.

[7] See HHS determination regarding the status of activities during the 2018-2019 shutdown in Letter to Dear Tribal Leader, Tribal Notification on Status of Federal Funding, December 21, 2018, https://www.ihs.gov/newsroom/announcements/2018-announcements/tribal-notification-on-status-of-federal-funding/.

[8] For further information on alternative periods of funding availability, see CRS Report R43482, *Advance Appropriations, Forward Funding, and Advance Funding: Concepts, Practice, and Budget Process Considerations*.

[9] Budget authority generally refers to authority provided by federal law to enter into financial obligations that will result in immediate or future outlays involving federal government funds. See GAO, *A Glossary of Terms Used in the Federal Budget Process*, GAO-05-734SP, September 2005, pp. 20-23, at https://www.gao.gov/products/GAO-05-734SP.

[10] In addition, in 2014, some veterans' benefit accounts were added to those authorized to receive advance appropriations. See Section 244 of P.L. 113-235.

[11] The Congressional Budget Act of 1974 requires the annual publication of advance appropriations information as part of the President's budget request to Congress. For example, see p. 1353 of the Appendix in the *FY2021 Budget of the U.S. Government*, February 10, 2020, https://www.govinfo.gov/content/pkg/BUDGET-2021-APP/pdf/BUDGET-2021-APP.pdf.

Overview of Federal Funding for Major Health Care Programs, by Type of Spending

Federal health care spending is provided through both mandatory and discretionary funding mechanisms. These funding streams may be structured in a variety of ways, which are discussed below.

Mandatory Spending

Mandatory spending, the larger portion of spending in the federal budget,[12] represents funding that is controlled outside of appropriations acts and is not usually tied to the annual budget cycle. Instead, the level of funding is controlled through provisions in authorizing statutes, often on a multiyear or permanent basis.[13] These authorization laws themselves either provide budget authority directly or create a requirement for budget authority to be provided in subsequent appropriations acts. In both cases, the funding is scored as mandatory spending, but the latter is generally termed "appropriated mandatory" spending. This funding structure may provide programs with a greater degree of operational continuity than those funded via discretionary spending (discussed below).

The authorizing law that governs a mandatory spending program typically creates an entitlement to certain services or benefits based on eligibility and additional factors, and includes language providing budget authority to fund that entitlement. Medicare and Medicaid make up the majority of mandatory health spending. Additional health care programs receiving mandatory funding include the State Children's Health Insurance Program (CHIP), subsidies offered through the health insurance marketplaces established under the Affordable Care Act, the Federal Employees Health Benefits (FEHB) program, and the TRICARE for Life program.

For "appropriated mandatory" spending, the authorizing statute establishes a similar entitlement to services or benefits, but that law does not include the language necessary to require the Treasury to make payments. Instead, appropriations must be provided through the annual appropriations process. In general, appropriators have little control over the amounts that must be provided, since a separate law entitles certain recipients to payments.[14] Health care programs receiving funding in this way include some Grants to States for Medicaid and some funding for the Centers for Disease Control and Prevention (CDC).[15]

Discretionary Spending

Discretionary spending refers to funding for which the level is controlled by appropriations acts, which generally are considered on an annual basis in advance of the fiscal year beginning on

[12] See calculations by the Congressional Budget Office (CBO) in "The Federal Budget in 2018: An Infographic," June 18, 2019, https://www.cbo.gov/publication/55342.

[13] Although discretionary spending may also be explicitly authorized in a previously enacted authorization law, that authorization law neither funds that activity nor requires that funding for that activity be provided in the future.

[14] For more, see CRS Report R44582, *Overview of Funding Mechanisms in the Federal Budget Process, and Selected Examples*.

[15] Some CDC-appropriated mandatory spending is provided under the terms of the Energy Employees Occupational Illness Compensation Program Act.

October 1.[16] Because funding decisions are made each year, the degree of budgetary priority given to individual programs may change annually, and those programs may consequently need to alter their operations to account for those changes. The bulk of discretionary funding for federal health care goes to the Veterans Health Administration (VHA of the Department of Veterans Affairs [VA]) to fund health care services for veterans. (A variety of small federal health care programs used to support health services are also funded through discretionary spending, including the Maternal and Child Health Block Grant, the Ryan White HIV/AIDS Program,[17] and block grants administered by the Substance Abuse and Mental Health Services Administration.)

IHS Funding Structure

Funding for IHS comprises three discretionary accounts, as discussed below. In addition, IHS receives a small amount of mandatory funding (approximately 2.5% of the agency's discretionary funding) to support diabetes programs.[18] As mentioned above, this funding structure differs from a number of other health programs that provide or pay for direct services. For example, Medicare and Medicaid receive mandatory funding. The other major health program that, like IHS, is funded through discretionary appropriations includes certain health care accounts at the VA. This VA funding, however, is provided through advance appropriations that are available on October 1 of the following fiscal year. In this way, the VA is able to obligate funds regardless of when the regular appropriations are enacted for that fiscal year.[19] Although IHS is also a direct health care provider, the agency has never received advance appropriations (or had significant program costs funded via mandatory spending).

Indian Health Service

This section discusses the three IHS budget accounts and the process the agency uses to allocate funding across the IHS system. The section also summarizes some of the issues that GAO has raised about IHS's current funding allocation methodology and discusses a new methodology that IHS is using to allocate a subset of its budget (the Indian Health Care Improvement Fund) to facilities with the highest level of unmet need.

Budget Accounts

Appropriations for IHS are organized into three accounts, which provide funding for a number of programs and activities.[20] The three accounts are Indian Health Services, Indian Health Facilities,

[16] The number of appropriations bills can change, but the number has held steady at 12 since FY2008. See CRS Report RL31572, *Appropriations Subcommittee Structure: History of Changes from 1920 to 2019*.

[17] HIV/AIDS: human immunodeficiency virus and acquired immune deficiency syndrome.

