DEPARTMENT OF HEALTH AND HUMAN SERVICES

Fiscal Year

2016

Indian Health Service

Justification of Estimates for Appropriations Committees

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Services

Indian Health Services
Rockville, MD 20852

JAN 15 2015

I am very pleased to present the Indian Health Service (IHS) FY 2016 Congressional Justification. This budget request provides support for the President's and the Secretary's priority initiatives and reflects the goals and objectives of the Department. The IHS budget represents extensive consultation with Tribes, and exemplifies the continued IHS and Tribal partnership on IHS priorities that are included in the FY 2016 budget request.

Performance measurement and reporting at IHS includes a comprehensive set of measures and outcomes in four major areas offering results-oriented information that enables IHS to share progress with stakeholders toward achieving our four Agency priorities:

- To renew and strengthen our partnership with Tribes;
- To reform the IHS;
- To improve the quality of and access to care; and
- To make our work accountable, transparent, fair, and inclusive.

IHS' implementation of performance management improvements has created a consistent framework for linking IHS-wide goals with program priorities and targeting resources to meet the needs of American Indian and Alaska Natives. The Agency's priorities provide a shared vision of what needs to be accomplished with our Tribal partners and provide a consistent and effective way to measure our achievement as we continue to change and improve the IHS.

Our FY 2016 budget request represents our efforts to ensure the Agency's valuable programs continue and to accomplish greater performance improvements and progress toward improving the health status of American Indian and Alaska Native people.

/Yvette Roubideaux, M.D., M.P.H./

Yvette Roubideaux, M.D., M.P.H.
Acting Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2016 Performance Budget Submission to Congress

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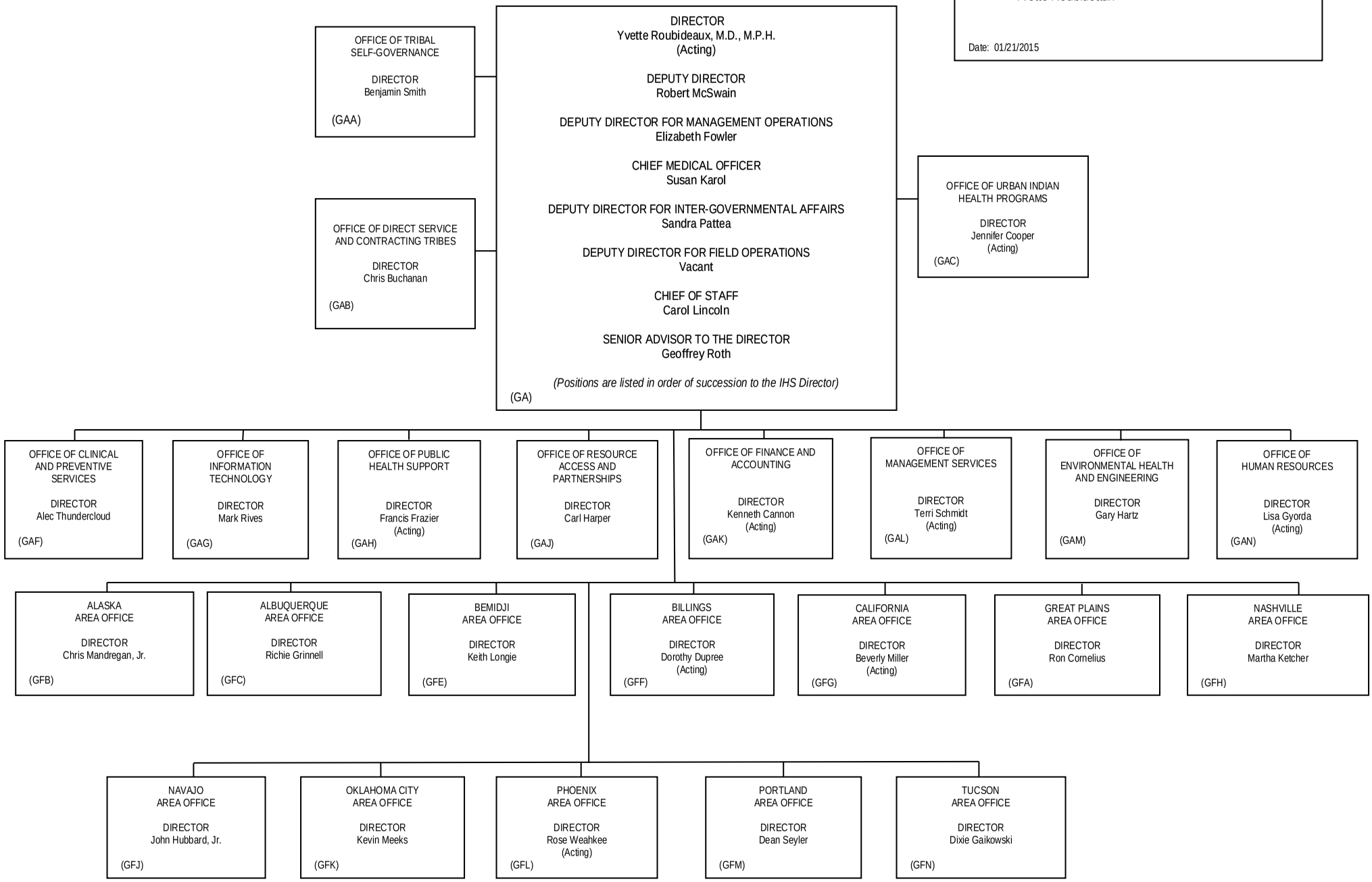
DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE

Approved: /Yvette Roubideaux/
Yvette Roubideaux

Date: 01/21/2015



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INTRODUCTION AND MISSION
Indian Health Service

The Indian Health Service (IHS), an Agency of the U.S. Department of Health and Human Services, is the principal Federal Agency charged with the mission of raising the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level.

The IHS provides comprehensive primary health care and disease prevention services to approximately 2.2 million American Indians and Alaska Natives through a network of over 650 hospitals, clinics, and health stations on or near Indian reservations. Facilities are predominantly located in rural primary care settings and are managed by IHS, Tribal, and Urban Indian health programs. The IHS provides a wide range of clinical, public health and community services primarily to members of 566 federally recognized Tribes in 35 states. The IHS has approximately 15,369 employees, including 2,482 nurses, 752 physicians, 669 engineers/ sanitarians, 696 pharmacists, and 280 dentists.

United States Government and Indian Nations

The provision of federal health services to American Indians and Alaska Natives is based on a special relationship between Indian Tribes and the United States. The Indian Commerce Clause of the United States Constitution, as well as numerous treaties and court decisions, have affirmed this special relationship and the plenary power of Congress to create statutes that benefit Indian people. Principal among these statutes is the Snyder Act of 1921, which provides the basic authority for health services provided by the federal government to American Indians and Alaska Natives.

Indian Health Service and Its Partnership with Tribes

In the 1970s, federal Indian policy was re-evaluated leading to adoption of a policy of Indian self-determination. This policy promotes Tribal administration of federal Indian programs, including health care. Self-Determination does not lessen any federal obligation, but provides an opportunity for Tribes to assume the responsibility of providing health care for their members. IHS partners with Tribes on health care delivery in the context of regular Tribal consultation.

The Indian Self-Determination and Education Assistance Act of 1975 (ISDEAA), as amended, and the Indian Health Care Improvement Act of 1976 (IHCIA), as amended, provided new opportunities for the IHS and Tribes to deliver quality and accessible health care. The Affordable Care Act builds upon these laws by including provisions to modernize and update the IHS, expanding health insurance and Medicaid coverage, and reforming health care delivery systems. The Affordable Care Act will help the Indian Health Service further improve access to quality, affordable health care.

The IHCIA includes specific authorizations such as improvements for urban Indian health programs, Indian health professions programs, and the authority to collect from Medicare/Medicaid and other third-party insurers for services rendered at IHS or Tribal facilities. Under the ISDEAA, many Tribes have assumed the administrative and program direction roles that were previously carried out by the federal government. Tribes currently administer over one-half of IHS resources through ISDEAA contracts and compacts. The IHS directly administers the remaining resources and manages facilities where Tribes have chosen not to contract or compact health programs.

EXECUTIVE SUMMARY
Indian Health Service

Overview of Budget Request

Tribal Consultation - For FY 2016, the Tribal budget formulation recommendations include a request for funding increases for Current Services (fixed costs – inflation, population growth, pay costs), Binding Agreements (Contract Support Costs, Health Care Facilities Construction projects, Staffing for new facilities, new Tribes), and program expansions. The top five program expansion priorities of Tribes are: Purchased/Referred Care, Hospital & Health Clinics, Mental Health, Alcohol/Substance Abuse and Health Care Facilities Construction & Other Authorities (e.g., the Joint Venture Construction program, Small Ambulatory program, etc.). This budget proposal incorporates Tribal priorities and recommendations to the greatest extent possible.

Summary of Request – The Indian Health Service budget request for FY 2016 of $5.103 billion in budget authority provides support for the priority initiatives of the President and Secretary and reflects the Healthy People 2020 goals and objectives of the Department. Tribal Consultation is fundamental to the IHS budget process, and at its core are the priorities and recommendations developed by Tribes through an annual budget formulation process.

The discretionary budget request of $5.103 billion in budget authority is an increase of $460.6 million above the FY 2015 Enacted level. The increase funds:

Current Services: +$147.3 million to fully fund medical inflation, pay raises and partially fund population growth.

- Medical Inflation: +$71.2 million
- Population Growth: +$56.7 million
- Pay Costs: +$19.4 million

Increases for current services are needed annually to maintain services levels. Otherwise, as costs arise, IHS must provide fewer services. In FY 2016, this funding is for shoring up the base operating budgets because of budget impacts from partial funding of fixed costs over several years. The majority of these funds will be allocated to the hospitals and health clinics that deliver health care.

Program Increases: +$313.3 million to fund priority programs.

- Staffing / Operating Costs for Newly-Constructed Healthcare Facilities and Youth Regional Treatment Centers: +$17.8 million
- Purchased/Referred Care (PRC): +$25.5 million, in addition to $43.6 million in PRC medical inflation and $1.2 million for staffing/operating costs (total PRC increase of $70.3 million)
- Hospital & Health Clinics
    - Improvements in Third Party Collections: +$10.0 million
    - Health Information Technology (under H&HC): +$10.0 million
        - To enhance the Resource Patient Management System (RPMS) Electronic Health Record (EHR) to comply with requirements for the 2015 EHR Certification and Stage 3 Meaningful Use.
- Tribal Behavioral Health Initiative for Native Youth (under Alcohol and Substance Abuse): +$25.0 million
    - $22,000,000 will fund 200 IHS, Tribal, and Urban Indian health care programs in the amount of $110,000 annually to hire behavioral health providers focused on youth.

  - $3,000,000 for national management, information technology systems for data collection and reporting, training and technical assistance, and national evaluation.
- Contract Support Costs: +$55.0 million to fund the estimated CSC need for new and expanded contracts and compacts.
- Maintenance and Improvement: +$35.0 million to address critical maintenance backlog of approximately $467 million.
- Sanitation Facilities Construction: +$35.0 million to address sanitation deficiencies and construct sanitation projects; provide sanitation facilities to approximately 7,200 Indian homes and reduce the backlog of sanitation deficiencies of feasible projects totaling $1.93 billion.
- Health Care Facilities Construction: +$100.0 million for a total funding level of $185 million.
  - Gila River Southeast Health Center, Chandler, AZ to complete construction.
  - Salt River Northeast Health Center, Scottsdale, AZ to design and begin construction.
  - Rapid City Health Center, Rapid City, SD to design and begin construction.
  - New Dilkon Alternative Rural Health Center, Dilkon, AZ to design and construct the infrastructure.

Mandatory Budget Proposals – The IHS mandatory budget proposal include:

Special Diabetes Program for Indians (SDPI): $150 million to reauthorize this successful diabetes prevention and treatment program. The FY 2016 request includes a proposal to extend the reauthorization for three years through FY 2018 at $150 million per year to continue to address the ongoing epidemic of diabetes complications and reverse the increasing incidence of diabetes through primary prevention in American Indian/Alaska Native communities. The program is currently authorized through FY 2015.

Contract Support Costs (CSC): the budget proposes to shift CSC to a mandatory appropriation in FY 2017. The mandatory CSC proposal includes three years of estimated CSC funding from FY 2017 to FY 2019. Through the reauthorization process, Congress will receive revised CSC estimates on a three-year cycle. IHS and Bureau of Indian Affairs will consult broadly with Tribes on this new approach prior to implementation.

Overview of Performance

The IHS mission is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives (AI/AN) to the highest level. To help undertake the mission, the IHS uses four Agency priorities as a strategic framework. The four strategic priorities are: to renew and strengthen the Agency's partnership with Tribes; to reform the IHS;, to improve the quality of and access to care; and to make all of the Agency's work transparent, accountable, fair and inclusive. The performance information throughout this performance budget request reflects the work accomplished under these four priorities. The IHS aligns its strategic planning, performance measurement and performance management activities with the Department of Health and Human Services (HHS) 2014-2018 Strategic Plan and the HHS Annual Performance Plan.

The first performance accomplishment highlighted in this section is representative of the Agency's first priority to renew and strengthen its partnership with Tribes. This priority is accomplished, in part, by making at least three improvements annually to the IHS Tribal consultation process. Progress for this performance measure is tracked by the HHS Strategic Review process for Goal 1, Objective E, of the Fiscal Year 2014-2018 HHS Strategic Plan and by

the HHS Annual Performance Plan and Report as a Government Performance and Results Act of 1993 (GPRA) and the GPRA Modernization Act of 2010 (GPRAMA). Since IHS started tracking progress for this measure in FY 2011, a total of 24 improvements have been made, with Tribal input, to the Tribal consultation process through FY 2014. This measure has significant impact on the IHS's ability to build a responsive and culturally relevant relationship with its Tribal partners in delivering health care to AI/ANs. A second performance highlight is representative of the Agency's third priority to improve the quality of and access to care, which links to HHS Strategic Goal 1, Objective E, and is tracked by the HHS Strategic Review process. The IHS has achieved 100 percent accreditation or certification for all IHS-operated facilities by a national health care organization and maintained this level since it first started being tracked as a budget measure in 1999. Leadership monitoring, staff training, and carrying out corrective actions have ensured progress for facilities to remain accredited or certified. This measure has significant impact on the ability of IHS-operated facilities to collect third-party revenue and use that revenue to ensure access to quality, culturally competent care. Both of these highlighted measures are in the HHS Strategic Planning System, a mechanism for reporting and tracking evidence related to the HHS Strategic Plan. The IHS has a total of six GPRAMA measures and we share in the FY 2014 Strategic Objective Reviews Summary Report in which the HHS strategic objectives, where the IHS measures are included, were rated as Progressing.

The IHS internal performance management process is established under an Agency-wide annual performance plan guided by the four Agency priorities. The selection of the four priorities included input from key stakeholders on areas of greatest interest for improvement. An organizational assessment on the objectives within the Agency Performance Plan is completed annually and submitted to HHS as evidence that the IHS holds its senior leaders accountable to drive progress on the Agency Performance Plan. The FY 2014 Performance Plan has 21 management, programmatic, and clinical objectives which are adjusted annually, as needed, to advance better performance. One performance objective within the Plan includes achieving or exceeding the 22 clinical performance measures annual targets; these measures represent a marker in the delivery of and access to quality health care. The Agency Performance Plan's objectives are cascaded, as appropriate, as performance elements to the performance plans of senior executives and to their staffs so that all employees relate their job duties to the progress on the Agency priorities. Regular progress reviews are conducted at least bi-annually on the Agency performance elements cascaded to employees and some performance measures, such as the 22 clinical measures, are analyzed and reported quarterly. The progress reviews contribute to Agency leadership decision making on how and when to adjust targets or to take corrective actions to address obstacles that could prevent achieving the desired results.

The IHS has used performance information for management purposes and presents the examples that follow. The IHS added the HHS Million Hearts Initiative® Controlling High Blood Pressure as a budget measure to our clinical measure set. Additionally, the measure logic for the following three measures was updated in 2014 to conform to new clinical standards of care: diabetes nephropathy assessed, pneumococcal vaccination for patients aged 65 and older, and cervical cancer screening. In FY 2016 IHS will replace the current Purchased/Referred Care budget measure by dividing it into two separate measures: one will track IHS referrals for care and the second will track self-referrals. This change was recommended by GAO report, GAO-14-57, with HHS concurrence in Appendix 1. In FY 2016 the IHS will retire the influenza vaccination coverage for patients aged sixty-five and older, and replace it with two new influenza measures that align with Healthy People 2020 objectives. A new HIV Screening Ever measure will replace the Alcohol Screening: Fetal Alcohol Syndrome (FAS) prevention measure. Targets for the clinical budget measures have been calculated for 2016 with consideration for current services and program expansion increases. The FY 2016 request includes current services increases (i.e.,

fixed costs-inflation, population growth, pay costs) for directly provided IHS and tribal health care services, which have not been previously funded in prior budget years. FY 2016 targets represent ambitious, yet realistic levels of performance.

As the United States medical community is now adopting certified electronic health records and reporting clinical quality measures electronically, the IHS is now in its fourteenth year of reporting electronic performance results for GPRA/GPRAMA clinical measures from the IHS's electronic health record, the Resource and Patient Management System's (RPMS) Clinical Reporting Software (CRS) module. The IHS CRS report is a comprehensive representation of patient data and clinical performance based upon an electronic review of 100 percent of all patient records in a local RPMS server. The future of quality reporting by the IHS is twofold: centralization of national, clinical performance reporting and alignment of clinical measures with national standard measures, where appropriate. This new direction aligns with the Affordable Care Act's National Strategy for Quality Improvement in Health Care (National Quality Strategy) as well as the HHS Measurement Policy Council's (MPC) efforts to align core performance measures across HHS.