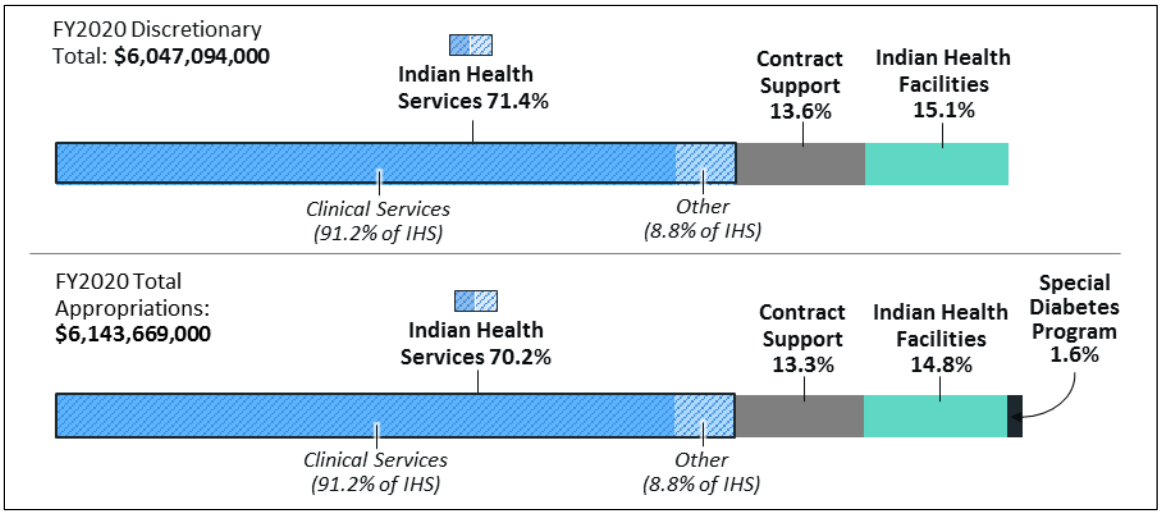
[18] CRS analysis of IHS's FY2019 appropriations at https://www.ihs.gov/sites/budgetformulation/themes/responsive2017/display_objects/documents/IHSFY2019OperatingPlan.pdf. Full-year FY2020 appropriations for the Special Diabetes Program have not been enacted; however, the program has received funding through May 22, 2020 in P.L. 116-94.

[19] In the House report accompanying the legislation making this change, Congress cited a "Sense of Congress" that "the provision of health care services to veterans could be more effectively and efficiently planned and managed if funding was provided for the management and provision of such services in the form of advance appropriations." U.S. Congress, House Committee on Veterans' Affairs, *Veterans Health Care Budget Reform and Transparency Act of 2009*, Report to Accompany H.R. 1016, 111th Cong., 1st sess., June 19, 2009, H.Rept. 111-171 (Washington: GPO, 2009).

[20] For more information on the IHS Budget, see CRS Report R45201, *Indian Health Service (IHS) FY2019 Budget*

and Contract Support Costs. The third account—Contract Support Costs—was previously part of the Indian Health Services account, but it was separated in FY2016 and made an indefinite appropriation.[21] **Figure 1** presents the relative distribution of the IHS budget accounts.

Figure 1. Indian Health Service Appropriation, FY2020



Source: CRS analysis of P.L. 116-94, Division D, Title III and Section 402 in Title I of Division N,

Indian Health Services Account

The *Indian Health Services* account is the largest IHS account. It includes the largest IHS budget item, which provides funding for clinical services provided either at federal facilities operated by IHS (called *direct federal*), facilities operated by Indian tribes (ITs) or tribal organizations (TOs), or through services provided by non-IHS providers paid for using the purchased referred care (PRC) program.[22] Over 60% of IHS's total appropriation is provided to ITs/TOs under ISDEAA contracts and compacts to administer facilities or programs.[23] ISDEAA funds have generally been made available across fiscal years to provide IT/TOs operating IHS programs with additional flexibility. For example, in FY2019 appropriations law for IHS, funds obligated under ISDEAA contracts/compacts were made available without limit to fiscal years; however, funds that IHS retains to administer facilities or manage functions were not. In FY2020, funds appropriated for the Indian Health Services account were made available for two fiscal years (i.e., through the end of FY2021, or September 30, 2021).[24] For FY2020, the Indian Health Services account is approximately 70% of IHS's discretionary appropriation (see **Figure 1**).[25]

Request and Funding History: A Fact Sheet.

[21] An indefinite appropriation, also termed a "no-year appropriation," remains available for obligation until expended. See GAO, *A Glossary of Terms Used in the Federal Budget Process*, GAO-05-734SP, September 2005, p. 22, at https://www.gao.gov/products/GAO-05-734SP.

[22] Indian Health Service, "Purchased/Referred Care (PRC)," https://www.ihs.gov/prc/.

[23] Indian Health Service, "IHS Profile," https://www.ihs.gov/newsroom/factsheets/ihsprofile/.

[24] P.L. 116-94, Division D, Title III.

[25] CRS analysis of Explanatory Statement Submitted by Mrs. Lowey, Chairwoman of the House Committee on Appropriations, Regarding H.R. 1865, Further Consolidated Appropriations Act, 2020, *Congressional Record*, daily edition, vol. 165, part No. 204—Book III (December 17, 2020), pp. H11295-H11296.

In FY2020, IHS's clinical services accounted for 65% of the agency's discretionary appropriation.[26] The majority of these funds are distributed using base funding (discussed below). In general, base funding is used to maintain programs and services with increases included (when appropriations permit) to adjust for a program's inflationary costs (including increased staffing costs). Some programs funded by the Indian Health Services account are awarded competitively, with funding priorities varying by program. Other programs use alternate methods to allocate funding, including formulas that IHS developed in consultation with tribes. In addition to the discretionary appropriations for this account, facilities—whether managed by IHS, an IT, TO, or Urban Indian Organization (UIO)—may collect reimbursements for services provided to an IHS beneficiary who has public or private insurance (e.g., Medicaid). IHS estimates that the IHS-operated facilities collected more than $1 billion annually to supplement the amount appropriated for clinical services ($3.9 billion in FY2020).[27] In recent annual appropriations acts for IHS, funds awarded under the ISDEAA contract or compacts are available until expended (i.e., they may be obligated in more than one fiscal year until exhausted).[28]

Indian Health Facilities Account

The *Indian Health Facilities* account provides funds to maintain facilities, purchase equipment, and construct new facilities. Much of the account's funds are allocated using formulas that provide similar funding levels to programs each year. Funds to construct new facilities (including new sanitation facilities) are generally distributed based on priority systems. IHS has more health and sanitation facilities in need of construction than its funding can support, resulting in a backlog.[29] The Indian Health Facilities account also supports the costs associated with newly opened facilities (e.g., acquiring equipment). These funds are approximately 15% of IHS's appropriation (see **Figure 1**).[30] For FY2020, these funds were made available until expended.[31]

Contract Support Costs

The third IHS account is an indefinite appropriation for *Contract Support Costs* to support the indirect costs associated with ISDEAA contracts and compacts. These funds are allocated in accordance with the terms of the relevant ISDEAA contract or compact. Beginning in FY2016, Contract Support Costs were funded as an indefinite discretionary appropriation. Specific amounts are estimated; for FY2020, the estimate was approximately $820 million, about 13% of IHS's total appropriation (see **Figure 1**).[32]

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[26] Ibid.

[27] Ibid. and FY2020 CJ. Information on the amount of reimbursements collected by IT/TO-operated facilities is not available.

[28] For example, see H.R. 1865, p. 198 at https://www.congress.gov/116/bills/hr1865/BILLS-116hr1865enr.pdf.

[29] Indian Health Service, "Healthcare Facilities Construction Priority System (HFCPS)," https://www.ihs.gov/dfpc/resources/.

[30] CRS analysis of Explanatory Statement Submitted by Mrs. Lowey, Chairwoman of the House Committee on Appropriations, Regarding H.R. 1865 Further Consolidated Appropriations Act, 2020, *Congressional Record*, daily edition, vol. 165, part No. 204 Book III (December 17, 2019), pp. H11295-H11296.

[31] P.L. 116-94, Division D, Title III.

[32] CRS analysis of Explanatory Statement Submitted by Mrs. Lowey, Chairwoman of the House Committee on Appropriations, Regarding H.R. 1865 Further Consolidated Appropriations Act, 2020, *Congressional Record*, daily edition, vol. 165, part No. 204 Book III (December 17, 2019), pp. H11295-H11296.

Special Diabetes Program

Although most of IHS's funds are discretionary, the agency receives $150 million in mandatory funding to support the Special Diabetes Program for Indians (SDPI). The program provides grants that support programs that aim to reduce diabetes rates and rates of diabetes-related complications among IHS beneficiaries.[33] This mandatory funding was provided in appropriations acts for FY2018 and FY2019, and has been extended through May 22, 2020.[34] As noted, the SDPI makes up a relative small percentage of IHS's overall funding (see **Figure 1**).

Agency Budget Formulation and Execution

This section discusses some ways that IHS allocates its funding, primarily through a "base funding" methodology, which relies on amounts provided in prior years to distribute funds across IHS facilities. GAO has critiqued this system at various points in time (see discussion below). This section also discusses a new methodology that IHS is using to allocate a subset of its budget (the Indian Health Care Improvement Fund, which provides funding to facilities that have the highest level of unmet need).

Base Funding

Base funding methodology is used to allocate the majority of IHS's discretionary appropriation. Under base funding, a program, facility, or IT/TO receives the amount of funding it received in the prior year, with increases to account for inflation and population changes, when appropriations permit. This allocation methodology creates a number of challenges, which have been outlined in three GAO reports over several decades.[35] GAO's main critique is that this methodology contributes to funding disparities across facilities, because the funding allocation is based on historical needs rather than present circumstances. In addition, a 2012 GAO report found that IHS generally does not know the origin of its base funding methodology, which dates back to the 1930s, making it difficult to determine the formula that was initially used to allocate funds and whether such a formula could be adapted or updated for present circumstances. In these three reports, GAO recommended that IHS modify its allocation methodology or that Congress require IHS to do so, either by enacting a law that alters the reliance on base funding methodology or through report language accompanying appropriations acts. Neither IHS nor Congress has acted to change the allocation methodology.

Both the IHCIA and ISDEAA contain restrictions that prevent IHS from changing how it allocates funds. In general, these restrictions prohibit the agency from reducing the amount allocated to a particular area, facility, or IT/TO.

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[33] For more information about this program, see CRS Insight IN11063, *Special Diabetes Programs Expire in FY2020: Policy Considerations and Extension Proposals*.

[34] CRS Report R45136, *Bipartisan Budget Act of 2018 (P.L. 115-123): CHIP, Public Health, Home Visiting, and Medicaid Provisions in Division E*, and Section 402 of Division N of Continuing Appropriations Act, 2020 (P.L. 116-94).

[35] GAO, *Indian Health Services: Not Yet Distributing Funds Equitably Among Tribes*, GAO/HRD-82-54 (July 2, 1982); *Funding Based on Historical Patterns, Not Need*, GAO/HRD-91-5, February 21, 1991; and *Indian Health Service: Action Needed to Ensure Equitable Allocation of Resources for the Contract Health Service Program*, GAO-12-446, June 15, 2012.

More than 60% of IHS's budget is allocated to ITs and TOs under ISDEAA contracts and compacts.[36] ISDEAA prohibits reducing funds in future years to an IT or TO under a particular ISDEAA contract or compact, except in the following circumstances:

- a reduction in appropriations from the previous fiscal year for the program or function to be included in a compact or funding agreement;
- a congressional directive in legislation or accompanying report;
- a funding reduction agreed to by a tribe;
- a change in the amount of pass-through funds subject to the terms of the funding agreement (i.e., a change in the amount of funds that an IT/TO distributes to a third-party contractor); or
- completion of a project, activity, or program for which such funds were provided.[37]

These terms restrict IHS from reallocating funds within the majority of activities funded by its budget absent a large funding increase. In addition to the terms in ISDEAA, IHCIA Section 817 (25 U.S.C. §1680g) states that IHS may implement a change that reduces a program's funding by more than 5% only after it has informed Congress. This requirement does not apply if the amount of the overall IHS appropriation is less than in the prior year, but IHS's appropriation has increased in recent years, meaning that this restriction does currently apply.[38]

When IHCIA was reauthorized in 2010, the statute required GAO to evaluate the distribution of contract health service funds (now called Purchased Referred Care, or PRC).[39] After the GAO report was completed, the HHS Secretary was required to consult with tribes about potential changes to how PRC funds are distributed. The GAO report was released in 2012. Among other things, the report discussed concerns with base funding methodology, disparities in PRC allocation across IHS areas, and constraints in IHS's authority to reallocate its PRC funding. The report also included a number of recommendations for improving the distribution of PRC funding. GAO closed several of these recommendations in 2017, noting that IHS informed GAO about limitations in its ability to reallocate funds in ways that would potentially reduce the amount of funds available to any tribe (beyond the ISDEAA and IHCIA statutory limitations mentioned above). In a follow-up report in December 2018, GAO noted that IHS had begun to analyze ways to streamline PRC eligibility and change geographic areas eligible for services; however, the methodology used to allocate funding has not changed.[40]

Agency Budget Planning Process

To develop its budget for future years, IHS begins planning three years in advance and undertakes a formal consultation process to solicit tribal input for what should be included in future year

[36] HHS, "HHS FY2020 Budget in Brief-IHS Indian Health Service," https://www.hhs.gov/sites/default/files/fy-2020-budget-in-brief.pdf, p.37.

[37] 25 U.S.C. §458aaa-7.

[38] For example, IHS's budget has increased each year since FY2000 (not adjusted for inflation). For information on the IHS budget from FY2010 to the present, see CRS Report R45201, *Indian Health Service (IHS) FY2019 Budget Request and Funding History: A Fact Sheet*; and CRS Report R44040, *Indian Health Service (IHS) Funding: Fact Sheet*.