As reported in the FY 2015 Congressional Justification, the IHS successfully completed a pilot demonstration of the ability to produce aggregated, clinical performance measures from the IHS' National Data Warehouse. The IHS originally planned to report clinical budget measure results from the new national performance data mart known as the Integrated Data Collection System (IDCS) in FY 2016. The IHS is now expecting to use IDCS for FY 2017 reporting. Programming clinical quality measures at one centralized location will allow IHS to quickly add, modify, or delete performance measures and run on demand, web-based reports instead of three CRS national reports currently aggregated from the twelve IHS Area Office's CRS reports each year. The new national performance data mart will be more efficient and provide performance results on a more frequent and ad hoc basis, providing information that can be used in program and management decision making. IHS envisions the national performance data mart as one source for data when program evaluations are planned in the future and with data in one central location, the cost of accessing that data will be reduced since new measures can be programmed and results calculated at the central data mart.

As electronic, clinical quality performance reporting becomes the norm in the United States, standardized national measures will become increasingly important. Standardized national measures are now being used by federal agencies and users of certified electronic health records. Two of IHS's current budget measures use the logic of National Quality Forum measures: colorectal cancer screening and the Million Hearts Controlling High Blood Pressure. The HHS MPC has been meeting since 2012 to align core performance measures around specific domains. As standardized national measures are developed which provide information on the AI/AN population that are useful in decision making, the IHS will adopt those measures as part of our GPRA/GPRAMA performance measures. Results for those measures may be compared directly to standard measures from other health care entities, providing another tool for programs to use in decision making and program evaluation.

The IHS is taking part in the changing landscape of clinical quality performance reporting. The Agency is working as part of the HHS MPC team to determine core measures for various health and medical conditions. When newly developed measures support the needs of our AI/AN population, the IHS will use those measures as markers for quality of care as well as for population reporting in our annual budget.

All Purpose Table
Indian Health Service
(Dollars in Thousands)

Jan 10, 2015

Program	FY 2014 Final	FY 2015 Enacted [3]	FY 2016 President's Budget	FY 2016 +/- FY 2015
SERVICES				
Hospitals & Health Clinics	1,773,931	1,836,789	1,936,323	99,534
Dental Services	165,260	173,982	181,459	7,477
Mental Health	77,980	81,145	84,485	3,340
Alcohol & Substance Abuse	186,378	190,981	227,062	36,081
Purchased/Referred Care	878,575	914,139	984,475	70,336
Total, Clinical Services	3,082,124	3,197,036	3,413,804	216,768
Public Health Nursing	70,829	75,640	79,576	3,936
Health Education	16,926	18,026	19,136	1,110
Community Health Representatives	57,895	58,469	62,363	3,894
Immunization AK	1,826	1,826	1,950	124
Total, Preventive Health	147,476	153,961	163,025	9,064
Urban Health	40,729	43,604	43,604	0
Indian Health Professions	28,466	48,342	48,342	0
Tribal Management Grants	1,442	2,442	2,442	0
Direct Operations	65,894	68,065	68,338	273
Self-Governance	4,227	5,727	5,735	8
Contract Support Costs	612,484	662,970	717,970	55,000
Total, Other Services	753,242	831,150	886,431	55,281
TOTAL, SERVICES	3,982,842	4,182,147	4,463,260	281,113
FACILITIES				
Maintenance & Improvement	53,614	53,614	89,097	35,483
Sanitation Facilities Construction	79,423	79,423	115,138	35,715
Health Care Facilities Construction	85,048	85,048	185,048	100,000
Facilities & Environmental Health Support	211,051	219,612	226,870	7,258
Equipment	22,537	22,537	23,572	1,035
TOTAL, FACILITIES[1]	451,673	460,234	639,725	179,491
TOTAL, BUDGET AUTHORITY	**4,434,515**	**4,642,381**	**5,102,985**	460,604
COLLECTIONS / MANDATORY				
Medicare	225,165	226,338	226,338	0
Medicaid	737,744	771,179	781,179	10,000
Subtotal, M / M	*962,909*	*997,517*	*1,007,517*	*10,000*
Private Insurance	90,246	90,303	95,303	5,000
VA Reimbursement[2]	6,622	18,244	28,062	9,818
Total, M / M / PI	*1,059,777*	*1,106,064*	*1,130,882*	*24,818*
Quarters	8,000	8,000	8,500	500
TOTAL, COLLECTIONS	*1,067,777*	*1,114,064*	*1,139,382*	*25,318*
Special Diabetes Program for Indians	147,000	150,000	150,000	0
TOTAL, MANDATORY	147,000	150,000	150,000	0
TOTAL, PROGRAM LEVEL	**5,649,292**	**5,906,445**	**6,392,367**	485,922

[1] The facilities scheduled to be constructed in FY 2016 include the Gila River Southeast Health Center, Salt River Northeast Health Center, Rapid City Health Center, and Dilkon Alternative Rural Health Center, depending on the availability of funding and construction schedules

[2] Estimates are revised from the FY 2015 PB. Please see Public and Private Collections narrative for discussion on the

[3] P.L. 113-235, Continuing and Consolidated Appropriations Act, 2015 signed December 16, 2014

INDIAN HEALTH SERVICE
FY 2016 President's Budget
Detail of Changes
(Dollars in Thousands)

Jan 26, 2015

Sub Sub Activity	FY 2014 Final	FY 2015 Enacted	Current Services: Federal Pay	Current Services: Tribal Pay	Current Services: Pay Total	Current Services: Medical Inflation 3.8%	Current Services: Population Growth	Curr Svcs Subtotal	Increases: Staffing for New Facilities	Increases: H&HC 3rd Party Improvemt	Increases: Purchased/ Referred Care	Increases: H&HC Health IT	Increases: ASA Behavioral Health	Increases: Contract Support Costs	Increases: M&I SFC HCFC	Increases Subtotal	FY 2016 President's Budget
SERVICES																	
Hospitals & Health Clinics	1,773,931	1,836,789	5,050	7,777	12,827	22,806	34,614	70,247	9,287	10,000	0	10,000	0	0	0	29,287	**1,936,323**
Dental Services	165,260	173,982	678	722	1,400	1,869	2,500	5,769	1,708	0	0	0	0	0	0	1,708	**181,459**
Mental Health	77,980	81,145	243	373	616	1,006	1,285	2,907	433	0	0	0	0	0	0	433	**84,485**
Alcohol & Substance Abuse	186,378	190,981	177	1,157	1,334	2,869	3,888	8,091	2,990	0	0	0	25,000	0	0	27,990	**227,062**
Purchased/Referred Care	878,575	914,139	0	0	0	35,249	8,362	43,611	1,208	0	25,517	0	0	0	0	26,725	**984,475**
Total, Clinical Services	3,082,124	3,197,036	6,148	10,029	16,177	63,799	50,649	130,625	15,626	10,000	25,517	10,000	25,000	0	0	86,143	**3,413,804**
Public Health Nursing	70,829	75,640	282	323	605	1,755	1,076	3,436	500	0	0	0	0	0	0	500	**79,576**
Health Education	16,926	18,026	33	100	133	547	334	1,014	96	0	0	0	0	0	0	96	**19,136**
Comm. Health Reps	57,895	58,469	6	431	437	2,223	1,234	3,894	0	0	0	0	0	0	0	0	**62,363**
Immunization AK	1,826	1,826	0	15	15	70	39	124	0	0	0	0	0	0	0	0	**1,950**
Total, Preventive Health	147,476	153,961	321	869	1,190	4,595	2,683	8,468	596	0	0	0	0	0	0	596	**163,025**
Urban Health	40,729	43,604	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**43,604**
Indian Health Professions	28,466	48,342	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**48,342**
Tribal Management	1,442	2,442	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**2,442**
Direct Operations	65,894	68,065	212	61	273	0	0	273	0	0	0	0	0	0	0	0	**68,338**
Self-Governance	4,227	5,727	8	0	8	0	0	8	0	0	0	0	0	0	0	0	**5,735**
Contract Support Costs	612,484	662,970	0	0	0	0	0	0	0	0	0	0	0	55,000	0	55,000	**717,970**
Total, Other Services	753,242	831,150	220	61	281	0	0	281	0	0	0	0	0	55,000	0	55,000	**886,431**
Total, Services	3,982,842	4,182,147	6,689	10,959	17,648	68,394	53,332	139,374	16,222	10,000	25,517	10,000	25,000	55,000	0	141,739	**4,463,260**
FACILITIES																	
Maintenance & Improvement	53,614	53,614	0	0	0	0	483	483	0	0	0	0	0	0	35,000	35,000	**89,097**
Sanitation Facilities Constr.	79,423	79,423	0	0	0	0	715	715	0	0	0	0	0	0	35,000	35,000	**115,138**
Health Care Fac. Constr.	85,048	85,048	0	0	0	0	0	0	0	0	0	0	0	0	100,000	100,000	**185,048**
Facil. & Envir. Hlth Supp.	211,051	219,612	1,026	731	1,757	1,931	1,986	5,674	1,584	0	0	0	0	0	0	1,584	**226,870**
Equipment	22,537	22,537	0	0	0	825	210	1,035	0	0	0	0	0	0	0	0	**23,572**
Total, Facilities	451,673	460,234	1,026	731	1,757	2,756	3,394	7,908	1,584	0	0	0	0	0	170,000	171,584	**639,725**
TOTAL, IHS	**4,434,515**	**4,642,381**	**7,715**	**11,690**	**19,405**	**71,150**	**56,726**	**147,282**	**17,806**	**10,000**	**25,517**	**10,000**	**25,000**	**55,000**	**170,000**	**313,323**	**5,102,985**

INDIAN HEALTH SERVICE
STAFFING AND OPERATING COSTS
FOR NEWLY-CONSTRUCTED HEALTHCARE FACILITIES -- Estimates
FY 2016 Budget Request
(Dollars in Thousands)

Jan 8, 2014

	Hemet, CA Southern California Youth Treatment Center		Choctaw, MS Choctaw Alternative Rural Healthcare Center (JV)		Winterhaven, CA Ft. Yuma Health Center (Replacement)		TOTAL	
Sub Sub Activity	FTE	Amount	Pos	Amount	FTE	Amount	**FTE/Pos**	**AMOUNT**
Hospitals & Health Clinics	0	$0	73	$7,609	16	$1,678	89	$9,287
Dental Health	0	$0	15	$1,504	2	$204	17	$1,708
Mental Health	0	$0	3	$339	1	$94	4	$433
Alcohol & Substance Abuse	32	$2,888	1	$102	0	$0	33	$2,990
Purchased/Referred Care	0	$0		$0	0	$1,208	0	$1,208
Total, Clinical Services	32	$2,888	92	$9,554	19	$3,184	143	$15,626
Public Health Nursing	0	$0	3	$378	1	$122	4	$500
Health Education	0	$0	1	$96	0	$0	1	$96
Total, Preventive Health	0	$0	4	$474	1	$122	5	$596
Total, Services	32	$2,888	96	$10,028	20	$3,306	148	$16,222
Facilities Support	3	$311	4	$930	1	$203	8	$1,444
Environmental Health Support	0	$0	0	$0	1	$140	1	$140
Total, FEHS	3	$311	4	$930	2	$343	9	$1,584
Total, Facilities	3	$311	4	$930	2	$343	9	$1,584
Grand Total [1]	**35**	**$3,199**	**100**	**$10,958**	**22**	**$3,649**	**157**	**$17,806**

[1] Includes utilities

Above data reflect **estimates** for new facilities anticipated to open in FY 2015 and 2016.

Statement of Personnel Resources
INDIAN HEALTH SERVICE

	FY 2014 Final	FY 2015 Enacted	FY 2016 Request
Direct:			
Hospitals & Health Clinics	6,232	6,557	6,573
Dental Health	633	701	703
Mental Health	196	222	223
Alcohol & Substance Abuse	176	224	256
Purchased/Referred Care	0	0	0
Total, Clinical Services	7,237	7,704	7,755
Public Health Nursing	190	223	224
Health Education	34	42	42
Community Health Reps	9	9	9
Immunization, AK	0	0	0
Total, Preventive Health	233	274	275
Urban Health	5	5	5
Indian Health Professions	19	19	19
Tribal Management	0	0	0
Direct Operations	268	268	268
Self Governance	13	13	13
Contract Support Costs	0	0	0
Total, SERVICES	7,775	8,283	8,335
Maint. & Improvement	0	0	0
Sanitation Facilities	161	161	161
Hlth Care Facs Construction	0	0	0
Facil. & Envir. Hlth Support	1,007	1,058	1,063
Equipment	0	0	0
Total, FACILITIES	1,168	1,219	1,224
Total, Direct FTE	8,943	9,502	9,559
Reimbursable:			
Buybacks	1,230	1,230	1,230
Medicare	813	813	813
Medicaid	3,662	3,662	3,662
Private Insurance	544	544	544
Quarters	29	29	29
Total, Reimbursable FTE	6,278	6,278	6,278
Trust Funds (Gift)	23	23	23
Health Reform non -add:	0	0	0
TOTAL FTE	**15,244**	**15,803**	**15,860**
Total, Civilian FTE	**13,163**	**13,722**	**13,779**
Total, Military FTE	**2,081**	**2,081**	**2,081**

FY 2014 Crosswalk
Budget Authority
Final Distribution
(Dollars in Thousands)

Sub Activity	Federal Health Administration								Tribal Health Administration								FY 2014 Final
	Clinical Services	Urban Health	Preventive Health	Indian Health Professions	Federal Administration	Self-Governance	Facilities	TOTAL Federal Health Admini-stration	Clinical Services	Preventive Health	Urban Health	Management Training	Self-Governance	Contract Support	Facilities	TOTAL Tribal Health Admini-stration	
SERVICES																	
Hospitals & Health Clinics	710,975	0	0	0	0	0	0	710,975	1,062,956	0	0	0	0	0	0	1,062,956	1,773,931
Dental Health	57,326	0	0	0	0	0	0	57,326	107,934	0	0	0	0	0	0	107,934	165,260
Mental Health	23,170	0	0	0	0	0	0	23,170	54,810	0	0	0	0	0	0	54,810	77,980
Alcohol & Substance Abuse	36,339	0	0	0	0	0	0	36,339	150,039	0	0	0	0	0	0	150,039	186,378
Purchased/Referred Care	310,313	0	0	0	0	0	0	310,313	568,262	0	0	0	0	0	0	568,262	878,575
Subtotal (CS)	1,138,123	0	0	0	0	0	0	1,138,123	1,944,001	0	0	0	0	0	0	1,944,001	3,082,124
Public Health Nursing	0	0	21,516	0	0	0	0	21,516	0	49,313	0	0	0	0	0	49,313	70,829
Health Education	0	0	3,299	0	0	0	0	3,299	0	13,627	0	0	0	0	0	13,627	16,926
Community Health Repr.	0	0	4,117	0	0	0	0	4,117	0	53,778	0	0	0	0	0	53,778	57,895
Immunization AK	0	0	0	0	0	0	0	0	0	1,826	0	0	0	0	0	1,826	1,826
Subtotal (PH)	0	0	28,932	0	0	0	0	28,932	0	118,544	0	0	0	0	0	118,544	147,476
Urban Health Project	0	15,911	0	0	0	0	0	15,911	0	0	24,818	0	0	0	0	24,818	40,729
Indian Health Professions	0	0	0	28,466	0	0	0	28,466	0	0	0	0	0	0	0	0	28,466
Tribal Management	0	0	0	143	0	0	0	143	0	0	0	1,299	0	0	0	1,299	1,442
Direct Operations	0	0	0	0	46,971	0	0	46,971	0	0	0	18,923	0	0	0	18,923	65,894
Self-Governance	0	0	0	0	0	2,654	0	2,654	0	0	0	0	1,573	0	0	1,573	4,227
Contract Support Costs	0	0	0	0	0	0	0	0	0	0	0	0	0	612,484	0	612,484	612,484
Subtotal (OS)	0	15,911	0	28,609	46,971	2,654	0	94,145	0	0	24,818	20,222	1,573	612,484	0	659,097	753,242
Total, Services	1,138,123	15,911	28,932	28,609	46,971	2,654	0	1,261,200	1,944,001	118,544	24,818	20,222	1,573	612,484	0	2,721,642	3,982,842
FACILITIES																	
Maintenance & Improvement	0	0	0	0	0	0	23,702	23,702	0	0	0	0	0	0	29,912	29,912	53,614
Sanitation Facilities Constr.	0	0	0	0	0	0	27,798	27,798	0	0	0	0	0	0	51,625	51,625	79,423
Health Care Facs. Constr.	0	0	0	0	0	0	72,548	72,548	0	0	0	0	0	0	12,500	12,500	85,048
Facs. & Env. Health Sup	0	0	0	0	0	0	96,323	96,323	0	0	0	0	0	0	114,728	114,728	211,051
Equipment	0	0	0	0	0	0	7,712	7,712	0	0	0	0	0	0	14,825	14,825	22,537
Total, Facilities	0	0	0	0	0	0	228,083	228,083	0	0	0	0	0	0	223,590	223,590	451,673
TOTAL, IHS	1,138,123	15,911	28,932	28,609	46,971	2,654	228,083	1,489,282	1,944,001	118,544	24,818	20,222	1,573	612,484	223,590	2,945,233	4,434,515
% Federal Health Admin.								33.6%									
% Tribal and Urban Health Admin.																	66.4%

FY 2015 Crosswalk
Budget Authority
Estimated Distribution
(Dollars in Thousands)