[39] 25 U.S.C. §1621y.

[40] For GAO's recommendations and IHS's response, see https://www.gao.gov/products/GAO-12-446. GAO also reported more recent progress on an additional recommendation related to the timely payment of claims.

budget requests.[41] Specifically, the agency consults annually with ITs to obtain their input into agency funding priorities. It then annually forms a Budget Formulation Working Group (BFWG), which provides more formal input and guidance as the agency develops its future budgets. The group is composed of representatives from each of the 12 IHS areas. The group's primary task is to prepare the final tribal budget recommendations that accompany testimony summarizing the results of the workgroup. This summary is presented to the IHS Director and senior HHS officials at the annual HHS Tribal Consultation meeting, where the department seeks tribal budget input for future-year department budget requests. The BFWG's most recent report was released in April 2019. It provided recommendations for the FY2021 budget.[42] In general, the IHS budget is not sufficient to pay for all needed services. As such, the BFWG has generally recommended increased levels of appropriations. For example, in its most recent report, the workgroup recommended that the FY2021 President's budget request include an agency funding level of $9.1 billion. For context, the FY2019 enacted appropriation was $5.8 billion and the FY2020 enacted appropriation was $6.0 billion.[43]

Although the agency undertakes a budget planning process to solicit tribal input in its budget development, IHS's budget request and its ultimate appropriation have generally been guided by the amounts appropriated in prior years. Under the President's FY2020 budget submission, some specific programs were recommended for increases, while others were suggested for reductions or elimination.[44] In general, Congress has increased funding for IHS in recent years and has targeted these increases for certain program priorities (e.g., increased funding for health professional recruitment).[45]

Indian Health Care Improvement Fund

As mentioned above, the majority of IHS funding is allocated using base funding methodology. However, in recent fiscal years the agency has received appropriations for the Indian Health Care Improvement Fund (IHCIF),[46] which provides one-time funding to individual facilities that have some of the lowest funding levels relative to the needs of the population served. To distribute the fund, IHS attempted to determine which facilities were most in need of funding and developed a formula to make this determination. Distribution of the IHCIF is determined by a data-driven allocation methodology that seeks to make allocations more equitable than they would be using the agency's base funding process. To allocate the funding appropriated to the IHCIF in FY2018,

[41] GAO reported that IHS officials noted that their budget planning process began three years in advance of the appropriations request. GAO, *Indian Health Service: Considerations Related to Providing Advance Appropriation Authority*, 18-652, September 13, 2018, https://www.gao.gov/products/GAO-18-652, p. 20. For more information about IHS's budget formulation process, see HHS, IHS, "Division of Budget Formulation," https://www.ihs.gov/budgetformulation/.

[42] See Andy Joseph Jr., Bruce Pratt, and Victor Joseph, The National Tribal Budget Formulation Workgroup's Recommendations on the Indian Health Service Fiscal Year 2021 Budget, Ending the Health Crisis in Indian Country; A Path to Fulfill the Trust and Treaty Obligations, April 2019, https://www.nihb.org/docs/04242019/307871_NIHB%20IHS%20Budget%20Book_WEB.PDF.

[43] FY2020 CJ and HHS, IHS, "Indian Health Service Operating Plan for FY2019," https://www.ihs.gov/sites/budgetformulation/themes/responsive2017/display_objects/documents/IHSFY2019OperatingPlan.pdf, and P.L. 116-94.

[44] See the Appendix in the *FY2020 Budget of the U.S. Government*, March 18, 2019, https://www.govinfo.gov/content/pkg/BUDGET-2020-APP/pdf/BUDGET-2020-APP.pdf, pp. 426-430.

[45] FY2020 CJ and Explanatory Statement Submitted by Mrs. Lowey, Chairwoman of the House Committee on Appropriations, Regarding H.R. 1865 Further Consolidated Appropriations Act, 2020, *Congressional Record*, daily edition, vol. 165, part No. 204 Book III (December 17, 2019), pp. H11295-H11296.

[46] 25 U.S.C. §1621.

IHS convened a group of tribal representatives from each area to develop a funding formula that took into account the IHS allocation that each facility receives, the services it provides, and its collection of alternate resources.[47] The workgroup updated an older formula that had been used to allocate these funds. The formula, created in 2018 and used in subsequent fiscal years, made a number of changes to better encompass the agency's full range of services and to improve how its population receives care. For example, it

- changed the benchmark used in the formula to better encompass the public health activities that the agency funds (e.g., sanitation facilities);
- updated the measures used to count the IHS service population to ensure that counts are unduplicated but that users who receive services at multiple facilities are counted appropriately in each facility's user count; and
- revised the measurement of alternate resources, which had previously been allocated as a nationwide average to adjust for differences in facility level collections.

The IHCIF working group, the methodology it developed, and the data it collected may help IHS determine how better to allocate its funding, develop its budget, and assess its funding needs. However, the agency is limited in its ability to apply such a formula more broadly, because without a change in legislation or a directive in an accompanying congressional report, IHS is not permitted under an ISDEAA contract to provide less funding than was provided in the previous year unless its appropriations have decreased. As such, the applicability of this methodology to a larger proportion of the agency's appropriation may be limited; however, the data collected and the formula developed may be useful as part of the overall agency budget planning process.

Budget Execution Challenges Associated with Current Funding Mechanism

IHS is funded primarily under regular annual appropriations acts. If such acts have not been enacted by the beginning of the federal fiscal year (October 1), interim funding is typically provided under one or more CRs. For context, IHS has received regular appropriations at the start of the fiscal year once since FY1997 (in FY2006). During this period, an average of at least five CRs have been signed into law for each fiscal year before the appropriations process was completed for that year. Over this period, CRs provided funding for an average of almost five months in each fiscal year.[48] In several instances, a lapse in federal funding resulted in a shutdown of IHS activities. As discussed below, both of these scenarios—CRs and a lapse in federal funding resulting in a shutdown—have presented operational challenges for the agency.

Continuing Resolutions (CRs)

Interim CRs can affect agency operations at various times, including the time planning for a CR and the anticipation of a potential funding gap; during the gap; and after funding resumes. While anomalies may be included in CRs,[49] the funding uncertainty associated with CRs has been

[47] In statute (25 U.S.C. §1641(a)) the agency's collections from federal programs (e.g., Medicare, Medicaid, and the State Children's Health Insurance Program) are not permitted to be considered when determining IHS's appropriations.

[48] See CRS Report R42647, *Continuing Resolutions: Overview of Components and Practices*.