Sub Activity	Federal Health Administration								Tribal Health Administration								FY 2015 Enacted
	Clinical Services	Urban Health	Preventive Health	Indian Health Professions	Federal Administration	Self-Governance	Facilities	TOTAL Federal Health Admini-stration	Clinical Services	Preventive Health	Urban Health	Management Training	Self-Governance	Contract Support	Facilities	TOTAL Tribal Health Admini-stration	
SERVICES																	
Hospitals & Health Clinics	725,644	0	0	0	0	0	0	725,644	1,111,145	0	0	0	0	0	0	1,111,145	1,836,789
Dental Health	57,356	0	0	0	0	0	0	57,356	116,626	0	0	0	0	0	0	116,626	173,982
Mental Health	23,170	0	0	0	0	0	0	23,170	57,975	0	0	0	0	0	0	57,975	81,145
Alcohol & Substance Abuse	36,339	0	0	0	0	0	0	36,339	154,642	0	0	0	0	0	0	154,642	190,981
Purchased/Referred Care	324,120	0	0	0	0	0	0	324,120	590,019	0	0	0	0	0	0	590,019	914,139
Subtotal (CS)	1,166,629	0	0	0	0	0	0	1,166,629	2,030,407	0	0	0	0	0	0	2,030,407	3,197,036
Public Health Nursing	0	0	21,596	0	0	0	0	21,596	0	54,044	0	0	0	0	0	54,044	75,640
Health Education	0	0	3,374	0	0	0	0	3,374	0	14,652	0	0	0	0	0	14,652	18,026
Community Health Repr.	0	0	4,567	0	0	0	0	4,567	0	53,902	0	0	0	0	0	53,902	58,469
Immunization AK	0	0	0	0	0	0	0	0	0	1,826	0	0	0	0	0	1,826	1,826
Subtotal (PH)	0	0	29,537	0	0	0	0	29,537	0	124,424	0	0	0	0	0	124,424	153,961
Urban Health Project	0	16,877	0	0	0	0	0	16,877	0	0	26,727	0	0	0	0	26,727	43,604
Indian Health Professions	0	0	0	48,342	0	0	0	48,342	0	0	0	0	0	0	0	0	48,342
Tribal Management	0	0	0	143	0	0	0	143	0	0	0	2,299	0	0	0	2,299	2,442
Direct Operations	0	0	0	0	48,971	0	0	48,971	0	0	0	19,094	0	0	0	19,094	68,065
Self-Governance	0	0	0	0	0	3,154	0	3,154	0	0	0	0	2,573	0	0	2,573	5,727
Contract Support Costs	0	0	0	0	0	0	0	0	0	0	0	0	0	662,970	0	662,970	662,970
Subtotal (OS)	0	16,877	0	48,485	48,971	3,154	0	117,487	0	0	26,727	21,393	2,573	662,970	0	713,663	831,150
Total, Services	1,166,629	16,877	29,537	48,485	48,971	3,154	0	1,313,653	2,030,407	124,424	26,727	21,393	2,573	662,970	0	2,868,494	4,182,147
FACILITIES																	
Maintenance & Improvement	0	0	0	0	0	0	23,702	23,702	0	0	0	0	0	0	29,912	29,912	53,614
Sanitation Facilities Constr.	0	0	0	0	0	0	27,798	27,798	0	0	0	0	0	0	51,625	51,625	79,423
Health Care Facs. Constr.	0	0	0	0	0	0	82,322	82,322	0	0	0	0	0	0	2,726	2,726	85,048
Facs. & Env. Health Sup	0	0	0	0	0	0	96,323	96,323	0	0	0	0	0	0	123,289	123,289	219,612
Equipment	0	0	0	0	0	0	7,712	7,712	0	0	0	0	0	0	14,825	14,825	22,537
Total, Facilities	0	0	0	0	0	0	237,857	237,857	0	0	0	0	0	0	222,377	222,377	460,234
TOTAL, IHS	1,166,629	16,877	29,537	48,485	48,971	3,154	237,857	1,551,509	2,030,407	124,424	26,727	21,393	2,573	662,970	222,377	3,090,872	4,642,381
% Federal Health Admin.								33.4%									
% Tribal and Urban Health Admin.																	66.6%

FY 2016 Crosswalk
Budget Authority
Estimated Distribution
(Dollars in Thousands)

Sub Activity	Federal Health Administration								Tribal Health Administration								FY 2016 PB
	Clinical Services	Urban Health	Preventive Health	Indian Health Professions	Federal Administration	Self-Governance	Facilities	TOTAL Federal Health Admini-stration	Clinical Services	Preventive Health	Urban Health	Management Training	Self-Governance	Contract Support	Facilities	TOTAL Tribal Health Admini-stration	
SERVICES																	
Hospitals & Health Clinics	749,612	0	0	0	0	0	0	749,612	1,186,711	0	0	0	0	0	0	1,186,711	1,936,323
Dental Health	58,872	0	0	0	0	0	0	58,872	122,587	0	0	0	0	0	0	122,587	181,459
Mental Health	23,780	0	0	0	0	0	0	23,780	60,705	0	0	0	0	0	0	60,705	84,485
Alcohol & Substance Abuse	40,796	0	0	0	0	0	0	40,796	186,266	0	0	0	0	0	0	186,266	227,062
Purchased/Referred Care	349,551	0	0	0	0	0	0	349,551	634,924	0	0	0	0	0	0	634,924	984,475
Subtotal (CS)	1,222,611	0	0	0	0	0	0	1,222,611	2,191,193	0	0	0	0	0	0	2,191,193	3,413,804
Public Health Nursing	0	0	22,587	0	0	0	0	22,587	0	56,989	0	0	0	0	0	56,989	79,576
Health Education	0	0	3,526	0	0	0	0	3,526	0	15,610	0	0	0	0	0	15,610	19,136
Community Health Repr.	0	0	4,614	0	0	0	0	4,614	0	57,749	0	0	0	0	0	57,749	62,363
Immunization AK	0	0	0	0	0	0	0	0	0	1,950	0	0	0	0	0	1,950	1,950
Subtotal (PH)	0	0	30,726	0	0	0	0	30,726	0	132,299	0	0	0	0	0	132,299	163,025
Urban Health Project	0	16,877	0	0	0	0	0	16,877	0	0	26,727	0	0	0	0	26,727	43,604
Indian Health Professions	0	0	0	48,342	0	0	0	48,342	0	0	0	0	0	0	0	0	48,342
Tribal Management	0	0	0	143	0	0	0	143	0	0	0	2,299	0	0	0	2,299	2,442
Direct Operations	0	0	0	0	49,183	0	0	49,183	0	0	0	19,155	0	0	0	19,155	68,338
Self-Governance	0	0	0	0	0	3,162	0	3,162	0	0	0	0	2,573	0	0	2,573	5,735
Contract Support Costs	0	0	0	0	0	0	0	0	0	0	0	0	0	717,970	0	717,970	717,970
Subtotal (OS)	0	16,877	0	48,485	49,183	3,162	0	117,707	0	0	26,727	21,454	2,573	717,970	0	768,724	886,431
Total, Services	1,222,611	16,877	30,726	48,485	49,183	3,162	0	1,371,043	2,191,193	132,299	26,727	21,454	2,573	717,970	0	3,092,217	4,463,260
FACILITIES																	
Maintenance & Improvement	0	0	0	0	0	0	38,296	38,296	0	0	0	0	0	0	50,801	50,801	89,097
Sanitation Facilities Constr.	0	0	0	0	0	0	40,298	40,298	0	0	0	0	0	0	74,840	74,840	115,138
Health Care Facs. Constr.	0	0	0	0	0	0	121,364	121,364	0	0	0	0	0	0	63,684	63,684	185,048
Facs. & Env. Health Sup	0	0	0	0	0	0	98,569	98,569	0	0	0	0	0	0	128,301	128,301	226,870
Equipment	0	0	0	0	0	0	7,994	7,994	0	0	0	0	0	0	15,578	15,578	23,572
Total, Facilities	0	0	0	0	0	0	306,521	306,521	0	0	0	0	0	0	333,203	333,203	639,725
TOTAL, IHS	1,222,611	16,877	30,726	48,485	49,183	3,162	306,521	1,677,565	2,191,193	132,299	26,727	21,454	2,573	717,970	333,203	3,425,420	5,102,985
% Federal Health Admin.								32.9%									
% Tribal and Urban Health Admin.																	67.1%

INDIAN HEALTH SERVICE

Federal Funds

General and Special Funds:

Indian Health Services

For expenses necessary to carry out the Act of August 5, 1954 (68 Stat. 674), the Indian Self-Determination and Education Assistance Act, the Indian Health Care Improvement Act, and titles II and III of the Public Health Service Act with respect to the Indian Health Service, **[**$4,182,147,000**]** *$4,463,260,000*, together with payments received during the fiscal year pursuant to 42 U.S.C. 238(b) and 238b for services furnished by the Indian Health Service: *Provided*, That funds made available to tribes and tribal organizations through contracts, grant agreements, or any other agreements or compacts authorized by the Indian Self-Determination and Education Assistance Act of 1975 (25 U.S.C. 450), shall be deemed to be obligated at the time of the grant or contract award and thereafter shall remain available to the tribe or tribal organization without fiscal year limitation: *Provided further*, That **[**$914,139,000**]** *$984,475,000* for Purchased/Referred Care, including $51,500,000 for the Indian Catastrophic Health Emergency Fund, shall remain available until expended: *Provided further*, That of the funds provided, up to $36,000,000 shall remain available until expended for implementation of the loan repayment program under section 108 of the Indian Health Care Improvement Act: *Provided further*, That the amounts collected by the Federal Government as authorized by sections 104 and 108 of the Indian Health Care Improvement Act (25 U.S.C. 1613a and 1616a) during the preceding fiscal year for breach of contracts shall be deposited to the Fund authorized by section 108A(c) of the Act (25 U.S.C. 1616a-1) and shall remain available until expended and, notwithstanding section 108A(c) of the Act (25 U.S.C. 1616a-1(c)), funds shall be available to make new awards under the loan repayment and scholarship programs under sections 104 and 108 of the Act (25 U.S.C. 1613a and 1616a): *Provided further*, That, notwithstanding any other provision of law, the amounts made available within this account for the methamphetamine and suicide prevention and treatment initiative [and], for the domestic violence prevention initiative, *and to improve collections from public and private insurance at IHS and tribally operated facilities* shall be allocated at the discretion of the

Director of the Indian Health Service and shall remain available until expended:[1] *Provided further*, That funds provided in this Act may be used for annual contracts and grants that fall within 2 fiscal years, provided the total obligation is recorded in the year the funds are appropriated: *Provided further*, That the amounts collected by the Secretary of Health and Human Services under the authority of title IV of the Indian Health Care Improvement Act shall remain available until expended for the purpose of achieving compliance with the applicable conditions and requirements of titles XVIII and XIX of the Social Security Act, except for those related to the planning, design, or construction of new facilities: *Provided further*, That funding contained herein for scholarship programs under the Indian Health Care Improvement Act (25 U.S.C. 1613) shall remain available until expended: *Provided further*, That amounts received by tribes and tribal organizations under title IV of the Indian Health Care Improvement Act shall be reported and accounted for and available to the receiving tribes and tribal organizations until expended. *Provided further*, That, the Bureau of Indian Affairs may collect from the Indian Health Service, 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.): *Provided further*, That, the Indian Health Care Improvement Fund may be used, as needed, to carry out activities typically funded under the Indian Health Facilities account. *(Department of the Interior, Environment, and Related Agencies Appropriations Act, 2015.)*

Indian Health Facilities

For construction, repair, maintenance, improvement, and equipment of health and related auxiliary facilities, including quarters for personnel; preparation of plans, specifications, and drawings; acquisition of sites, purchase and erection of modular buildings, and purchases of trailers; and for provision of domestic and community sanitation facilities for Indians, as authorized by section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a), the Indian Self-Determination Act, and the Indian Health Care Improvement Act, and for expenses necessary to carry out such Acts and titles II and III of the Public Health Service Act with respect to environmental health and facilities

support activities of the Indian Health Service, [$460,234,000,] *$639,725,000*, to remain available until expended: *Provided*, That, notwithstanding any other provision of law, funds appropriated for the planning, design, construction, renovation or expansion of health facilities for the benefit of an Indian tribe or tribes may be used to purchase land on which such facilities will be located: *Provided further*, That not to exceed $500,000 may be used by the Indian Health Service to purchase TRANSAM equipment from the Department of Defense for distribution to the Indian Health Service and tribal facilities: *Provided further*, That none of the funds appropriated to the Indian Health Service may be used for sanitation facilities constructions for new homes funded with grants by the housing programs of the United States Department of Housing and Urban Development: *Provided further*, That not to exceed $2,700,000 from this account and the "Indian Health Services" account may be used by the Indian Health Service to obtain ambulances for the Indian Health Service and tribal facilities in conjunction with an existing interagency agreement between the Indian Health Service and the General Services Administration: *Provided further*, That not to exceed $500,000 may be placed in a Demolition Fund, to remain available until expended, and be used by the Indian Health Service for the demolition of Federal buildings. *(Department of the Interior, Environment, and Related Agencies Appropriations Act, 2015.)*

ADMINISTRATIVE PROVISIONS, INDIAN HEALTH SERVICE

Appropriations provided in this Act to the Indian Health Service shall be available for services as authorized by 5 U.S.C. 3109 at rates not to exceed the per diem rate equivalent to the maximum rate payable for senior-level positions under 5 U.S.C. 5376; hire of passenger motor vehicles and aircraft; purchase of medical equipment; purchase of reprints; purchase, renovation and erection of modular buildings and renovation of existing facilities; payments for telephone service in private residences in the field, when authorized under regulations approved by the Secretary; uniforms or allowances therefor as authorized by 5 U.S.C. 5901-5902; and for expenses of attendance at meetings that relate to the functions or activities of the Indian Health Service: *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: *Provided further,* That notwithstanding any other law or regulation, funds transferred from the Department of Housing and Urban Development to the Indian Health Service shall be administered under Public Law 86-121, the Indian Sanitation Facilities Act and Public Law 93-638, as amended: *Provided further,* That funds appropriated to the Indian Health Service in this Act, except those used for administrative and program direction purposes, shall not be subject to limitations directed at curtailing Federal travel and transportation: *Provided further,* That none of the funds made available to the Indian Health Service in this Act shall 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**]** *notified to* the House and Senate Committees on Appropriations through the reprogramming process:[2] *Provided further,* That notwithstanding any other provision of law, funds previously or herein made available to a tribe or tribal organization through a contract, grant, or agreement authorized by title I or title V of the Indian Self-Determination and Education Assistance Act of 1975 (25 U.S.C. 450), may be deobligated and reobligated to a self-determination contract under title I, or a self-governance agreement under title V of such Act and thereafter shall remain available to the tribe or tribal organization without fiscal year limitation: *Provided further,* That none of the funds made available to the Indian Health Service in this Act shall be used to implement the final rule published in the Federal Register on September 16, 1987, by the Department of Health and Human Services, relating to the eligibility for the health care services of the Indian Health Service until the Indian Health Service has submitted a budget request reflecting the increased costs associated with the proposed final rule, and such request has been included in an appropriations Act and enacted into law: *Provided further,* That with respect to functions transferred by the Indian Health Service to tribes or tribal organizations, the Indian Health Service is authorized to provide goods and services to those entities on a reimbursable basis, including payments in advance with subsequent adjustment, and the reimbursements received therefrom, along with the funds received from those entities pursuant to the Indian Self-Determination Act,

may be credited to the same or subsequent appropriation account from which the funds were originally derived, with such amounts to remain available until expended: *Provided further*, That reimbursements for training, technical assistance, or services provided by the Indian Health Service will contain total costs, including direct, administrative, and overhead associated with the provision of goods, services, or technical assistance: *Provided further*, That the appropriation structure for the Indian Health Service may not be altered without advance notification to the House and Senate Committees on Appropriations. *(Department of the Interior, Environment, and Related Agencies Appropriations Act, 2015.)*

Language Analysis

Language Provision	Explanation
SERVICES PROVISIONS	
[1]*Provided further*, That, notwithstanding any other provision of law, the amounts made available within this account for the methamphetamine and suicide prevention and treatment initiative, [and] for the domestic violence prevention initiative, *and to improve collections from public and private insurance at IHS and tribally operated facilities* shall be allocated at the discretion of the Director of the Indian Health Service and shall remain available until expended:	Language is needed to ensure funds are available at the Headquarters level to improve business practices and increase third-party collections at the Service Units level. The overall improvement will benefit both Federal and Tribal sites.
[2]*Provided further*, That none of the funds made available to the Indian Health Service in this Act shall 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**]** *notified to* the House and Senate Committees on Appropriations through the reprogramming process:	This correction is necessary to align the appropriations language with constitutional requirements.

GENERAL PROVISIONS

CONTRACT SUPPORT COSTS, PRIOR YEAR LIMITATION

SEC. **[**405**]** *404.* [Notwithstanding any other provision of law, amounts appropriated to or otherwise designated in committee reports for the Bureau of Indian Affairs and the Indian Health Service by Public Laws 103-138, 103-332, 104-134, 104-208, 105-83, 105-277, 106-113, 106-291, 107-63, 108-7, 108-108, 108-447, 109-54, 109-289, division B and Continuing Appropriations Resolution, 2007 (division B of Public Law 109-289, as amended by Public Laws 110-5 and 110-28), Public Laws 110-92, 110-116, 110-137, 110-149, 110-161, 110-329, 111-6, 111-8, 111-88, 112-10, 112-74, and 113-6 for payments for contract support costs associated with self-determination or self-governance contracts, grants, compacts, or annual funding agreements with the Bureau of Indian Affairs or the Indian Health Service as funded by such Acts, are the total amounts available for fiscal years 1994 through 2013 for such purposes, except that the Bureau of Indian Affairs, tribes and tribal organizations may use their tribal priority allocations for unmet contract support costs of ongoing contracts, grants, self-governance compacts, or annual funding agreements.**]** *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 2016.*[3]

[CONTRACT SUPPORT COSTS, FISCAL YEAR 2014 LIMITATION]

[Sec. 406. Amounts provided under the headings "Department of the Interior, Bureau of Indian Affairs and Bureau of Indian Education, Operation of Indian Programs" and "Department of Health and Human Services, Indian Health Service, Indian Health Services" in the Consolidated Appropriations Act, 2014 (P.L. 113–76) are the only amounts available for contract support costs arising out of self-determination or self-governance contracts, grants, compacts, or annual funding agreements with the Bureau of Indian Affairs or the Indian Health Service for activities funded by the FY 2014 appropriation: *Provided*, That such amounts provided by that Act are not available for payment of claims for contract support costs for prior years, or for repayments of payments for settlements or judgments awarding contract support costs for prior years.**]**[3]

CONTRACT SUPPORT COSTS, FISCAL YEAR **[**2015**]** 2016 LIMITATION

Sec. **[**407**]** *405.* Amounts provided by this Act for fiscal year **[**2015**]** *2016* under the headings "Department of Health and Human Services, Indian Health Service, Indian Health Services" and "Department of the Interior, Bureau of Indian Affairs and Bureau of Indian Education, Operation of Indian Programs" 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 **[**2015**]** *2016* 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 repayments of payments for settlements or judgments awarding contract support costs for prior years.[4]

Language Analysis

Language Provision	Explanation
GENERAL PROVISIONS	
[3]SEC. **[**405**]** *404*. [Notwithstanding any other provision of law, amounts appropriated to or otherwise designated in committee reports for the Bureau of Indian Affairs and the Indian Health Service by Public Laws 103-138, 103-332, 104-134, 104-208, 105-83, 105-277, 106-113, 106-291, 107-63, 108-7, 108-108, 108-447, 109-54, 109-289, division B and Continuing Appropriations Resolution, 2007 (division B of Public Law 109-289, as amended by Public Laws 110-5 and 110-28), Public Laws 110-92, 110-116, 110-137, 110-149, 110-161, 110-329, 111-6, 111-8, 111-88, 112-10, 112-74, and 113-6 for payments for contract support costs associated with self-determination or self-governance contracts, grants, compacts, or annual funding agreements with the Bureau of Indian Affairs or the Indian Health Service as funded by such Acts, are the total amounts available for fiscal years 1994 through 2013 for such purposes, except that the Bureau of Indian Affairs, tribes and tribal organizations may use their tribal priority allocations for unmet contract support costs of ongoing contracts, grants, self-governance compacts, or annual funding agreements.**]** *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 2016.*	This provision was stricken and consolidated.
[3]**[**Sec. 406 Amounts provided under the headings "Department of the Interior, Bureau of Indian Affairs and Bureau of Indian Education, Operation of Indian Programs" and "Department of Health and Human Services, Indian Health Service, Indian	This provision was stricken and consolidated.