[49] CRs may include provisions that enumerate exceptions to the duration, amount, or purposes for which those funds may be used for certain appropriations accounts or activities. Such provisions are commonly referred to as "anomalies." For instance, in the first FY2020 CR (P.L. 116-59), IHS was allowed a higher rate of spending for two accounts (Indian

shown to hinder agencies' ability to plan for new programs that may need to be carried out across budget years.[50] In addition, when agencies operate under a CR, the Office of Management and Budget (OMB) usually apportions funds based on a pro-rata share of an annualized level for the period of the CR. For example, if the annualized level is the previous year's level, and the duration is 90 days, the agency would have approximately one-quarter of the previous year's appropriation available for obligation. The actual amount apportioned would be adjusted in accordance with other provisions typically included in CRs. Such provisions could include (1) a requirement to apportion funds up to the rate for operations necessary to avoid furloughs, (2) a limit on the availability of funds for programs that would otherwise have high initial rates of operation, or (3) a requirement to complete the distribution of appropriations at the beginning of a fiscal year or at a set date during a fiscal year. CRs typically include language specifying that the funding provided in the CR should be apportioned so that only the most limited funding action permitted be taken, thereby preserving congressional prerogative to later determine the total amount available for the whole year. Finally, a CR generally makes amounts available subject to the same terms and conditions specified in the enacted appropriations acts from the prior fiscal year.

A number of the restrictions on CR funding may be particularly challenging for IHS's operations, given the agency's role as a direct provider of health services. For instance, in testimony before the House Committee on Natural Resources, witnesses reported that CRs inhibit tribal entities' ability to make up-front purchases because there is no guarantee that the tribe will be reimbursed. For example, Alaska Native health facilities report that they rely on bulk purchases of heating oil for the winter. Buying the oil earlier rather than later allows it to be transported on barges, which is less costly than using the bush planes required during the winter; however, under a CR the health facilities are unable to make these bulk purchases and consequently incur higher costs when they purchase fuel later in the winter.[51] In addition, tribes have reported that CRs make it difficult to implement new programs and plan for improvements, because they do not have stable funding available to make large up-front purchases. Moreover, tribes have noted that both CRs and shutdowns have harmed their relationships with vendors because they are unable to pay them on a timely basis. Tribes have also noted that CRs lead them to incur higher costs on commercial loans, due to a downgraded credit rating given uncertainty about whether the tribe will have sufficient funds to make loan payments.[52]

CRs are also labor-intensive for the agency. IHS must execute its ISDEAA contracts/compacts with ITs/TOs for each CR to provide the authority and funding for tribally operated programs. These contracts/compacts must then be reconciled, and doing this multiple times per year is labor-intensive for both the agency and the tribes. According to GAO, tribes reported that the process for a short-term extension was the same as a full-year appropriation.[53]

Health Services and Indian Health Facilities) for specific purposes. See Section 136 and CRS Report R45982, *Overview of Continuing Appropriations for FY2020 (P.L. 116-59)*.

[50] See CRS Report RL34700, *Interim Continuing Resolutions (CRs): Potential Impacts on Agency Operations*.

[51] Tribal Testimony Before House Natural Resources Subcommittee on the Indigenous People of the United States, Hearing on "Advance Appropriations: Protecting Tribal Communities from the Effects of a Government Shutdown." See, for example, testimony from Verné Boerner, President and CEO, Alaska Native Health Board, at https://naturalresources.house.gov/imo/media/doc/Witness%20Testimony%202%20-%20Boerner%20(ANHB).pdf.

[52] GAO, *Indian Health Service: Considerations Related to Providing Advance Appropriation Authority*, 18-652, September 13, 2018, https://www.gao.gov/products/GAO-18-652.

[53] Ibid.

When GAO examined challenges related to IHS's current funding structure, it found many of the same issues that tribes described in their testimony.[54] GAO's investigation also examined the VA and how its advance appropriations authority has affected the agency's ability to deliver health services. One of the main challenges that GAO noted for IHS involved the recruitment and retention of providers, because the fiscal year funding schedule can delay the recruitment/retention process and because the lack of stable funding may deter job candidates. Given the IHS's high vacancy rates, filling vacant provider positions has been a long-standing agency priority.[55] For example, in 2018 GAO found that, on average, 25% of all health provider positions were vacant.[56] According to GAO, the VA noted similar challenges in its recruitment process prior to receiving advance appropriations, and the VA indicated that receiving advance appropriations has been beneficial to the hiring process. GAO also noted that advance appropriations enabled the VA to make larger up-front purchases to secure lower costs (e.g., vaccines), and that IHS and the ITs/TOs might likewise benefit from this kind of purchasing power.

Shutdown

When federal agencies lack funding authority (upon the expiration of either full-year or interim appropriations), they experience a lapse in appropriations, also known as a funding gap. When a funding gap begins and appears likely to continue one calendar day or longer, federal agencies generally are required to begin a "shutdown" of affected activities. In general, a shutdown includes the furlough of certain personnel and the curtailment of agency activities and services.[57] The longest recorded shutdown—35 consecutive days—occurred from December 2018 to January 2019. Other recent shutdowns have lasted 3 days, in January 2018, and 16 days, in October 2013.[58]

Under a funding lapse, the Antideficiency Act (31 U.S.C. §§1341-1342, 1511-1519) generally prohibits the obligation or expenditure of federal funds in the absence of an appropriation; however, there are certain exceptions, including most notably for IHS, one that allows obligations for activities involving the "safety of human life or the protection of property."[59] Under this exception, much of IHS's activities as a health care provider have continued during recent shutdowns. As a result, most of the agency's employees continued to work, without pay, until appropriations were subsequently enacted.[60] During the 2018-2019 shutdown, HHS determined that tribally operated health programs were excepted because of the health services they provided; services were to continue to the extent possible—despite the fact that no new funding would be available (because the shutdown also precluded IHS's execution of its contracts/compacts with ITs/TOs under ISDEAA authority).[61] As a consequence of maintaining services without new federal funds, ITs and Urban Indian Organizations (UIOs) reportedly curtailed services during the

[54] Ibid.

[55] For example, see discussion in FY2020 CJ.

[56] GAO, *Indian Health Service: Agency Faces Ongoing Challenge Filling Provider Vacancies*, 15-580, August 15, 2018, https://www.gao.gov/products/GAO-18-580.

[57] See CRS Report RL34680, *Shutdown of the Federal Government: Causes, Processes, and Effects*.

[58] For discussion, see CRS Report RS20348, *Federal Funding Gaps: A Brief Overview*.

[59] Ibid.

[60] See HHS determination regarding the status of activities during the 2018-2019 shutdown in Letter to Dear Tribal Leader, Tribal Notification on Status of Federal Funding, December 21, 2018, https://www.ihs.gov/newsroom/announcements/2018-announcements/tribal-notification-on-status-of-federal-funding/.