Health Services" in the Consolidated Appropriations Act, 2014 (P.L. 113–76) are the only amounts available for contract support costs arising out of self-determination or self-governance contracts, grants, compacts, or annual funding agreements with the Bureau of Indian Affairs or the Indian Health Service for activities funded by the FY 2014 appropriation: Provided, That such amounts provided by that Act are not available for payment of claims for contract support costs for prior years, or for repayments of payments for settlements or judgments awarding contract support costs for prior years**]**.	
[4]*Sec.* **[**407**]** *405.* Amounts provided by this Act for fiscal *year* **[**2015**]** *2016* under the headings "Department of Health and Human Services, Indian Health Service, Indian Health Services" and "Department of the Interior, Bureau of Indian Affairs and Bureau of Indian Education, Operation of Indian Programs" 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 **[**2015**]** *2016* 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 repayments of payments for settlements or judgments awarding contract support costs for prior years.	Added to ensure that FY 2016 appropriations will not be used to pay prior year contract support costs claims nor to repay the Judgment Fund for payments on prior year claims.

INDIAN HEALTH SERVICE
Amounts Available for Obligations

SERVICES

	FY 2014	FY 2015	FY 2016
General Fund Discretionary Appropriation:			
Appropriation (Interior)	$3,982,842,000	$4,182,147,000	$4,463,260,000
Across-the-board reductions (Interior)	$0	$0	$0
Subtotal, Appropriation (Interior)	$3,982,842,000	$4,182,147,000	$4,463,260,000
Mandatory Appropriation:			
Appropriation	$147,000,000	$150,000,000	$150,000,000
Offsetting Collections:			
Federal sources	($354,000,000)	($374,000,000)	($375,000,000)
Non-federal sources	($903,000,000)	($797,000,000)	($797,000,000)
Subtotal, Offsetting Collections	($1,257,000,000)	($1,171,000,000)	($1,172,000,000)
Unobligated Balances:			
Discrentionary, Start of Year	$576,000,000	$670,000,000	$585,000,000
Mandatory, Start of Year	$94,000,000	($85,000,000)	--
End of Year	$670,000,000	$585,000,000	$626,000,000
Total Obligations, Services	$2,872,842,000	$3,161,147,000	$3,400,260,000

INDIAN HEALTH SERVICE
Amounts Available for Obligations

FACILITIES

	FY 2014	FY 2015	FY 2016
General Fund Discretionary Appropriation:			
Appropriation (Interior)	$451,673,000	$460,234,000	$639,725,000
Across-the-board reductions (Interior)	$0	$0	$0
Subtotal, Appropriation (Interior)	$451,673,000	$460,234,000	$639,725,000
Offsetting Collections:			
Federal sources	($49,000,000)	($55,000,000)	($55,000,000)
Subtotal, Offsetting Collections	($49,000,000)	($55,000,000)	($55,000,000)
Unobligated Balances:			
Discrentionary, Start of Year	$155,000,000	$170,000,000	$177,000,000
End of Year	$170,000,000	$177,000,000	$185,000,000
Total Obligations, Facilities	$387,673,000	$398,234,000	$576,725,000

INDIAN HEALTH SERVICE

SERVICES

Summary of Changes

FY 2015 Enacted	$4,182,147,000
Total estimated budget authority	4,182,147,000
Less Obligations	(4,182,147,000)
FY 2016 Estimate	4,463,260,000
Less Obligations	(4,463,260,000)
Net Change	281,113,000
Less Obligations	(281,113,000)

		FY 2015 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2013 CO Pay Raise (3months)	--	n/a	--	267,000
2	FY 2014 Pay Raise CO (9months)	--	n/a	--	809,000
3	Annualization of FY 2013 CS Pay Raise (3months)	--	n/a	--	1,568,000
4	FY 2014 Pay Raise CS (9months)	--	n/a	--	4,263,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	11,019,000
7	Increased Cost of Travel	--	40,159,000	--	1,546,000
8	Increased Cost of Transportation & Things	--	5,502,000	--	134,000
9	Increased Cost of Printing	--	102,000	--	3,000
10	Increased Cost of Rents, Communications, & Utilities	--	25,930,000	--	398,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	497,879,000	--	18,027,000
12	Increased Cost of Supplies	--	97,720,000	--	3,959,000
13	Increased Cost of Medical or other Equipment	--	10,256,000	--	193,000
14	Increased Cost of Land & Structure	--	105,000	--	3,000
15	Increased Cost of Grants	--	2,796,345,000	--	44,715,000
16	Increased Cost of Insurance / Indemnities	--	924,000	--	14,000
17	Increased Cost of Interest / Dividends	--	31,000	--	0
18	Population Growth	--	n/a	--	62,844,000
	Subtotal, Built-In	--	3,474,953,000	--	149,762,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	148	16,222,000
C. Program Increases		--	0	--	126,725,000
	TOTAL INCREASES	--	3,474,953,000	148	292,709,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(11,596,000)
	TOTAL DECREASES	--	0	--	(11,596,000)
NET CHANGE		--	**$3,474,953,000**	**148**	**$281,113,000**

INDIAN HEALTH SERVICE
CLINICAL Services
Summary of Changes

FY 2015 Enacted	$3,197,036,000
Total estimated budget authority	3,197,036,000
Less Obligations	(3,197,036,000)
FY 2016 Estimate	3,413,804,000
Less Obligations	(3,413,804,000)
Net Change	216,768,000
Less Obligations	(216,768,000)

		FY 2015 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2014 CO Pay Raise (3months)	--	n/a	--	243,000
2	FY 2015 Pay Raise CO (9months)	--	n/a	--	727,000
3	Annualization of FY 2014 CS Pay Raise (3months)	--	n/a	--	1,418,000
4	FY 2015 Pay Raise CS (9months)	--	n/a	--	3,760,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	10,029,000
7	Increased Cost of Travel	--	38,807,000	--	1,531,000
8	Increased Cost of Transportation & Things	--	4,300,000	--	114,000
9	Increased Cost of Printing	--	60,000	--	3,000
10	Increased Cost of Rents, Communications, & Utilities	--	25,194,000	--	384,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	481,725,000	--	17,733,000
12	Increased Cost of Supplies	--	93,930,000	--	3,849,000
13	Increased Cost of Medical or other Equipment	--	9,197,000	--	167,000
14	Increased Cost of Land & Structure	--	105,000	--	3,000
15	Increased Cost of Grants	--	1,906,128,000	--	40,002,000
16	Increased Cost of Insurance / Indemnities	--	778,000	--	13,000
17	Increased Cost of Interest / Dividends	--	31,000	--	0
18	Population Growth	--	n/a	--	59,863,000
	Subtotal, Built-In	--	2,560,255,000	--	139,839,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	143	15,626,000
C. Program Increases		--	0	--	71,725,000
	TOTAL INCREASES	--	2,560,255,000	143	227,190,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(10,422,000)
	TOTAL DECREASES	--	0	--	(10,422,000)
NET CHANGE		--	**$2,560,255,000**	**143**	**$216,768,000**

INDIAN HEALTH SERVICE
Hospitals & Health Clinics
Summary of Changes

FY 2015 Enacted	$1,836,789,000
Total estimated budget authority	1,836,789,000
Less Obligations	(1,836,789,000)
FY 2016 Estimate	1,936,323,000
Less Obligations	(1,936,323,000)
Net Change	99,534,000
Less Obligations	(99,534,000)

		FY 2015 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2015 CO Pay Raise (3months)	--	n/a	--	200,000
2	FY 2016 Pay Raise CO (9months)	--	n/a	--	588,000
3	Annualization of FY 2015 CS Pay Raise (3months)	--	n/a	--	1,202,000
4	FY 2016 Pay Raise CS (9months)	--	n/a	--	3,060,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	7,777,000
7	Increased Cost of Travel	--	2,664,000	--	66,000
8	Increased Cost of Transportation & Things	--	3,780,000	--	102,000
9	Increased Cost of Printing	--	36,000	--	2,000
10	Increased Cost of Rents, Communications, & Utilities	--	24,642,000	--	373,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	133,758,000	--	4,064,000
12	Increased Cost of Supplies	--	75,541,000	--	3,080,000
13	Increased Cost of Medical or other Equipment	--	7,759,000	--	116,000
14	Increased Cost of Land & Structure	--	23,000	--	0
15	Increased Cost of Grants	--	1,054,968,000	--	14,992,000
16	Increased Cost of Insurance / Indemnities	--	209,000	--	11,000
17	Increased Cost of Interest / Dividends	--	1,000	--	0
18	Population Growth	--	n/a	--	34,614,000
	Subtotal, Built-In	--	1,303,381,000	--	70,247,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	89	9,287,000
C. H&HC - Third Party Improvement		--	0	--	10,000,000
D. H&HC - Health IT		--	0	--	10,000,000
	TOTAL INCREASES	--	1,303,381,000	89	99,534,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	0
	TOTAL DECREASES	--	0	--	0
NET CHANGE		--	**$1,303,381,000**	**89**	**$99,534,000**

INDIAN HEALTH SERVICE
Dental Health
Summary of Changes

FY 2015 Enacted	$173,982,000
Total estimated budget authority	173,982,000
Less Obligations	(173,982,000)
FY 2016 Estimate	181,459,000
Less Obligations	(181,459,000)
Net Change	7,477,000
Less Obligations	(7,477,000)

		FY 2015 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2015 CO Pay Raise (3months)	--	n/a	--	36,000
2	FY 2016 Pay Raise CO (9months)	--	n/a	--	119,000
3	Annualization of FY 2015 CS Pay Raise (3months)	--	n/a	--	128,000
4	FY 2016 Pay Raise CS (9months)	--	n/a	--	395,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	722,000
7	Increased Cost of Travel	--	315,000	--	5,000
8	Increased Cost of Transportation & Things	--	97,000	--	4,000
9	Increased Cost of Printing	--	5,000	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	210,000	--	5,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	5,343,000	--	195,000
12	Increased Cost of Supplies	--	6,452,000	--	215,000
13	Increased Cost of Medical or other Equipment	--	846,000	--	13,000
14	Increased Cost of Land & Structure	--	82,000	--	0
15	Increased Cost of Grants	--	97,297,000	--	1,432,000
16	Increased Cost of Insurance / Indemnities	--	4,000	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	3,162,000
	Subtotal, Built-In	--	110,651,000	--	6,431,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	17	1,708,000
	TOTAL INCREASES	--	110,651,000	17	8,139,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(662,000)
	TOTAL DECREASES	--	0	--	(662,000)
NET CHANGE		--	**$110,651,000**	**17**	**$7,477,000**

INDIAN HEALTH SERVICE
Mental Health
Summary of Changes

FY 2015 Enacted	$81,145,000
Total estimated budget authority	81,145,000
Less Obligations	(81,145,000)
FY 2016 Estimate	84,485,000
Less Obligations	(84,485,000)
Net Change	3,340,000
Less Obligations	(3,340,000)

		FY 2015 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2015 CO Pay Raise (3months)	--	n/a	--	4,000
2	FY 2016 Pay Raise CO (9months)	--	n/a	--	14,000
3	Annualization of FY 2015 CS Pay Raise (3months)	--	n/a	--	54,000
4	FY 2016 Pay Raise CS (9months)	--	n/a	--	171,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	373,000
7	Increased Cost of Travel	--	218,000	--	5,000
8	Increased Cost of Transportation & Things	--	282,000	--	6,000
9	Increased Cost of Printing	--	1,000	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	169,000	--	2,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	3,924,000	--	160,000
12	Increased Cost of Supplies	--	1,809,000	--	64,000
13	Increased Cost of Medical or other Equipment	--	60,000	--	2,000
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	51,644,000	--	767,000
16	Increased Cost of Insurance / Indemnities	--	2,000	--	0
17	Increased Cost of Interest / Dividends	--		--	0
18	Population Growth	--	n/a	--	1,476,000
	Subtotal, Built-In	--	58,109,000	--	3,098,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	4	433,000
	TOTAL INCREASES	--	58,109,000	4	3,531,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(191,000)
	TOTAL DECREASES	--	0	--	(191,000)
NET CHANGE		--	**$58,109,000**	**4**	**$3,340,000**

INDIAN HEALTH SERVICE
Alcohol and Substance Abuse
Summary of Changes

FY 2015 Enacted	$190,981,000
Total estimated budget authority	190,981,000
Less Obligations	(190,981,000)
FY 2016 Estimate	227,062,000
Less Obligations	(227,062,000)
Net Change	36,081,000
Less Obligations	(36,081,000)

		FY 2015 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2015 CO Pay Raise (3months)	--	n/a	--	3,000
2	FY 2016 Pay Raise CO (9months)	--	n/a	--	6,000
3	Annualization of FY 2015 CS Pay Raise (3months)	--	n/a	--	34,000
4	FY 2016 Pay Raise CS (9months)	--	n/a	--	134,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	1,157,000
7	Increased Cost of Travel	--	191,000	--	2,000
8	Increased Cost of Transportation & Things	--	141,000	--	2,000
9	Increased Cost of Printing	--	18,000	--	1,000
10	Increased Cost of Rents, Communications, & Utilities	--	169,000	--	4,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	9,262,000	--	328,000
12	Increased Cost of Supplies	--	1,186,000	--	20,000
13	Increased Cost of Medical or other Equipment	--	376,000	--	6,000
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	162,649,000	--	2,505,000
16	Increased Cost of Insurance / Indemnities	--	3,000	--	1,000
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	3,888,000
	Subtotal, Built-In	--	173,995,000	--	8,091,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	33	2,990,000
C. ASA - Behavioral Health		--	0	--	25,000,000
	TOTAL INCREASES	--	173,995,000	33	36,081,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	0
	TOTAL DECREASES	--	0	--	0
NET CHANGE		--	**$173,995,000**	**33**	**$36,081,000**

INDIAN HEALTH SERVICE
Purchased/Referred Care
Summary of Changes

FY 2015 Enacted	$914,139,000
Total estimated budget authority	914,139,000
Less Obligations	(914,139,000)
FY 2016 Estimate	984,475,000
Less Obligations	(984,475,000)
Net Change	70,336,000
Less Obligations	(70,336,000)

		FY 2015 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2015 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2016 Pay Raise CO (9months)	--	n/a	--	0
3	Annualization of FY 2015 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2016 Pay Raise CS (9months)	--	n/a	--	0
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	0
7	Increased Cost of Travel	--	35,419,000	--	1,453,000
8	Increased Cost of Transportation & Things	--	0	--	0
9	Increased Cost of Printing	--	0	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	4,000	--	0
11	Increased Cost of Health Care Provided under Contracts & Grants	--	329,438,000	--	12,986,000
12	Increased Cost of Supplies	--	8,942,000	--	470,000
13	Increased Cost of Medical or other Equipment	--	156,000	--	30,000
14	Increased Cost of Land & Structure	--	0	--	3,000
15	Increased Cost of Grants	--	539,570,000	--	20,306,000
16	Increased Cost of Insurance / Indemnities	--	560,000	--	1,000
17	Increased Cost of Interest / Dividends	--	30,000	--	0
18	Population Growth	--	n/a	--	16,723,000
	Subtotal, Built-In	--	914,119,000	--	51,972,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	--	1,208,000
C. PRC Increase		--	0	--	26,725,000
	TOTAL INCREASES	--	914,119,000	--	79,905,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(9,569,000)
	TOTAL DECREASES	--	0	--	(9,569,000)
NET CHANGE		--	**$914,119,000**	--	**$70,336,000**

INDIAN HEALTH SERVICE
PREVENTIVE Health
Summary of Changes

FY 2015 Enacted	$153,961,000
Total estimated budget authority	153,961,000
Less Obligations	(153,961,000)
FY 2016 Estimate	163,025,000
Less Obligations	(163,025,000)
Net Change	9,064,000
Less Obligations	(9,064,000)