[61] Ibid.

shutdown,[62] and some reported exhausting necessary medical supplies, such as medications.[63] In addition, some tribally operated facilities reported that they considered eliminating certain services or temporarily closing services due to insufficient funds. ITs and TOs experienced similar circumstances during the 2013 shutdown, after which some medical providers reportedly left their positions as a result of the shutdown. For example, one tribally operated facility reported that it was unable to retain a physician and a nurse practitioner after the 2013 shutdown.[64]

Advance Appropriations for IHS: Issues for Congress

Following the FY2013 government shutdown, Congress has held hearings and introduced legislation that would authorize advance appropriations for IHS.[65] In 2014, the Senate Committee on Indian Affairs considered a bill to authorize advance appropriations. In 2019, following a longer shutdown, the House Committee on Natural Resources, Subcommittee on Indigenous Peoples of the United States, held a hearing on more recent proposed legislation. Several bills have been introduced in the 116th Congress to provide advance appropriation authority to IHS.[66] Also in the 116th Congress, the report accompanying the House-passed FY2020 Interior-Environment Appropriations bill contained language about advance appropriations. Specifically, it noted the 2018 GAO report on the topic and would have directed the IHS to examine its existing budget processes to determine what, if any, changes are needed to develop and manage an advance appropriations process. It also would have required the IHS to report to the committee within 180 days of enactment on the processes needed and whether the agency would require additional authority to develop advance appropriations processes.[67] The Senate appropriations report (S.Rept. 116-123) did not include similar language.

Given recent congressional interest in advance appropriations authority for IHS, this report discusses a number of issues that might arise should Congress choose to pursue granting IHS such authority. Among these are issues related to budget process and enforcement, as well as those related to implementation.

[62] Tribal Testimony Before House Interior Appropriations Subcommittee on FY2020 Appropriations Bill, March 6-7, 2019. See, for example, testimony from Maureen Rosette, President of the National Council of Urban Indian Health, at https://docs.house.gov/meetings/AP/AP06/20190306/109001/HHRG-116-AP06-Wstate-RosetteM-20190306.pdf.

[63] Kellie Mejdrich, "House Lawmakers Seek to Free Up Tribal Health Funds," *CQ News*, April 9, 2019, pp. https://plus.cq.com/doc/news-5506523?0.

[64] Audie Cornish, "The Effects of the Government Shutdown on Native American Tribes," *National Public Radio*, January 3, 2019, https://www.npr.org/2019/01/03/682021523/the-effects-of-the-government-shutdown-on-native-american-tribes.

[65] U.S. Congress, Senate Committee on Indian Affairs, S. 1474, S. 1570, S. 1574, S. 1622, and S. 2160, committee print, for the use of the Committee on Indian Affairs, 113th Cong., 2nd sess., April 2, 2014 (S. 1570 was the legislation introduced that would have provided advance appropriations to IHS), and House Committee on Natural Resources, Subcommittee on Indigenous Peoples of the United States, "Advance Appropriations: Protecting Tribal Communities from the Effects of a Government Shutdown," hearing, September 25, 2019, https://naturalresources.house.gov/hearings/subcommittee-for-indigenous-peoples-of-the-united-states-legislative-hearing3.

[66] These bills are discussed in the "Congressional Process to Initiate Advance Appropriations" section below.

[67] U.S. Congress, House Committee on Appropriations, Subcommittee on Interior, Environment, and Related Agencies, Department of the Interior, Environment, and Related Agencies Appropriations Bill, FY2020, report to accompany H.R. 3152, 116th Cong., 1st sess., June 3, 2019, H.Rept. 116-100, p. 114.

IHS Budget Planning and Forecasting

For an agency to implement advance appropriations, it requires the capacity to estimate its budget in future years. IHS may face several challenges in doing this. Though the agency begins its budget formulation process up to three years in advance of each fiscal year, it may be difficult for the agency to accurately estimate future budget amounts.[68] For example, new needs or new costs may arise in the interim that are not accounted for in the initial budget estimates (see text box for an example).

Example of New Unexpected Cost: Lease Funding

IHS may encounter unexpected expenses that make it difficult to estimate its future funding needs. For example, the agency's assessment of its funding responsibilities changed substantially following a 2016 federal court decision (*Maniilaq Association v. Burwell,* 170 F. Supp. 3d 243 (D.D.C. 2016)), which related to IHS's requirements to pay for leases entered into upon the request of a tribal organization, which have been termed 105(l) leases because of the section in ISDEAA that authorizes them. That decision found that the statute and regulations governing 105(l) leases were ambiguous, and because such ambiguities must generally be resolved in favor of tribes, the court rejected the Secretary's interpretation that strictly limited the cost of one particular 105(l) lease. In light of that decision, IHS determined that it was responsible for paying the full reasonable costs of 105(l) leases. As an initial stopgap, IHS used funds appropriated for inflationary increases to meet those unanticipated lease cost obligations; the most recent estimate of those costs totaled $101 million. To support these leases, FY2020 appropriations (P.L. 116-94) provided $125 million for these costs, which was an increase of $89 million from FY2019; however, the appropriators noted that these costs have the potential to increase and make the budget process unpredictable.

Sources: 170 F. Supp. 3d 243 (D.D.C. 2016); letter from Michael D. Weahkee, Assistant Surgeon General, United States Public Health Service, and Acting Director, Indian Health Service, to Tribal Leaders and Urban Organization Leader, July 10, 2018, https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/2018_Letters/DTLL_DUIOLL_07102018.pdf, and January 22, 2020, letter at https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/2020_Letters/DTLL_DUIOLL_105l_01222020.pdf. For most recent lease cost estimates, see "Explanatory Statement Submitted by Mrs. Lowey, Chairwoman of the House Committee on Appropriations," Proceedings and Debates of the 116th Congress, 1st Session, *Congressional Record*, vol. 165 (December 16, 2019). pp. H11281 and H11295.

Potential to Increase Area-Level Funding Disparities

Another concern that might arise for IHS under advance appropriations is a worsening of funding disparities across areas and facilities within its system. As mentioned above, GAO has been critical of how IHS distributes its funding across the system, noting that it does not comport well with current needs. Planning further in advance may make it more difficult to institute funding allocation changes designed to distribute funding more equitably. However, in its discussion with GAO, IHS noted that it already undertakes its budget process three years in advance to ensure input from ITs/TOs. Given this lead time, IHS believes it would have the capacity to generate the funding estimates needed for advance appropriations without major changes to its existing budget processes.[69]

[68] GAO, *Indian Health Services: Not Yet Distributing Funds Equitably Among Tribes*, GAO/HRD-82-54 (July 2, 1982); *Funding Based on Historical Patterns, Not Need*, GAO/HRD-91-5, February 21, 1991; and *Indian Health Service: Action Needed to Ensure Equitable Allocation of Resources for the Contract Health Service Program*, GAO-12-446, June 15, 2012.