		FY 2015 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2015 CO Pay Raise (3months)	--	n/a	--	14,000
2	FY 2016 Pay Raise CO (9months)	--	n/a	--	42,000
3	Annualization of FY 2015 CS Pay Raise (3months)	--	n/a	--	54,000
4	FY 2016 Pay Raise CS (9months)	--	n/a	--	211,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	869,000
7	Increased Cost of Travel	--	130,000	--	2,000
8	Increased Cost of Transportation & Things	--	1,002,000	--	18,000
9	Increased Cost of Printing	--	9,000	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	266,000	--	2,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	2,463,000	--	61,000
12	Increased Cost of Supplies	--	2,973,000	--	102,000
13	Increased Cost of Medical or other Equipment	--	525,000	--	12,000
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	118,334,000	--	4,398,000
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	2,981,000
	Subtotal, Built-In	--	125,702,000	--	8,766,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	5	596,000
	TOTAL INCREASES	--	125,702,000	5	9,362,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(298,000)
	TOTAL DECREASES	--	0	--	(298,000)
NET CHANGE		--	**$125,702,000**	**5**	**$9,064,000**

INDIAN HEALTH SERVICE
Public Health Nursing
Summary of Changes

FY 2015 Enacted	$75,640,000
Total estimated budget authority	75,640,000
Less Obligations	(75,640,000)
FY 2016 Estimate	79,576,000
Less Obligations	(79,576,000)
Net Change	3,936,000
Less Obligations	(3,936,000)

		FY 2015 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2015 CO Pay Raise (3months)	--	n/a	--	13,000
2	FY 2016 Pay Raise CO (9months)	--	n/a	--	39,000
3	Annualization of FY 2015 CS Pay Raise (3months)	--	n/a	--	47,000
4	FY 2016 Pay Raise CS (9months)	--	n/a	--	183,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	323,000
7	Increased Cost of Travel	--	84,000	--	1,000
8	Increased Cost of Transportation & Things	--	932,000	--	17,000
9	Increased Cost of Printing	--	8,000	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	252,000	--	2,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	1,769,000	--	35,000
12	Increased Cost of Supplies	--	2,556,000	--	85,000
13	Increased Cost of Medical or other Equipment	--	419,000	--	9,000
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	45,448,000	--	1,606,000
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	1,374,000
	Subtotal, Built-In	--	51,468,000	--	3,734,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	4	500,000
	TOTAL INCREASES	--	51,468,000	4	4,234,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(298,000)
	TOTAL DECREASES	--	0	--	(298,000)
NET CHANGE		--	**$51,468,000**	**4**	**$3,936,000**

INDIAN HEALTH SERVICE
Health Education
Summary of Changes

FY 2015 Enacted	$18,026,000
Total estimated budget authority	18,026,000
Less Obligations	(18,026,000)
FY 2016 Estimate	19,136,000
Less Obligations	(19,136,000)
Net Change	1,110,000
Less Obligations	(1,110,000)

		FY 2015 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2015 CO Pay Raise (3months)	--	n/a	--	1,000
2	FY 2016 Pay Raise CO (9months)	--	n/a	--	2,000
3	Annualization of FY 2015 CS Pay Raise (3months)	--	n/a	--	6,000
4	FY 2016 Pay Raise CS (9months)	--	n/a	--	24,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	100,000
7	Increased Cost of Travel	--	34,000	--	1,000
8	Increased Cost of Transportation & Things	--	33,000	--	1,000
9	Increased Cost of Printing	--	1,000	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	12,000	--	0
11	Increased Cost of Health Care Provided under Contracts & Grants	--	340,000	--	12,000
12	Increased Cost of Supplies	--	405,000	--	17,000
13	Increased Cost of Medical or other Equipment	--	97,000	--	3,000
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	13,832,000	--	513,000
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	334,000
	Subtotal, Built-In	--	14,754,000	--	1,014,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	1	96,000
	TOTAL INCREASES	--	14,754,000	1	1,110,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	0
	TOTAL DECREASES	--	0	--	0
NET CHANGE		--	**$14,754,000**	**1**	**$1,110,000**

INDIAN HEALTH SERVICE
Community Health Representatives
Summary of Changes

FY 2015 Enacted	$58,469,000
Total estimated budget authority	58,469,000
Less Obligations	(58,469,000)
FY 2016 Estimate	62,363,000
Less Obligations	(62,363,000)
Net Change	3,894,000
Less Obligations	(3,894,000)

		FY 2015 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2015 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2016 Pay Raise CO (9months)	--	n/a	--	1,000
3	Annualization of FY 2015 CS Pay Raise (3months)	--	n/a	--	1,000
4	FY 2016 Pay Raise CS (9months)	--	n/a	--	4,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	431,000
7	Increased Cost of Travel	--	12,000	--	0
8	Increased Cost of Transportation & Things	--	37,000	--	0
9	Increased Cost of Printing	--	0	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	2,000	--	0
11	Increased Cost of Health Care Provided under Contracts & Grants	--	354,000	--	14,000
12	Increased Cost of Supplies	--	12,000	--	0
13	Increased Cost of Medical or other Equipment	--	9,000	--	0
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	57,228,000	--	2,209,000
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	1,234,000
	Subtotal, Built-In	--	57,654,000	--	3,894,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	--	0
	TOTAL INCREASES	--	57,654,000	--	3,894,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	0
	TOTAL DECREASES	--	0	--	0
NET CHANGE		--	**$57,654,000**	--	**$3,894,000**

INDIAN HEALTH SERVICE
Immunization AK
Summary of Changes

FY 2015 Enacted	$1,826,000
Total estimated budget authority	1,826,000
Less Obligations	(1,826,000)
FY 2016 Estimate	1,950,000
Less Obligations	(1,950,000)
Net Change	124,000
Less Obligations	(124,000)

		FY 2015 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2015 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2016 Pay Raise CO (9months)	--	n/a	--	0
3	Annualization of FY 2015 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2016 Pay Raise CS (9months)	--	n/a	--	0
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	15,000
7	Increased Cost of Travel	--	0	--	0
8	Increased Cost of Transportation & Things	--	0	--	0
9	Increased Cost of Printing	--	0	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	0	--	0
11	Increased Cost of Health Care Provided under Contracts & Grants	--	0	--	0
12	Increased Cost of Supplies	--	0	--	0
13	Increased Cost of Medical or other Equipment	--	0	--	0
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	1,826,000	--	70,000
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	39,000
	Subtotal, Built-In	--	1,826,000	--	124,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	--	0
	TOTAL INCREASES	--	1,826,000	--	124,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	0
	TOTAL DECREASES	--	0	--	0
NET CHANGE		--	**$1,826,000**	--	**$124,000**

INDIAN HEALTH SERVICE
OTHER Services
Summary of Changes

FY 2015 Enacted	$831,150,000
Total estimated budget authority	831,150,000
Less Obligations	(831,150,000)
FY 2016 Estimate	886,431,000
Less Obligations	(886,431,000)
Net Change	55,281,000
Less Obligations	(55,281,000)

		FY 2015 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2013 CO Pay Raise (3months)	--	n/a	--	10,000
2	FY 2014 Pay Raise CO (9months)	--	n/a	--	40,000
3	Annualization of FY 2013 CS Pay Raise (3months)	--	n/a	--	96,000
4	FY 2014 Pay Raise CS (9months)	--	n/a	--	292,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	121,000
7	Increased Cost of Travel	--	1,222,000	--	13,000
8	Increased Cost of Transportation & Things	--	200,000	--	2,000
9	Increased Cost of Printing	--	33,000	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	470,000	--	12,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	13,691,000	--	233,000
12	Increased Cost of Supplies	--	817,000	--	8,000
13	Increased Cost of Medical or other Equipment	--	534,000	--	14,000
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	771,883,000	--	315,000
16	Increased Cost of Insurance / Indemnities	--	146,000	--	1,000
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	0
	Subtotal, Built-In	--	788,996,000	--	1,157,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	--	0
C. Program Increase		--	0	--	55,000,000
	TOTAL INCREASES	--	788,996,000	--	56,157,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(876,000)
	TOTAL DECREASES	--	0	--	(876,000)
NET CHANGE		--	**$788,996,000**	--	**$55,281,000**

INDIAN HEALTH SERVICE
Urban Indian Health
Summary of Changes

FY 2015 Enacted	$43,604,000
Total estimated budget authority	43,604,000
Less Obligations	(43,604,000)
FY 2016 Estimate	43,604,000
Less Obligations	(43,604,000)
Net Change	0
Less Obligations	0

		FY 2015 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2015 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2016 Pay Raise CO (9months)	--	n/a	--	0
3	Annualization of FY 2015 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2016 Pay Raise CS (9months)	--	n/a	--	0
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	0
7	Increased Cost of Travel	--	83,000	--	0
8	Increased Cost of Transportation & Things	--	0	--	0
9	Increased Cost of Printing	--	1,000	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	34,000	--	0
11	Increased Cost of Health Care Provided under Contracts & Grants	--	6,184,000	--	0
12	Increased Cost of Supplies	--	280,000	--	0
13	Increased Cost of Medical or other Equipment	--	47,000	--	0
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	35,293,000	--	0
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	0
	Subtotal, Built-In	--	41,922,000	--	0
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	--	0
	TOTAL INCREASES	--	41,922,000	--	0
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	0
	TOTAL DECREASES	--	0	--	0
NET CHANGE		--	**$41,922,000**	--	**$0**

INDIAN HEALTH SERVICE
Indian Health Professions
Summary of Changes

FY 2015 Enacted	$48,342,000
Total estimated budget authority	48,342,000
Less Obligations	(48,342,000)
FY 2016 Estimate	48,342,000
Less Obligations	(48,342,000)
Net Change	0
Less Obligations	0

		FY 2015 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2015 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2016 Pay Raise CO (9months)	--	n/a	--	0
3	Annualization of FY 2015 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2016 Pay Raise CS (9months)	--	n/a	--	0
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	0
7	Increased Cost of Travel	--	43,000	--	0
8	Increased Cost of Transportation & Things	--	4,000	--	0
9	Increased Cost of Printing	--	1,000	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	1,000	--	0
11	Increased Cost of Health Care Provided under Contracts & Grants	--	2,504,000	--	0
12	Increased Cost of Supplies	--	5,000	--	0
13	Increased Cost of Medical or other Equipment	--	0	--	0
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	44,374,000	--	0
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	0
	Subtotal, Built-In	--	46,932,000	--	0
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	--	0
	TOTAL INCREASES	--	46,932,000	--	0
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	0
	TOTAL DECREASES	--	0	--	0
NET CHANGE		--	**$46,932,000**	--	**$0**

INDIAN HEALTH SERVICE
Tribal Management
Summary of Changes

FY 2015 Enacted	$2,442,000
Total estimated budget authority	2,442,000
Less Obligations	(2,442,000)
FY 2016 Estimate	2,442,000
Less Obligations	(2,442,000)
Net Change	0
Less Obligations	0

		FY 2015 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2015 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2016 Pay Raise CO (9months)	--	n/a	--	0
3	Annualization of FY 2015 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2016 Pay Raise CS (9months)	--	n/a	--	0
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	0
7	Increased Cost of Travel	--	0	--	0
8	Increased Cost of Transportation & Things	--	0	--	0
9	Increased Cost of Printing	--	0	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	0	--	0
11	Increased Cost of Health Care Provided under Contracts & Grants	--	10,000	--	0
12	Increased Cost of Supplies	--	0	--	0
13	Increased Cost of Medical or other Equipment	--	0	--	0
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	2,432,000	--	0
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	0
	Subtotal, Built-In	--	2,442,000	--	0
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	--	0
	TOTAL INCREASES	--	2,442,000	--	0
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	0
	TOTAL DECREASES	--	0	--	0
NET CHANGE		--	**$2,442,000**	--	**$0**

INDIAN HEALTH SERVICE
Direct Operations
Summary of Changes

FY 2015 Enacted	$68,065,000
Total estimated budget authority	68,065,000
Less Obligations	(68,065,000)
FY 2016 Estimate	68,338,000
Less Obligations	(68,338,000)
Net Change	273,000
Less Obligations	(273,000)

		FY 2015 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2015 CO Pay Raise (3months)	--	n/a	--	10,000
2	FY 2016 Pay Raise CO (9months)	--	n/a	--	40,000
3	Annualization of FY 2015 CS Pay Raise (3months)	--	n/a	--	92,000
4	FY 2016 Pay Raise CS (9months)	--	n/a	--	281,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	121,000
7	Increased Cost of Travel	--	992,000	--	12,000
8	Increased Cost of Transportation & Things	--	196,000	--	2,000
9	Increased Cost of Printing	--	19,000	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	417,000	--	12,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	4,819,000	--	221,000
12	Increased Cost of Supplies	--	519,000	--	8,000
13	Increased Cost of Medical or other Equipment	--	487,000	--	14,000
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	23,121,000	--	257,000
16	Increased Cost of Insurance / Indemnities	--	146,000	--	1,000
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	0
	Subtotal, Built-In	--	30,716,000	--	1,071,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	--	0
	TOTAL INCREASES	--	30,716,000	--	1,071,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(798,000)
	TOTAL DECREASES	--	0	--	(798,000)
NET CHANGE		--	**$30,716,000**	--	**$273,000**

INDIAN HEALTH SERVICE
Self-Governance
Summary of Changes

FY 2015 Enacted	$5,727,000
Total estimated budget authority	5,727,000
Less Obligations	(5,727,000)
FY 2016 Estimate	5,735,000
Less Obligations	(5,735,000)
Net Change	8,000
Less Obligations	(8,000)

		FY 2015 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2015 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2016 Pay Raise CO (9months)	--	n/a	--	0
3	Annualization of FY 2015 CS Pay Raise (3months)	--	n/a	--	4,000
4	FY 2016 Pay Raise CS (9months)	--	n/a	--	11,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	0
7	Increased Cost of Travel	--	104,000	--	1,000
8	Increased Cost of Transportation & Things	--	0	--	0
9	Increased Cost of Printing	--	12,000	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	18,000	--	0
11	Increased Cost of Health Care Provided under Contracts & Grants	--	77,000	--	12,000
12	Increased Cost of Supplies	--	12,000	--	0
13	Increased Cost of Medical or other Equipment	--	0	--	0
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	3,791,000	--	58,000
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	0
	Subtotal, Built-In	--	4,014,000	--	86,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	--	0
	TOTAL INCREASES	--	4,014,000	--	86,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(78,000)
	TOTAL DECREASES	--	0	--	(78,000)
NET CHANGE		--	**$4,014,000**	--	**$8,000**

INDIAN HEALTH SERVICE
Contract Support Costs
Summary of Changes

FY 2015 Enacted	$662,970,000
Total estimated budget authority	662,970,000
Less Obligations	(662,970,000)
FY 2016 Estimate	717,970,000
Less Obligations	(717,970,000)
Net Change	55,000,000
Less Obligations	(55,000,000)

		FY 2015 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2015 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2016 Pay Raise CO (9months)	--	n/a	--	0
3	Annualization of FY 2015 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2016 Pay Raise CS (9months)	--	n/a	--	0
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	0
7	Increased Cost of Travel	--	0	--	0
8	Increased Cost of Transportation & Things	--	0	--	0
9	Increased Cost of Printing	--	0	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	0	--	0
11	Increased Cost of Health Care Provided under Contracts & Grants	--	97,000	--	0
12	Increased Cost of Supplies	--	1,000	--	0
13	Increased Cost of Medical or other Equipment	--	0	--	0
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	662,872,000	--	0
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	0
	Subtotal, Built-In	--	662,970,000	--	0
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	--	0
C. Contract Support Costs		--	0	--	55,000,000
	TOTAL INCREASES	--	662,970,000	--	55,000,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	0
	TOTAL DECREASES	--	0	--	0
NET CHANGE		--	**$662,970,000**	--	**$55,000,000**

INDIAN HEALTH SERVICE

FACILITIES

Summary of Changes

FY 2015 Enacted	$460,234,000
Total budget authority	460,234,000
Less Obligations	(460,234,000)
FY 2016 Estimate	639,725,000
Less Obligations	(639,725,000)
Net Change	179,491,000
Less Obligations	(179,491,000)

		FY 2015 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2015 CO Pay Raise (3months)	--	n/a	--	80,000
2	FY 2016 Pay Raise CO (9months)	--	n/a	--	259,000
3	Annualization of FY 2015 CS Pay Raise (3months)	--	n/a	--	152,000
4	FY 2016 Pay Raise CS (9months)	--	n/a	--	535,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	731,000
7	Increased Cost of Travel	--	1,896,000	--	42,000
8	Increased Cost of Transportation & Things	--	3,801,000	--	79,000
9	Increased Cost of Printing	--	98,000	--	0
10	Increased Cost of Rents, Communications, & Utilties	--	17,081,000	--	356,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	85,979,000	--	1,917,000
12	Increased Cost of Supplies	--	6,529,000	--	142,000
13	Increased Cost of Medical or other Equipment	--	8,979,000	--	325,000
14	Increased Cost of Land & Structure	--	87,466,000	--	1,693,000
15	Increased Cost of Grants	--	143,307,000	--	3,769,000
16	Increased Cost of Insurance / Indemnities	--	53,000	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Increased Cost of Service & Supply Fund	--	0	--	0
19	Population Growth	--	n/a	--	6,786,000
	Subtotal, Built-In	--	355,189,000	--	16,866,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	9	1,584,000
C. Program Increases		--	0	--	170,000,000
	TOTAL INCREASES	--	355,189,000		188,450,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(8,959,000)
	TOTAL DECREASES	--	0	--	(8,959,000)
NET CHANGE		**--**	**$355,189,000**	**9**	**$179,491,000**

INDIAN HEALTH SERVICE
Maintenance & Improvement
Summary of Changes

FY 2015 Enacted	$53,614,000
Total budget authority	53,614,000
Less Obligations	(53,614,000)
FY 2016 Estimate	89,097,000
Less Obligations	(89,097,000)
Net Change	35,483,000
Less Obligations	(35,483,000)