[69] GAO, *Indian Health Service: Considerations Related to Providing Advance Appropriation Authority*, GAO-18-652, September 13, 2018, p. 20, https://www.gao.gov/products/GAO-18-652.

Challenges Due to Lack of a Health Benefits Package

Another challenge that IHS may face in implementing advance appropriations is that IHS does not have a defined benefits package that entitles its beneficiaries to a specific set of services. The absence of a defined benefits package means that there is no benchmark for IHS to use to estimate the needs and costs for services for a future year. Nor is there a benchmark against which IHS could adjust estimates to request additional appropriations in the event that the prior estimates were insufficient. Some have cited the VA's experience with advance appropriations as a possible model for IHS; however, the VA has a standard health benefits package, which provides a way for the agency to estimate its budgetary needs and request additional appropriations if that estimate is ultimately too low.

Challenges Related to Forecasting User Population

The future budget that the IHS would require to deliver services is, in part, a function of the population that receive services at IHS facilities. All members of federally recognized Indian Tribes are eligible to receive services at IHS, though some may not choose to do so. IHS measures its service population as the population that received services at an IHS facility in the past three years, and attempts to project its potential user population using data from the U.S. Census Bureau.[70] Although IHS attempts to project its future service population (i.e., the population eligible to receive IHS services), outside events may make it difficult to make accurate projections. For example, in recent years, additional tribes have been recognized by Congress, which would increase the population eligible for IHS services.[71] While Congress has at times appropriated funding to accommodate new tribes,[72] this may be more difficult under advance appropriations if new tribes are recognized after advance appropriations have been enacted.

In addition to changes in the overall population that would be eligible for IHS, there may be changes in whether the eligible population chooses to use IHS services (as opposed to receiving services outside the system). Such changes could either increase or decrease IHS use. For example, whether individual American Indians/Alaska Natives use IHS may be affected by their access to insurance coverage that would pay for services outside of the IHS system. Increases in insurance coverage could reduce the use of IHS, while declines in insurance coverage could have the opposite effect.[73] These changes are likely beyond IHS's control (e.g., a result of larger health system changes) so may make it more challenging for IHS to project its future user population.

Potential for Supplemental Funds

A related issue is that IHS's previous appropriations levels have generally not been sufficient to fund all needed services. In contrast, the VA typically receives sufficient appropriations to meet the estimated health care needs of the population that it serves, and the VA has received additional

[70] For a discussion of IHS's service and user population, see CRS Report R43330, *The Indian Health Service (IHS): An Overview*.

[71] For example, in January of 2018, P.L. 115-121, provided federal recognition to six new tribes in Virginia.

[72] For example, the House report accompanying FY2020 appropriations specified that funding provided to support hospital and health clinics included approximately $11 million to support services for newly recognized tribes. U.S. Congress, House Committee on Appropriations, Subcommittee on Interior, Environment, and Related Agencies, Department of the Interior, Environment, and Related Agencies Appropriations Bill, FY2020, to accompany H.R. 3152, 116th Cong., 1st sess., June 3, 2019, H.Rept. 116-100, p. 115.

[73] Beyond changes in system usage, outside changes in insurance coverage could also affect IHS facilities' ability to obtain reimbursements for services provided, which facilities can retain to provide additional services.

appropriations to meet these commitments, when necessary (e.g., to adjust for new data or to cover additional services due to changes in policy).

In providing advance appropriations, Congress is not required to make these supplemental appropriations in response to changing circumstances. As such, there is no expectation that IHS would receive additional funds (which the VA refers to as a "second bite of the apple") with advance appropriations having been previously provided. Because IHS's appropriations have generally not been sufficient to fund all needed services, it is possible that providing funding further in advance may exacerbate IHS's budgetary challenges, particularly if unanticipated needs arise that were not factored into the advance appropriations.

Despite these funding concerns, advance appropriations may provide IHS with administrative efficiencies that could expand the agency's funding capacity by reducing some of the activities required under CRs (e.g., having to issue and reconcile fewer ISDEAA contracts and compacts with ITs/TOs). In addition, IHS may, like the VA, realize recruitment and retention benefits associated with the certainty of having an advance appropriation. As noted, IHS has recruitment and retention concerns, so reducing vacancy rates has been a long-standing agency goal. In addition, the more services that IHS is able to provide within its facility, the fewer patients it has to refer outside, which could reduce the rates at which services are deferred or denied.[74]

Congressional Process to Initiate Advance Appropriations

In practice, there is no single procedural process for programs to begin receiving advance appropriations. Some programs have received an explicit prior authorization for advance appropriations (e.g., certain medical care accounts at the VA via P.L. 111-81), and such funding has been subsequently provided in appropriations acts. Other programs have been provided advance appropriations without any explicit underlying authorization for an alternative period of funding.[75] In at least one instance, advance appropriations were provided through the annual appropriations process even though the particular authorization provided for a different period of availability for funds.[76] The programs (and funding levels) provided with advance appropriations have generally been consistent since changes made in 2009 (P.L. 111-81) and 2014 (P.L. 113-235).[77]

If Congress were to initiate advance appropriations for IHS, various considerations or strategies could be factored into the choice of approaches, including whether (1) clear authorization from a legislative committee is preferred, and (2) a change is desired in the language explicitly limiting advance appropriations in budget resolutions. For IHS to receive advance appropriations, Congress may need to explicitly change the list of programs eligible to receive them; it may also need to adjust the funding ceiling for advance appropriations set in budget resolutions (or House rules).

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[74] For example, IHS reports that it denied or deferred more than 160,000 services in FY2018, see FY2020 CJ, p. 117.

[75] For example, historically, the Corporation for Public Broadcasting is provided a two-year advance appropriation outside of specific authorization for this funding availability. See CRS Report RS22168, *The Corporation for Public Broadcasting: Federal Funding and Issues*.

[76] For example, the authorization for a home energy assistance program (LIHEAP) in P.L. 101-501 provided for "forward funding," but from FY1994 through FY2001, excluding FY1997, advance appropriations were provided. Forward funding is budget authority that becomes available beginning late in the budget year (usually the last quarter) and is carried into at least one following fiscal year. See CRS Report RL31865, *LIHEAP: Program and Funding*.

[77] For discussion of these subsequent laws, see the "Advance Appropriations" section in CRS Report R45047, *Department of Veterans Affairs FY2018 Appropriations*.