		FY 2015 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2015 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2016 Pay Raise CO (9months)	--	n/a	--	0
3	Annualization of FY 2015 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2016 Pay Raise CS (9months)	--	n/a	--	0
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	0
7	Increased Cost of Travel	--	40,000	--	1,000
8	Increased Cost of Transportation & Things	--	37,000	--	1,000
9	Increased Cost of Printing	--	1,000	--	0
10	Increased Cost of Rents, Communications, & Utilties	--	204,000	--	4,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	17,693,000	--	346,000
12	Increased Cost of Supplies	--	3,059,000	--	66,000
13	Increased Cost of Medical or other Equipment	--	280,000	--	5,000
14	Increased Cost of Land & Structure	--	3,628,000	--	51,000
15	Increased Cost of Grants	--	28,672,000	--	652,000
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Increased Cost of Service & Supply Fund	--	0	--	0
19	Population Growth	--	0	--	965,000
	Subtotal, Built-In	--	53,614,000	--	2,091,000
B.	Maintenance & Improvement Increase	--	0	--	35,000,000
	TOTAL INCREASES	--	53,614,000	--	37,091,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(1,608,000)
	TOTAL DECREASES	--	0	--	(1,608,000)
NET CHANGE		--	**$53,614,000**	--	**$35,483,000**

INDIAN HEALTH SERVICE
Sanitation Facilities Construction
Summary of Changes

FY 2015 Enacted	$79,423,000
Total budget authority	79,423,000
Less Obligations	(79,423,000)
FY 2016 Estimate	115,138,000
Less Obligations	(115,138,000)
Net Change	35,715,000
Less Obligations	(35,715,000)

		FY 2015 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2015 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2016 Pay Raise CO (9months)	--	n/a	--	0
3	Annualization of FY 2015 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2016 Pay Raise CS (9months)	--	n/a	--	0
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	0
7	Increased Cost of Travel	--	45,000	--	1,000
8	Increased Cost of Transportation & Things	--	571,000	--	20,000
9	Increased Cost of Printing	--	6,000	--	0
10	Increased Cost of Rents, Communications, & Utilties	--	42,000	--	1,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	54,086,000	--	1,115,000
12	Increased Cost of Supplies	--	287,000	--	11,000
13	Increased Cost of Medical or other Equipment	--	30,000	--	2,000
14	Increased Cost of Land & Structure	--	0	--	67,000
15	Increased Cost of Grants	--	21,126,000	--	366,000
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Increased Cost of Service & Supply Fund	--	0	--	0
19	Population Growth	--	0	--	1,430,000
	Subtotal, Built-In	--	76,193,000	--	3,013,000
B. Sanitation Increase		--	0	--	35,000,000
	TOTAL INCREASES	--	76,193,000	--	38,013,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(2,298,000)
	TOTAL DECREASES	--	0	--	(2,298,000)
NET CHANGE		--	**$76,193,000**	--	**$35,715,000**

INDIAN HEALTH SERVICE
Health Care Facilities Construction
Summary of Changes

FY 2015 Enacted	$85,048,000
Total budget authority	85,048,000
Less Obligations	(85,048,000)
FY 2016 Estimate	185,048,000
Less Obligations	(185,048,000)
Net Change	100,000,000
Less Obligations	(100,000,000)

		FY 2015 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2015 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2016 Pay Raise CO (9months)	--	n/a	--	0
3	Annualization of FY 2015 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2016 Pay Raise CS (9months)	--	n/a		0
5	One Days Pay	--	n/a		0
6	Tribal Pay Cost	--	n/a	--	0
7	Increased Cost of Travel	--	0	--	0
8	Increased Cost of Transportation & Things	--	0	--	0
9	Increased Cost of Printing	--	0	--	0
10	Increased Cost of Rents, Communications, & Utilties	--	0	--	0
11	Increased Cost of Health Care Provided under Contracts & Grants	--	22,000	--	167,000
12	Increased Cost of Supplies	--	0	--	0
13	Increased Cost of Medical or other Equipment	--	0	--	0
14	Increased Cost of Land & Structure	--	83,803,000	--	1,574,000
15	Increased Cost of Grants	--	1,223,000	--	46,000
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Increased Cost of Service & Supply Fund	--	0	--	0
19	Population Growth	--	0	--	0
	Subtotal, Built-In	--	85,048,000	--	1,787,000
B. HCFC Increase		--	0	--	100,000,000
	TOTAL INCREASES	--	85,048,000	--	101,787,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(1,787,000)
	TOTAL DECREASES	--	0	--	(1,787,000)
NET CHANGE		--	**$85,048,000**	--	**$100,000,000**

INDIAN HEALTH SERVICE
Facilities & Environmental Health Support
Summary of Changes

FY 2015 Enacted	$219,612,000
Total budget authority	219,612,000
Less Obligations	(219,612,000)
FY 2016 Estimate	226,870,000
Less Obligations	(226,870,000)
Net Change	7,258,000
Less Obligations	(7,258,000)

		FY 2015 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2015 CO Pay Raise (3months)	--	n/a	--	80,000
2	FY 2016 Pay Raise CO (9months)	--	n/a	--	259,000
3	Annualization of FY 2015 CS Pay Raise (3months)	--	n/a	--	152,000
4	FY 2016 Pay Raise CS (9months)	--	n/a	--	535,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	731,000
7	Increased Cost of Travel	--	1,806,000	--	40,000
8	Increased Cost of Transportation & Things	--	3,064,000	--	54,000
9	Increased Cost of Printing	--	91,000	--	0
10	Increased Cost of Rents, Communications, & Utilties	--	16,748,000	--	348,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	13,056,000	--	265,000
12	Increased Cost of Supplies	--	3,053,000	--	63,000
13	Increased Cost of Medical or other Equipment	--	2,573,000	--	47,000
14	Increased Cost of Land & Structure	--	34,000	--	1,000
15	Increased Cost of Grants	--	77,319,000	--	2,151,000
16	Increased Cost of Insurance / Indemnities	--	53,000	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Increased Cost of Service & Supply Fund	--	0	--	0
19	Population Growth	--	n/a	--	3,971,000
	Subtotal, Built-In	--	117,797,000	--	8,697,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	9	1,584,000
	TOTAL INCREASES	--	117,797,000	--	10,281,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(3,023,000)
	TOTAL DECREASES	--	0	--	(3,023,000)
NET CHANGE		**--**	**$117,797,000**	**9**	**$7,258,000**

INDIAN HEALTH SERVICE
Equipment
Summary of Changes

FY 2015 Enacted	$22,537,000
Total budget authority	22,537,000
Less Obligations	(22,537,000)
FY 2016 Estimate	23,572,000
Less Obligations	(23,572,000)
Net Change	1,035,000
Less Obligations	(1,035,000)

		FY 2015 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2015 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2016 Pay Raise CO (9months)	--	n/a	--	0
3	Annualization of FY 2015 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2016 Pay Raise CS (9months)	--	n/a	--	0
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	0
7	Increased Cost of Travel	--	5,000	--	0
8	Increased Cost of Transportation & Things	--	129,000	--	4,000
9	Increased Cost of Printing	--	0	--	0
10	Increased Cost of Rents, Communications, & Utilties	--	87,000	--	3,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	1,122,000	--	24,000
12	Increased Cost of Supplies	--	130,000	--	2,000
13	Increased Cost of Medical or other Equipment	--	6,096,000	--	271,000
14	Increased Cost of Land & Structure	--	1,000	--	0
15	Increased Cost of Grants	--	14,967,000	--	554,000
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Increased Cost of Service & Supply Fund	--	0	--	0
19	Population Growth	--	0	--	420,000
	Subtotal, Built-In	--	22,537,000	--	1,278,000
	TOTAL INCREASES	--	22,537,000	--	1,278,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(243,000)
	TOTAL DECREASES	--	0	--	(243,000)
NET CHANGE		--	**$22,537,000**	--	**$1,035,000**

INDIAN HEALTH SERVICE
Budget Authority by Activity

(Dollars in Thousands)

	2014 Final		2015 Enacted		2016 President's Budget	
	FTE	Amount	FTE	Amount	FTE	Amount
SERVICES:						
Hospitals & Health Clinics	6,232	$1,773,931	6,557	$1,836,789	6,573	$1,936,323
Dental Services	633	165,260	701	173,982	703	181,459
Mental Health	196	77,980	222	81,145	223	84,485
Alcohol & Substance Abuse	176	186,378	224	190,981	256	227,062
Contract Health Services	0	878,575	0	914,139	0	984,475
Total, Clinical Services	7,237	3,082,124	7,704	3,197,036	7,755	3,413,804
Public Health Nursing	190	70,829	223	75,640	224	79,576
Health Education	34	16,926	42	18,026	42	19,136
Comm. Health Reps.	9	57,895	9	58,469	9	62,363
Immunization AK	0	1,826	0	1,826	0	1,950
Total, Preventive Health	233	147,476	274	153,961	275	163,025
Urban Health	5	40,729	5	43,604	5	43,604
Indian Health Professions	19	28,466	19	48,342	19	48,342
Tribal Management	0	1,442	0	2,442	0	2,442
Direct Operations	268	65,894	268	68,065	268	68,338
Self-Governance	13	4,227	13	5,727	13	5,735
Contract Support Costs	0	612,484	0	662,970	0	717,970
Total, Other services	305	753,242	305	831,150	305	886,431
Total, Services	7,775	3,982,842	8,283	4,182,147	8,335	4,463,260
FACILITIES:						
Maintenance & Improvement	0	53,614	0	53,614	0	89,097
Sanitation Facilities Constr.	161	79,423	161	79,423	161	115,138
Health Care Facs. Constr.	0	85,048	0	85,048	0	185,048
Facil. & Envir. Health Supp.	1,007	211,051	1,058	219,612	1,063	226,870
Equipment	0	22,537	0	22,537	0	23,572
Total, Facilities	1,168	451,673	1,219	460,234	1,224	639,725
Total IHS	8,943	$4,434,515	9,502	$4,642,381	9,559	$5,102,985

FTE estimates exclude FTEs funded by reimbursements such as Medicaid and Medicare collections.

Indian Health Service

Authorizing Legislation

(Dollars in Thousands)

January 10, 2015

	FY 2014		FY 2015		FY 2016	
	Amount Authorized	Final	Amount Authorized	Enacted	Amount Authorized	Budget Request
1. Services Appropriation: Snyder Act, 25 U.S.C. 13. Transfer Act (P.L. 83-568), 42 U.S.C. 2001. Indian Health Care Improvement Act (IHCIA) (P.L. 94-437), as amended (most recently amended by the Patient Protection and Affordable Care Act (ACA) (P.L. 111-148), § 10221, 124 Stat. 119, 935 (2010)), 25 U.S.C. 1601 *et seq.* Indian Self Determination and Education Assistance Act (P.L. 93-638), as amended, 25 U.S.C. 450 *et seq.* Public Health Service Act, titles II & III, as amended, 25 U.S.C. 201-280m.	3,982,842	3,982,842	4,182,147	4,182,147	4,463,260	4,463,260
2. Contract Support Costs Appropriation: Indian Self Determination and Education Assistance Act (P.L. 93-638), as amended, 25 U.S.C. 450 *et seq.*	0	0	0	0	0	0
3. Facilities Appropriation: Indian Sanitation Facilities Act (P.L. 86-121), as amended, 42 U.S.C. 2004a. IHCIA, title III, as amended, 25 U.S.C. 1631-1638g. ISDEAA, sec. 102 & 509, as amended, 25 U.S.C. 450f & 458aaa-8. 5 U.S.C. 5911 note (Quarters Rent Funds).	451,673 8,000	451,673 8,000	460,234 8,000	460,234 8,000	639,725 8,500	639,725 8,500
4. Public and Private Collections: IHCIA sec. 206, 25 U.S.C. 1621e. Social Security Act, sec. 1880 & 1911, 42 U.S.C. 1395qq & 1396j.	1,059,777	1,059,777	1,106,064	1,106,064	1,130,882	1,130,882
5. Special Diabetes Program for Indians: 42 U.S.C. 245c-3.	147,000	147,000	150,000	150,000	150,000	150,000
Unfunded authorizations:	0	0	0	0	0	0
Total appropriations:	5,649,292	5,649,292	5,906,445	5,906,445	6,392,367	6,392,367
Total appropriations against Definite authorizations:	5,649,292	5,649,292	5,906,445	5,906,445	6,392,367	6,392,367

INDIAN HEALTH SERVICE
Appropriation History Table
Services

December 30, 2014

	Budget Request to Congress	House Allowance	Senate Allowance	Appropriation
2005	$2,612,824,000	$2,627,918,000	$2,633,624,000	$2,632,667,000
Rescission (PL 108-447, Sec. 501)				($15,638,000)
Rescission (PL 108-447, Sec. 122)				($20,936,000)
2006	$2,732,298,000	$2,732,298,000	$2,732,323,000	$2,732,298,000
Rescission (PL 109-54)				($13,006,000)
Rescission (PL 109-148)				($27,192,000)
2007	$2,822,449,000	$2,830,085,000	$2,835,493,000	$2,818,871,000
2008	$2,931,530,000	$3,023,532,000	$2,991,924,000	$3,018,624,000
Rescission (PL 110-161)				($47,091,000)
2009 Omnibus	$2,971,533,000	-	-	$3,190,956,000
2009 ARRA (PL 111-5)	-	-	-	$85,000,000
2010	$3,639,868,000	$3,657,618,000	$3,639,868,000	$3,657,618,000
2011	$3,657,618,000	-	-	$3,672,618,000
Rescission (PL 112-10)				($7,345,000)
2012	$4,166,139,000	$4,034,322,000	-	$3,872,377,000
Recission (PL 112-74)				($6,195,804)
2013	$3,978,974,000	-	$ 3,914,599,000	$3,914,599,000
Sequestration				($194,492,111)
Rescission				($7,829,198)
2014 Omnibus (PL 113-64)	$3,982,498,000	-	-	$3,982,842,000
2015 Omnibus (PL 113-235)	$4,172,182,000	$4,180,557,000	-	$4,182,147,000
2016 President's Budget	$4,463,260,000	-	-	-

INDIAN HEALTH SERVICE
Appropriation History Table
Facilities

December 30, 2014

	Budget Request to Congress	House Allowance	Senate Allowance	Appropriation
2005	$354,448,000	$405,453,000	$364,148,000	$394,453,000
Rescission (PL 108-447, Sec. 501)				($2,343,000)
Rescission (PL 108-447, Sec. 122)				($3,137,000)
2006	$315,668,000	$370,774,000	$335,643,000	$358,485,000
Rescission (PL 109-54)				($1,706,000)
Rescission (PL 109-148)				($3,569,000)
2007	$347,287,000	$363,573,000	$357,287,000	$361,226,000
2008	$339,196,000	$360,895,000	$375,475,000	$380,583,000
Rescission (PL 110-161)				($5,937,000)
2009 Omnibus	$353,329,000	-	-	$390,168,000
2009 ARRA (PL 111-5)	-	-	-	$415,000,000
2010	$394,757,000	$394,757,000	$394,757,000	$394,757,000
2011	$394,757,000	-	-	$404,757,000
Rescission (PL 112-10)				($810,000)
2012	$457,669,000	$427,259,000	-	$441,052,000
Rescission (PL 112-74)				($705,683)
2013	$443,502,000	-	$ 441,605,000	$441,605,000
Sequestration				($22,152,062)
Rescission				($883,210)
2014 Omnibus (PL 113-64)	$448,139,000	-	-	$451,673,000
2015 Omnibus (PL 113-235)	$461,995,000	$461,995,000	-	$460,234,000
2016 President's Budget	$639,725,000	-	-	-

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Services: 75-0390-0-1-551
CLINICAL SERVICES

(Dollars in Thousands)

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$3,082,124	$3,197,036	$3,413,804	+$216,768
FTE*	7,245	7,712	7,763	+51

*FTE numbers reflect only federal staff and do not include Tribal staff.

SUMMARY OF THE BUDGET REQUEST

The FY 2016 budget request for Clinical Services of $3.4 billion is an increase of $216.8 million above the FY 2015 Enacted level. The detailed explanation of the request is described in each of the budget narratives that follow.

- $1.9 billion for **Hospitals and Health Clinics** to support essential personal health services including inpatient care, routine and emergency ambulatory care, and medical support services including laboratory, pharmacy, nutrition, diagnostic imaging, medical records, physical therapy, etc. In addition, specialized programs are conducted to address diabetes, maternal and child health, youth services, communicable diseases including HIV/AIDS, tuberculosis, and hepatitis, women's and elder's health, disease surveillance, and healthcare quality improvement.

- $ 181.5 million for **Dental Health** to provide preventive, basic care, and emergency care, with approximately 90 percent of services covering basic and emergency care. Basic services are prioritized over more complex rehabilitative care such as root canals, crown and bridge, dentures, and surgical extractions. The demand for dental treatment remains high due to the high dental caries rate in AI/AN children; however, a continuing emphasis on community oral health promotion/disease prevention is essential to impact long-term improvement of the oral health of AI/AN people.

- $ 84.5 million for **Mental Health** to provide a community-oriented clinical and preventive mental health service program that provides outpatient mental health and related services integrated with outpatient and inpatient care, crisis triage, case management, prevention programming, and outreach services.

- $ 227.1 million for **Alcohol and Substance Abuse** to provide overall program support. The program exists as part of an integrated behavioral health approach to collaboratively reduce the incidence of alcoholism and other drug dependencies in AI/AN communities. This total also includes $25 million in funding for the new, government-wide Generation Indigenous effort. This funding will allow IHS to increase the number of child and adolescent behavioral health professionals who provide direct services and implement youth-based programming at IHS, Tribal, and urban Indian health programs, school-based health centers, or youth-based programs through additional grants within the Methamphetamine and Suicide Prevention Initiative.

- $ 984.5 million for **Purchased/Referred Care** to purchase essential health care services not available in IHS and Tribal healthcare facilities including inpatient and outpatient care, routine emergency ambulatory care, transportation, and medical support services (e.g., laboratory, pharmacy, nutrition, diagnostic imaging, physical therapy, etc.). The demand for PRC remains high as the cost of medical care increases. The PRC Program continues to emphasize adherence to medical priorities, enrolling patients in alternate resources available to them (such as Medicare, Medicaid and private insurance), negotiating discounted rates with medical providers, and implementing improvements recommended by Tribes and oversight authorities.

The bulk of clinical services funds are provided to 12 Area (regional) Offices which distribute resources, monitor and evaluate activities, and provide administrative and technical support to 170 Federal and Tribal Service Units (local level) for 652 healthcare facilities providing care to 2.2 million AI/ANs primarily in service areas that are rural, isolated, and underserved.

Performance Summary Table -- The following annual and long-term performance measures are considered overarching because they are accomplished through a variety of programs and activities in the IHS Services budget.

Long Term Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	Long Term Target
31: Childhood Weight Control: Proportion of children, ages 2-5 years, with a BMI of 95 percent or higher. IHS – All (Outcome) *The goal is a lower percentage for this long term measure that is not reportable until 2016.*	FY 2014: 22.8% FY 2014 Reportable Year Target: 24.0% (Target Exceeded)	FY 2016 Target is 22.8%
28: Unintentional Injury Rates: Unintentional injury mortality rate in AI/AN population. IHS – All (Outcome) (Targets and results are expressed as age-adjusted rates per 100,000 population.)	FY 2008: 94.5 FY 2008 Target: 95.3 (Target Exceeded)	FY 2016: 94.5 (Results available Dec 2020)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Services: 75-0390-0-1-551

HOSPITALS AND HEALTH CLINICS

(Dollars in Thousands)

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$1,773,931	$1,836,789	$1,936,323	+$99,534
FTE*	6,240	6,565	6,581	+16

*FTE numbers reflect only federal staff and do not include Tribal staff.

Authorizing Legislation .....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended

FY 2016 Authorization.....Permanent

Allocation Method… .....Direct Federal; P.L. 93-638 contracts and compacts with Tribal nations and Tribal consortia; interagency agreements; commercial contracts

PROGRAM DESCRIPTION and ACCOMPLISHMENTS

Hospitals and Health Clinics (H&HC) funds essential personal health services for 2.2 million American Indians and Alaska Natives (AI/AN) including medical and surgical inpatient care, routine and emergency ambulatory care, and medical support services including laboratory, pharmacy, nutrition, diagnostic imaging, medical records, and physical therapy. In addition, the program includes public/community health initiatives targeting health conditions disproportionately affecting AI/ANs such as diabetes, maternal and child health, and communicable diseases including influenza, HIV/AIDS, and hepatitis. The IHS system of care is unique in that personal health care services are integrated with community health services. Collecting, analyzing, and interpreting health information is done through a network of Tribally-operated epidemiology centers in collaboration with a national IHS coordinating center leading to the identification of health conditions as well as promoting interventions. Information technology that supports both personal health services (including the Electronic Health Record and telemedicine) and public health initiatives is primarily funded through the H&HC budget.

The services funded under H&HC align and integrate with HHS goals and objectives 1B, Improve health care quality and patient safety; 1E, Ensure access to quality, culturally competent care, including long-term services and supports, for vulnerable populations ; 3D, Promote prevention and wellness across the lifespan; and 3E, Reduce the occurrence of infectious diseases. These services are deployed in accordance with strategic planning, are data driven, and support program integrity through adherence to rigorous reporting requirements including two measures that align with HHS measures.

Slightly more than one-half of the H&HC budget is transferred under P.L. 93-638 contracts or compacts to Tribal governments or Tribal organizations that design and manage the delivery of individual and community health services and through care purchased from private providers. The remainder is managed by direct federal programs that provide health care at the Service Unit (SU) and community level. The federal system consists of 28 hospitals, 62 health centers, and 25 health stations. Through P.L. 93-638 Self-Determination contracts or compacts, American Indian

Tribes administer 18 hospitals, 282 health centers, 80 health stations, and 150 Alaska village clinics.

Although the health status of AI/ANs has improved significantly in the past 60 years since the inception of the IHS, the average life expectancy at birth is 73.8 years (data years 2006-2008) compared to the U.S. all races life expectancy of 77.9 years[1]. The IHS and Tribes primarily serve small, rural populations with primary medical care and community-health services, relying on the private sector for much of the secondary and most of the tertiary medical care needs. Some IHS and Tribal hospitals provide secondary medical services such as ophthalmology, orthopedics, infectious disease, emergency medicine, radiology, general and gynecological surgery, and anesthesia.

The following are brief examples of specific activities funded through H&HC that are helping improve the quality of services throughout the IHS healthcare system:

Improving Patient Care – The Improving Patient Care (IPC) program is an important contribution to the Agency's implementation of the Affordable Care Act through its emphasis on IHS' priority to improve quality of and access to care. The IPC Program is IHS' initiative to implement the Patient Centered Medical Home model. The IPC implements improvements from a medical evidence base (HHS Strategic Goal 1: Strengthen Health Care). IPC teams implement improvements in the coordination of care that result in better outcomes for patients such as reduced waiting times in clinics, quicker access to appointments, and better continuity and quality of care.

The aim of the IPC Program is to transform the Indian health system by developing high-performing, innovative health care teams (HHS Strategic Goal 2: Advance Scientific Knowledge and Innovation) to improve the quality of and access to care. There are currently 172 IHS, tribal, and urban (I/T/U) sites that have participated in or are currently participating in IPC via webinars, online collaboration, and face-to-face meetings. The IPC collaborative teams work toward organizational transformation by using a system-wide model of care that focuses on improvements in continuity of care, care management and coordination, patient self-management support, and improved care team functioning. The IPC Program serves to strengthen the positive relationships among the health care system, care team, individual, family, community, and Tribes.

IPC sites participate in a systematic approach to health care quality improvement in which they will test and measure practice innovations at the local level. Assessment is conducted in the following domains: clinical preventive screenings, management and prevention of chronic conditions, patient experience of care, and access to care. Sites use a detailed measurement strategy via an online data portal sponsored by the IPC Program to assess the impact of their changes and to identify additional opportunities for improvement. IPC addresses 63 measures (referred to as IPC measures), including 17 Government Performance and Results Act/Modernization Act (GPRA/GPRAMA) measures (HHS Strategic Goal 4: Ensure Efficiency, Transparency, Accountability, and Effectiveness of HHS Programs). A smaller number of IPC measures are being considered to focus improvement activities on the highest value outcomes which align with 14 nationally recognizable measures (GPRA/GPRAMA, National Quality Forum, and Physician Quality Reporting System) in order to improve integrity in data collection, comparability of measures, and alignment with national initiatives (i.e., Million Hearts Campaign, Baby Friendly Hospitals). These focused measures will continue to assess elements of care

[1] *Life Expectancy: American Indians and Alaska Natives, Data Years 2006-2008*. Indian Health Service Division of Program Statistics, Indian Health Service, United States Department of Health and Human Services.

across all ages, empanelment, and continuity of care. Simultaneously, improvements in patient access will improve meeting GPRA prevention and chronic illness care goals (HHS Strategic Goal: Advance the Health, Safety, and Well-being of the American People). IPC sites are instructed to document and institutionalize achievements and innovations to service delivery within organizational manuals and standard operating procedures to immortalize and protect improvements from the impact of staff turnover.

Nursing – Nursing represents the largest provider of health care in the Indian health system and has a major impact on patient safety and health care outcomes. The link between reduced nurse staffing and adverse outcomes is well documented. A higher nurse staffing ratio (e.g., 1 Registered Nurse: 4 patients) is associated with lower failure-to-rescue incidents, lower rates of infection, and shorter hospital stays. According to the 2014 IHS Nurse Position Report there are 2,545 RNs employed with the IHS, Tribal and Urban Health programs. The IHS Nurse Position Report identified a Registered Nurse (RN)/Advanced Practice Nurse (APN) vacancy rate of 20.6 percent. Facilities that provide in-patient services are providing staffing to prevent adverse outcomes at a staffing ratio of 1 nurse for every 5 patients. APNs have strengthened IHS multidisciplinary medical teams and improved access to efficient, high quality care.

Nursing services funded under H&HC align and integrate with HHS goals and objectives to improve health care quality and patient safety, ensure access to quality, culturally competent care, promote prevention and wellness across the lifespan, and reduce the occurrence of infectious diseases. Nursing services were deployed in accordance with strategic planning, are data driven, and support program integrity through adherence to rigorous reporting requirements including two measures that align with Department measures. Nursing services focus heavily on the third IHS agency priority to improve quality and access to care for AI/ANs. Nurses are important leaders and contributors to every facet of clinical care and are critical to the success of the IPC, Partnership for Patients Initiative, Million Hearts Campaign and the Baby Friendly Hospital Initiative (BFHI). Nurses are actively engaged in the transformation of the health care system into one that places more emphasis on prevention, wellness, and coordination of care.

IHS nurses were also instrumental in implementing and promoting the IHS BFHI, a component of the First Lady's *Let's Move! In Indian Country* campaign dedicated to solving childhood obesity within a generation. This IHS initiative promotes breastfeeding to reduce the risk that children will develop obesity, diabetes, and other obesity-related conditions in the future.[2] The IHS adopted "Baby-Friendly," as the official standard of care for AI/AN mothers and babies in 2011. IHS received 100 percent "Baby Friendly," designation of all its obstetric care hospitals in 2014. Nationally, fewer than 10 percent of all U.S. hospitals are "Baby-Friendly" designated.

Ambulatory Care, Inpatient, and Public Health Nursing are also focused on quality measurements identified in the Partnership for Patients Initiative. By the end of FY 2016, this initiative aims to reduce re-hospitalization and to reduce hospital acquired conditions.

Trauma Care – Trauma is the leading cause of death and disability among the AI/AN population under age 45, and AI/AN trauma death rates are three times higher than U.S. all races rates.[3] The closest facility for emergency medical service providers to transport individuals with traumatic injuries is frequently the local IHS or Tribal hospital. Adequate staffing levels and

[2] Ip, S. Chung M., Raman G., et al. *Breastfeeding and Maternal Infant Health Outcomes in Developed Countries*. Evid Rep Technol Assess. 2007 (153): 1-186.

[3] U.S Department of Health and Human Services, Indian Health Service, (2009). *Trends in Indian Health*, 2002-2003 ed. Washington, D.C. U.S. Government Printing Office.

capabilities as well as state of the art equipment are essential for quality care. Emergency medicine physicians, RNs, APNs, and other highly trained staff are essential for improving patient care and disaster preparedness. These efforts align with HHS Strategic Goal 3: Objective E: Protect Americans' health and safety during emergencies, and foster resilience to withstand and respond to emergencies.

The IHS Capstone program, based on the Illinois Trauma Nurse Specialist program, provides RNs from rural IHS emergency departments and critical care areas with the opportunity to enhance their critical thinking skills, competence and confidence as trauma nurses in the emergency department setting. The capstone trauma nurse training program is ongoing in the Navajo Area and includes population specific services, pediatric emergency services, and geriatric trauma. In 2014, the program trained 25 nurses.

State trauma programs designate hospitals with emergency departments as trauma centers. The level is based on resources available in the trauma center and the number of patients admitted annually. Currently, there are 25 IHS hospitals with emergency departments. Two of the IHS hospitals have been designated as trauma centers. One is level III and one is a level IV trauma center. In addition, there are 18 tribally operated hospitals with emergency departments. Six of these hospitals have been designated as trauma centers. One is designated a level II and five are designated as level IV trauma centers.

HIV/AIDS Program – The HIV/AIDS Program goal is to ensure access to quality health services for AI/ANs living with HIV/AIDS and those at risk of contracting the diseases. The HIV/AIDS program contributes to the Agency's implementation of the Affordable Care Act through its emphasis on improving quality of and access to care, while also aligning with HHS Strategic Goals 1 and 3: Strengthen Health Care and Advance the Health, Safety, and Well-Being of the American People. The IHS has shown recent improvements in screening and HIV/AIDS care. By 2014, 100 percent of IHS sites served at least one patient living with an HIV diagnosis and by the third quarter of 2014, IHS had screened 39 percent of all 13 to 64 year-old patients for HIV/AIDS, which represents a 36 percent increase in unique patients tested from 2013. Prenatal screening remains consistently high, at 88 percent of all pregnant women. To improve access to care in remote areas, IHS has provided technical support to sites on screening and treatment, and extended the use of tele-health. In September 2013, a monthly secure webinar clinic for IHS HIV/AIDS-care providers was launched, with the support of the University of New Mexico, focusing on HIV care. Eight sessions were hosted for forty-one participants at nine sites throughout 11 states since the launch and the clinic continues to prove a valuable and desired asset in the care of AI/AN patients with HIV/AIDS.`

Domestic Violence Prevention Initiative (DVPI) – Domestic and intimate partner violence has a large impact on AI/AN communities. According to the CDC, 45.9 percent of AI/AN woman have experienced intimate partner violence – the highest rate of any race or ethnicity in the U.S.[4] In addition, one out of every three AI/AN woman will be sexually assaulted in her lifetime,[5] and AI/AN victims of intimate and family violence are more likely than victims of all other races to be injured and need hospital care.[6] Intimate partner violence and sexual assault have been correlated with adverse health conditions, including increases in heart disease, asthma, and stroke as well as migraines and fibromyalgia. Victims also experience mental health

[4] *National Intimate Partner and Sexual Violence Survey. 2010.* Centers for Disease Control and Prevention. Available at, http://www.cdc.gov/violenceprevention/pdf/nisvs_report2010-a.pdf
[5] *Restoration of Native Sovereignty, 5*. Restoration of Safety for Native Women .Sacred Circle and the National Congress of American Indians Task Force on Violence Against Women in Indian Country. (2006, September).
[6] *American Indians and Crime, 1992-96 Report*. Bureau of Justice Statistics, Office of Justice Programs, US Department of Justice.

problems such as depression and post-traumatic stress disorder. Domestic violence and sexual assault have been correlated with an increase in high-risk health behaviors, including an increased likeliness to smoke cigarettes, drink alcohol, use drugs, and engage in risky sexual behaviors.[7]

The DVPI is a congressionally appropriated, nationally-coordinated demonstration/pilot project that provides culturally appropriate domestic violence and sexual assault prevention and intervention resources to AI/AN communities. The annual Congressional appropriation supports 57 pilot projects to expand outreach advocacy programs into AI/AN communities, expands the Domestic Violence, Sexual Assault, and Sexual Assault Nurse Examiner-Sexual Assault Response Team Pilot projects, and provides training and the purchase of forensic equipment through the Tribal Forensic Healthcare Training project.

DVPI projects adhere to reporting requirements established by IHS and report on data and evidence-based outcome measures designed to help determine the most effective means for combating these issues in Tribal and Urban Indian communities. Three measures support the HHS Strategic Goal 1: Strengthen Healthcare Objective E: Ensure access to quality, culturally competent care, as well as the IHS priority to improve the quality of and access to care. A national evaluation of the DVPI is set to be complete after the demonstration phase concludes in August 2015 and will allow identification of successful evidence-based and practice-based programs that can be replicated across the Indian health system. The DVPI utilizes a revised data collection tool for IHS, Tribal, and Urban projects to collect a rich and wide range of data informed by knowledge gained through process measures.

The DVPI funded projects are addressing the social determinants associated with domestic and sexual violence. In the first four years of implementation (August 1, 2010 – August 31, 2014), the DVPI resulted in over 50,500 direct service encounters including crisis intervention, victim advocacy, case management, and counseling services. More than 38,000 referrals were made for domestic violence services, culturally-based services, and clinical behavioral health services. In addition, a total of 600 forensic evidence collection kits were submitted to Federal, State, and Tribal law enforcement.

IHS is collaborating with other agencies working in the field of domestic and sexual violence. In 2010, IHS and the Department of Justice's (DOJ) Office for Victims of Crime established an Interagency Agreement (IAA) to provide support to enhance the capacity of AI/AN communities to provide coordinated community, victim-centered sexual assault responses to adult and child victims through the AI/AN Sexual Assault Nurse Examiner-Sexual Assault Response Team Initiative. The IAA funded a full-time coordinator at IHS to ensure health care facilities respond more effectively to victims of sexual violence. To address the need for coordinated efforts within federal agencies, the initiative involves partnerships with IHS, the Bureau of Indian Affairs, the Federal Bureau of Investigation, and the DOJ's Office on Violence Against Women. The overall goal of the initiative is to restore the dignity, respect, and mental and physical health of victims of sexual assault and ensure more effective and victim-centered investigations and prosecutions. The initiative supports victim recovery, satisfaction, and cooperation with the federal criminal justice system, as well as support for victims of sexual assault and tribal communities' need for justice.

[7] *Ibid.*

FUNDING HISTORY

Fiscal Year	Amount	DVPI
2011 Omnibus	$1,762,865,000	($9,980,000)
2012 Enacted	$1,810,966,000	($9,440,870)
2013 Enacted	$1,749,072,000	($8,967,278)
2014 Final	$1,773,931,000	($8,967,278)
2015 Enacted	$1,836,789,000	($8,967,278)

BUDGET REQUEST

The FY 2016 budget request for Hospitals and Health Clinics of $1,936,323,000 is an increase of $99,534,000 over the FY 2015 Enacted level.

FY 2015 Base Funding of $1,836,789,000
The H&HC budget supports the largest portion of clinical care at IHS and Tribal health facilities, including salaries and benefits for the hospital/clinic administration; salaries and benefits for physicians, nurses, and ancillary staff; pharmaceuticals; and medical supplies. These funds make up the lump sum recurring base distribution to the Areas each fiscal year. In addition, there is an amount of H&HC funding that initially is allocated to Headquarters each year, which is allocated on a non-recurring basis to Areas during the fiscal year or which supports national activities.

FY 2016 Funding Increase of $99,534,000 includes:

- Inflation +$22,806,000 – to cover inflationary costs of providing health care services.

- Population Growth +$34,614,000 – to fund the additional services need arising from the growing AI/AN population. The growth rate is projected to be 1.8 percent in CY 2016 based on state births and deaths data.

- Pay Costs +$12,827,000 – to cover pay raises for federal and Tribal employees, of which about 90 percent are working at the service unit level providing health care and related services.

- Staffing/Operating Cost Requirements for Newly Constructed Facilities +$9,287,000 – H&HC funding is requested for two new and expanded healthcare facilities that are planned to open in FY 2016. Funding for two of these facilities allows IHS to expand provision of health care in those areas where capacity has been expanded to address critical health care needs.