The general limit on providing funding without authorization beyond the fiscal year covered by a general appropriations bill, working in tandem with the explicit limits placed on advance appropriations, may limit appropriators' ability to provide advance appropriations for any additional program without specific statutory direction.[78]

In the 116th Congress, various bills have been introduced to authorize advance appropriations for IHS. These bills use different statutory approaches, and the approach used may determine which committees have jurisdiction over the particular bill. For example, S. 2541 would amend IHCIA to authorize advance appropriations, and the bill was referred to the Committee on Indian Affairs, which has jurisdiction over IHCIA. In contrast, S. 229 was referred to the Budget Committee, presumably because it would not amend IHCIA but would amend Title 31 of the *U.S. Code* (related to money and finance).

Appropriations Oversight and Adjustments in the Budget Year

Congress may face a number of implementation issues should it decide to provide IHS with advance appropriations. Appropriations levels and program distributions are one way that Congress exercises oversight over federal agencies. Under advance appropriations, Congress would be making funding decisions about the agency more than a year in advance (as opposed to the regular budget cycle, where Congress would begin debating agency funding in the spring before it would become available at the beginning of the new fiscal year in the fall). Given this, in enacting advance appropriations, Congress may lose some ability to affect the IHS budget (both the overall funding level and the distribution of funds across programs) on a more immediate basis. Further, by setting aside (or "committing") some funds from subsequent budgets in advance, Congress may also reduce its future budgetary flexibility for other programs or priorities. This reduced flexibility would occur because advance appropriations effectively decrease the remaining funding available to be allocated by an appropriations subcommittee in the following year.

Congressional Budget Enforcement Considerations for Advance Appropriations

Although budget control enforcement is a consideration for both mandatory and discretionary spending,[79] advance appropriations involve a number of congressional budget process issues due

[78] If the period of availability has not been authorized by law, making funds available on a schedule different from the upcoming fiscal year in an appropriations bill or amendment thereto may be subject to a point of order under House or Senate rules. House precedents generally prohibit appropriations for durations beyond the fiscal year covered by a general appropriations bill, such as appropriations that are made "available until expended," except when "existing law can be interpreted to permit that availability." Because advance appropriations are by definition available for a duration that is beyond the budget year, it appears that these periods of availability would need to be authorized or permitted by law in order for such subsequent appropriations to be in order under House rules. Senate precedents are more ambiguous, although those that prohibit no-year appropriations when no authorization for such availability exists may be applicable to advance appropriations as well. See Charles W. Johnson, John V. Sullivan, and Thomas J. Wickham, Jr., *House Practice: A Guide to the Rules, Precedents and Procedures of the House*, 115th Cong., 1st sess. (Washington: GPO, 2017), ch. 4, §28, p. 99; §39, p. 110. This principle is discussed further in Lewis Deschler, *Deschler's Precedents of the U.S. House of Representatives*, 94th Cong., 1st sess., H.Doc. 94-661 (Washington: GPO, 1977-1991), vol. 8, ch. 26, §§32.1, 32.2; and Floyd M. Riddick and Alan S. Frumin, *Riddick's Senate Procedure: Precedents and Practices*, 101st Cong., 2nd sess., S.Doc. 101-28 (Washington: GPO, 1992), p. 212.

[79] For a broader discussion, see CRS Report R41510, *Budget Enforcement Procedures: House Pay-As-You-Go (PAYGO) Rule*; CRS Report RL31943, *Budget Enforcement Procedures: The Senate Pay-As-You-Go (PAYGO) Rule*; CRS Report 98-815, *Budget Resolution Enforcement*; and CRS In Focus IF10680, *When Congress Does Not Agree on*

to (1) the timing of their enactment, and (2) procedural rules that limit advance appropriations each year to a specific list of programs and a total budgetary amount.

Under long-standing scorekeeping guidelines, new budget authority is attributed to the first fiscal year that it is available for obligation. Consequently, advance appropriations are not scored against the same fiscal year covered by the bulk of the bill in which they are enacted, but instead against the first fiscal year for which they are provided (one or more years after the fiscal year for the rest of the bill).[80]

Because most enforcement mechanisms are based on limiting funding for the upcoming fiscal year, they do not have an immediate impact on advance appropriations. As a consequence, Congress has provided an additional separate enforceable limit on the amount of funding provided through advance appropriations. These limits have been adopted for various fiscal years via budget resolutions, statutory budget law, and House rules, and have curtailed any expansion of advance appropriations for new programs.[81] For example, House rules adopted on January 3, 2019, for the 116th Congress prohibited advance appropriations in FY2019 appropriations bills, except for those designated by the chair of the Budget Committee and printed in the *Congressional Record*. These exceptions have a funding cap under House rules ($28.852 billion for FY2020 for "Accounts Identified for Advance Appropriations" and $75.551 billion for FY2020 for "Veterans Accounts Identified for Advance Appropriations").[82] The House and Senate have also operated under separate limits (for example under the Bipartisan Budget Acts of 2018 and 2019, P.L. 115-123 and P.L. 116-37, respectively). Provisions in P.L. 115-123 (§30104) extended limits included in the previous budget resolution (H.Con.Res. 71), while provisions in P.L. 116-37 (§203 for the House and §206 for the Senate) extended a general prohibition on advance appropriations for FY2021, except for those accounts identified.

A number of these limitations may need to be considered should Congress expand advance appropriation authority to IHS. In general, a point of order could be raised against any advance appropriations that exceed a ceiling on advance appropriations or that provide such funding to any program that is not specified in the list of accounts eligible for advance appropriations.

A list of specific limitations included in House rules, congressional budget resolutions, and Bipartisan Budget Acts since FY2001 is available in the appendix to CRS Report R43482, *Advance Appropriations, Forward Funding, and Advance Funding: Concepts, Practice, and Budget Process Considerations*.

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a Budget Resolution: Use of Existing Budget Enforcement and Deeming Resolutions.

[80] This differs from forward funding, another alternative funding mechanism, in which additional budget authority is made available generally in the last quarter of the budget year. The budget authority for such programs, however, is included in the budget totals for the year in which it is appropriated, and forward funding is also scored in the fiscal year in which the funds are provided, unlike advance appropriations. Forward funding is discussed in CRS Report R43482, *Advance Appropriations, Forward Funding, and Advance Funding: Concepts, Practice, and Budget Process Considerations*.

[81] In years preceding these limitations, advance appropriations were more widespread. For example, see the President's budget submission from FY1996, "Appendix, Budget of the United States Government" (February 1, 1995), https://www.govinfo.gov/content/pkg/BUDGET-1996-APP/pdf/BUDGET-1996-APP-3-4.pdf.

[82] See §103(c) in H.Res. 6; H.Res. 6 was agreed to by the House on January 9, 2019.

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Acknowledgments

Amber Wilhelm, CRS Graphics Specialist, prepared the graphic used in this report.

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