Staff and Operating Costs for New Facility	Amount	FTE/Tribal Positions
Choctaw Alternative Rural Healthcare Center (JV), Choctaw, MS	$7,609,000	73
Ft. Yuma Health Center, Winterhaven, CA	$1,678,000	16
Grand Total:	**$9,287,000**	**89**

Program Increases +$10,000,000 – for Health Information Technology (HIT). Increase to HIT for enhancement of the Resource Patient Management System and to fund compliance with requirements of the Electronic Health Record implementation and Stage 3 of Meaningful Use. Please see separate HIT program narrative for more detailed information.

Program Increase +$10,000,000 – Third-Party Collections Improvement - The $10 million increase in the H&HC budget will be used to improve the IHS Business Office activities by:

- Centralizing and increasing training,
- Targeted outreach and education,
- Providing systems enhancement and program monitoring that focuses on billing practices and patient enrollment, and
- Implementing best practices.

Improved business practices that are designed to help service units increase third party collection will enhance IHS' ability to provide care. Third party revenue can be used at the facility level to increase access to care for patients. Third party collections increases can be used to expand and improve patient services at IHS and tribal facilities and to increase access to health care for patients referred out to the private sector. This funding will be targeted towards service units that need assistance with billing practices.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result/ Target for Recent Result/ (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
5: Diabetes: Nephropathy Assessment: Proportion of patients with diagnosed diabetes assessed for nephropathy. IHS-All	FY 2014: 60% Target: 60% (Baseline)	60%	61.1%	+1.1%
5: Tribally Operated Health Programs	FY 2014: 57.8% Target: 57.8% (Baseline)	57.8%	58.9%	+1.1%
20: 100 percent of hospitals and outpatient clinics operated by the Indian Health Service are accredited or certified (excluding tribal and urban facilities)	FY 2013: 100% Target: 100% (Target Met)	100%	100%	0
6: Diabetic Retinopathy: Proportion of patients with diagnosed diabetes who receives an annual retinal examination. IHS-All	FY 2014: 59.9% Target: 58.6% (Target Exceeded)	60.1%	61.6%	+1.5%
6: Tribally Operated Health Programs	FY 2014: 58.5% Target: 55.5% (Target Exceeded)	57%	59.6%	+2.6%
7: Pap Smear Rates: Proportion of eligible women who have had a Pap screen within the previous four years. IHS-All	FY 2014: 54.6% Target: 54.6% (Baseline)	54.6%	55.6%	+1.0%
7: Tribally Operated Health Programs	FY 2014: 55.1% Target: 55.1% (Baseline)	55.1%	56.1%	+1.0%

Measure	Year and Most Recent Result/ Target for Recent Result/ (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
8: Mammogram Rates: Proportion of eligible women who have had mammography screening within the previous two years. IHS-All	FY 2014: 54.2% Target: 54.7% (Target Not Met but Improved)	54.8%	55.9%	+1.1%
8: Tribally Operated Health Programs	FY 2014: 55.3% Target: 55.8% (Target Not Met but Improved)	55.9%	57.1%	+1.2%
9: Colorectal Cancer Screening Rates: Proportion of eligible patients who have had appropriate colorectal cancer screening. IHS-All	FY 2014: 37.5% Target: 35% (Target Exceeded)	35.2%	38.7%	+3.5%
9: Tribally Operated Health Programs	FY 2014: 39.6% Target: 36.2% (Target Exceeded)	36.4%	40.9%	+4.5%
TOHP-2: Number of designated annual clinical performance goals met. (Outcome)	FY 2014: 12/18 Target: 13/16 (Target Exceeded)	13/16	13/18	0
44: Years of Potential Life Lost (YPLL) in the American Indian/Alaska Native (AI/AN) population (Outcome) IHS-All	FY 2007: 89.4 years (Target Not In Place)	N/A	TBD	N/A
24: American Indian and Alaska Native patients, aged 19-35 months, receive the following childhood immunizations: 4 DTaP (diphtheria, tetanus, and acellular pertussis); 3 IPV (polio); 1 MMR (measles, mumps, rubella); 3 or 4 Hib (*Haemophilus* influenzae type b); 3 HepB (hepatitis B); 1 Varicella (chicken pox); 4 Pneumococcal conjugate. IHS - All (Outcome)	FY 2014: 75.4% Target: 74.8% (Target Exceeded)	73.9%	76.8%%	+2.9%
24: Tribally Operated Health Programs	FY 2014: 69.7% Target: 68.8% (Target Exceeded)	68.0%	71.0%	+3.0%
45: Hospital Admissions per 100,000 service population for long term complications of diabetes. (Efficiency) IHS-All	FY 2013: 83.6 (Target Not in Place)	TBD	TBD	N/A

Measure	Year and Most Recent Result/ Target for Recent Result/ (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
16: Domestic (Intimate Partner) Violence Screening: Proportion of women who are screened for domestic violence at health care facilities. IHS-All	FY 2014: 63.5% Target: 64.1% (Target Not Met but Improved)	61.6%	64.6%	+3.0%
16: Tribally Operated Health Programs	FY 2014: 59.2% Target: 58% (Target Exceeded)	56.0%	60.3%	+4.3%
25: Adult Immunizations: Influenza: Influenza vaccination rates among adult patients aged 65 years and older. IHS-All	FY 2014: 68.1% Target: 69.1% (Target Not Met but Improved)	67.2%	Retire	N/A
25: Tribally Operated Health Programs	FY 2014: 65.5% Target: 66.5% (Target Not Met but Improved)	64.6%	Retire	N/A
26: Adult Immunizations: Pneumococcal vaccination rates among adult patients aged 65 years and older. IHS-All	FY 2013: 85.7% Target: 85.7% (Baseline)	85.7%	87.3%	+1.6%
26: Tribally Operated Health Programs	FY 2014: 81.7% Target: 81.7% (Baseline)	81.7%	83.3%	+1.6%
48: Influenza vaccination rates among children 6 months to 17 years (IHS-All)	N/A	N/A	Baseline	N/A
48: Tribally Operated Health Programs	N/A	N/A	Baseline	N/A
49: Influenza vaccination rates among adults 18 years and older (IHS-All)	N/A	N/A	Baseline	N/A
49: Tribally Operated Health Programs	N/A	N/A	Baseline	N/A
33: HIV Screening: Proportion of pregnant women screened for HIV.	FY 2014: 88% Target: 89.1% (Target Not Met but Improved)	86.6%	Retired	N/A
32: Tobacco Cessation Intervention**:** Proportion of tobacco-using patients that receive tobacco cessation intervention. IHS-All	FY 2014: 48.2% Target: 45.7% (Target Exceeded)	46.3%	49.1%	+2.8%
32: Tribally Operated Health Programs	FY 2014: 43.1% Target: 42.8% (Target Exceeded)	43.4%	43.9%	+0.5%
30: CVD Comprehensive Assessment: Proportion of CHD patients who have a	FY 2014: 52.3% Target: 51% (Target Exceeded)	47.3%	53.3%	+6.0%

Measure	Year and Most Recent Result/ Target for Recent Result/ (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
comprehensive assessment for all CVD-related risk factors. IHS-All				
30: Tribally Operated Health Programs	FY 2014: 48.4% Target: 49.7% (Target Not Met but Improved)	46.0%	49.3%	+3.3%
43: Breastfeeding Rates: Proportion of infants 2 months old (45-89 days old) that are exclusively or mostly breastfed.	FY 2014: 35.1% Target: 29.0% (Target Exceeded)	29.0%	35.8%	+6.8%
43: Tribally Operated Health Programs	FY 2014: 37.9% Target: 27.8% (Target Exceeded)	27.8%	38.6%	+10.8%
46: Million Hearts -- Controlling High Blood Pressure. IHS-All	FY 2014: 59.5% Target: 59.5% (Baseline)	59.5%	60.6%	+1.1%
46: Tribally Operated Health Programs	FY 2014: 59.1% Target: 59.1% (Baseline)	59.1%	60.2%	+1.1%
47: HIV Screening Ever			Baseline	N/A
47: Tribally Operated Health Programs			Baseline	N/A
H&HC 4: Inpatient Admissions - IHS Direct *(Output)*	FY 2013: 20,469 Target: 22,500 (Target Exceeded)	19,900	20,000	+100
Domestic Violence Prevention Initiative				
H&HC 1: Percent of Domestic Violence Prevention Initiative-funded programs providing case management services to victims and children of victims *(Output)*	FY 2014: 66.7% Target: 84% (Target Not Met but Improved)	61.9%	68.7%	+6.8%
H&HC 2: Percent of sexual assault community developed model (SACDM) programs that have an active interdisciplinary Sexual Assault Response Team (SART) *(Output)*	FY 2014: 83% Target: 100% (Target Not Met but Improved)	42.1%	85%	42.9%
H&HC 3: Percent of SANE/SART Programs with written sexual assault response policies and procedures *(Output)*	FY 2014: 87.5% Target: 100% (Target Not Met)	87.5%	100%	12.5%

During the past few years, the IHS has experienced positive and sustained performance results. After several years of meeting all clinical targets, IHS set more aggressive performance goals for most indicators in FY2014. Even with higher target levels, IHS met the majority of its target measures, and made progress and came within 1 percent of meeting other measures. For example, when compared to the FY 2013 results, the Agency increased performance by 1.1 percent in FY 2014 for domestic violence screening and missed meeting the target goal by only 0.6 percent. Contributing factors to missing the target are a combination of setting a much higher goal than usual, staff turnover, and recruitment of new staff not yet familiar with screening processes.

H&HC provides funds for clinical services across the country; the leadership at each hospital and health center works with their staff to assure continuous monitoring and fulfillment of these clinical targets that includes performance data feedback. Extensive efforts are exerted to maintain staff competencies, provide opportunities for continuing education, to recruit and retain staff, enhance policies, disseminate evidence-based strategies, and other quality and access improvement activities to support fulfillment of clinical targets. Health screening and early prevention and intervention provide opportunities to improve the health status of AI/AN patients. Screening, case management and other tools including the electronic health record are utilized to further improve patient assessment, monitoring, and progress over time. This is particularly important in the management of chronic diseases, such as diabetes, which requires ongoing monitoring and treatment of complications, including retinopathy and nephropathy and prevention efforts such as HIV screening and immunizations.

In FY 2016, these efforts will continue through the Agency's focus on system-wide priorities that include improving quality and access to health care through the methods and approaches listed above, as well as an emphasis on team work, strengthening of partnerships and relationships with tribes and customers, and effectiveness.

GRANTS AWARDS - H&HC funds support one grant program: the Healthy Lifestyles in Youth Grant, a $1 million limited cooperative agreement with the National Congress of American Indians. This grant program promotes healthy lifestyles among AI/AN youth using the curriculum "Together Raising Awareness for Indian Life" at selected Boys and Girls Club sites across the country and represents responsiveness to Tribal input for more prevention activities.

CFDA No. – 93.933 – Demonstration Projects for Indian Health			
	FY 2014 Enacted	FY 2015 Pres. Budget	FY 2016 Request
Number of Awards	1	1	1
Average Award	$1,000,000	$1,000,000	$1,000,000
Range of Awards	$1,000,000	$1,000,000	$1,000,000
Total Awards	$1,000,000	$1,000,000	$1,000,000

AREA ALLOCATION

Hospital and Health Clinics

(dollars in thousands)

DISCRETIONARY SERVICES	Actual Base	FY 2014 Final			FY 2015 Enacted			FY 2016 President's Budget			FY '16 +/- FY '15
		Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$166,046	$67,495	$100,910	$168,406	$68,888	$105,485	$174,373	$71,163	$112,659	$183,822	$9,449
Albuquerque	252,264	102,542	153,308	255,850	104,658	160,258	264,916	108,115	171,156	279,271	14,356
Bemidji	76,297	31,014	46,368	77,381	31,654	48,470	80,123	32,699	51,766	84,465	4,342
Billings	97,468	39,620	59,234	98,854	40,437	61,919	102,356	41,773	66,130	107,903	5,547
California	62,854	25,549	38,198	63,747	26,076	39,930	66,006	26,938	42,645	69,583	3,577
Great Plains	69,636	28,306	42,320	70,626	28,890	44,238	73,128	29,844	47,247	77,091	3,963
Nashville	54,325	22,082	33,014	55,097	22,538	34,511	57,049	23,282	36,858	60,140	3,091
Navajo	221,753	90,140	134,765	224,904	91,999	140,874	232,874	95,038	150,455	245,493	12,619
Oklahoma	319,124	129,720	193,940	323,659	132,396	202,732	335,128	136,769	216,519	353,288	18,160
Phoenix	156,603	63,657	95,171	158,828	64,970	99,486	164,456	67,116	106,252	173,368	8,912
Portland	73,839	30,014	44,874	74,888	30,634	46,908	77,542	31,646	50,098	81,744	4,202
Tucson	19,567	7,954	11,891	19,845	8,118	12,430	20,548	8,386	13,276	21,661	1,113
Headquarters	179,298	72,882	108,964	181,846	74,386	113,904	188,290	76,843	121,650	198,493	10,203
Total, H&HC	**$1,749,072**	**$710,975**	**$1,062,956**	**$1,773,931**	**$725,644**	**$1,111,145**	**$1,836,789**	**$749,612**	**$1,186,711**	**$1,936,323**	**+$99,534**

Note: Allocation amounts are estimates.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Services: 75-0390-0-1-551
HOSPITALS AND HEALTH CLINICS
Epidemiology Centers

(Dollars in Thousands)

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$1,773,931	$1,836,789	$1,936,323	+$99,534
Epi Centers	*$4,679*	*$4,679*	*$4,679*	*0*

Authorizing Legislation .....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended 2010

FY 2016 Authorization.....Permanent

Allocation Method.....Cooperative Agreements

PROGRAM DESCRIPTION and ACCOMPLISHMENTS

The Indian Health Service (IHS) Tribal Epidemiology Center (TEC) Program was first authorized and funded by Congress in FY 1996. The intent has been to develop public health infrastructure by augmenting existing Tribal organizations with expertise in epidemiology and public health via Epidemiology Centers. Funding is distributed to the TECs through cooperative agreements to Tribes and Tribal organizations such as Indian health boards.

Operating within Tribal organizations, TECs are uniquely positioned to provide support to local Tribal disease surveillance and control programs, and assess the effectiveness of public health programs. The Indian Health Care Improvement Act (Section 130) included language to designate the TECs as public health authorities. To ensure secured data access, data sharing agreements are required, thereby mitigating risk against improper use. All TECs monitor the health status of their constituent Tribes, produce reports annually or bi-annually, and provide critical support to Tribes who self-govern their health programs. Data generated locally and analyzed by TECs enable Tribes to evaluate Tribal and community-specific health status for planning the needs of their Tribal membership. Immediate feedback is provided to the local data systems and leads to improvements in Indian health data overall. TECs support national public health goals by working to improve data for the Government Performance and Results Act, agency performance reports, and monitoring of the Healthy People 2020 objectives at the Tribal level. TECs also support the HHS Strategic Plan 2014-2018 by increasing access to and sharing of data and supporting epidemiology programs at the state, local, and tribal government levels and by urban Indian organizations (HHS Strategic Goal 2: Objective E). Health status reports across all TECs will lead to a more comprehensive picture of Indian health.

The IHS Division of Epidemiology and Disease Prevention (DEDP) functions as the national coordinating center and provides technical support and guidance to TECs. DEDP and TECs collect, analyze, interpret, and disseminate health information in addition to identifying diseases to target for intervention, suggesting strategies, and testing the effectiveness of implemented health interventions. The TECs play a critical role in IHS' overall public health infrastructure.

The TEC funds support the above listed activities and improve TEC capacity in support of the HHS and IHS missions. TECs submit semi-annual reports indicating achievement in the three key measures: health status and monitoring (surveys, assessments and reports), producing regional health profiles, and providing tribal support (technical training in public health practice). These key measures have routinely been attained on an annual basis, which is a representation of the proficiency of each TEC. To facilitate continued improvement, and to properly identify and manage risks to performance, DEDP will develop new epidemiology measures in conjunction with the TECs to begin with the new 5-year Cooperative Agreement cycle to replace the current measures in the outputs/outcomes table. The new measures will be developed in FY 2015, initiated in FY 2016 along with any applicable database or performance structure, and reported in FY 2017. Since TECs have historically met program targets, new measure development will allow TEC performance evaluation to be improved.

Over 90 percent of the TEC Program budget is distributed through cooperative agreements. Through a competitive 5-year cooperative agreement award process in FY 2011, all 12 TECs were awarded an average of $360,000 per award to serve a major portion of the AI/AN population in 12 regions comparable to the IHS Administrative Area service population. Up to $1,000,000 in funding for each TEC was initially authorized by the Indian Health Care Improvement Act.

FUNDING HISTORY

Fiscal Year	Amount*
2011 Omnibus	*$4,686,346*
2012 Enacted	*$4,678,847*
2013 Enacted	*$4,433,361*
2014 Final	*$4,678,847*
2015 Enacted	*$4,678,847*

*Funded under the H&HC budget.

BUDGET REQUEST

The FY 2016 budget request for the Tribal Epidemiology Centers Program of $4,678,847 (funded within Hospitals and Health Clinics budget line) is the same as the FY 2015 Enacted level.

DEDP/TEC Program uses the TEC base budget to address the following Agency Priorities:

1) Renew and strengthen our partnership with Tribes – The TECs are fundamental to the IHS' partnership with Tribes by supporting epidemiology and public health functions critical to the delivery of healthcare services. Independent TEC goals are set as directed by their constituent Tribes and health boards. DEDP tracks these goals and objectives as written in their cooperative agreements (i.e., surveillance of disease and control programs and collecting epidemiological data for use in determining health status of Tribal communities). DEDP sets a national outcome for each TEC to develop and disseminate regional health profiles for their constituent Tribes and communities.
2) Reform the IHS – TECs represent an important link to IHS reform efforts through their efforts to build capacity in the Indian health system to evaluate and monitor the effectiveness of health programs.
3) Improve the quality of and access to care – In the expanding environment of Tribally-operated health programs, epidemiology centers provide additional public health services, such as disease control and prevention programs, in areas such as sexually transmitted disease control, HIV, and cancer prevention. TECs assist Tribes with projects such as conducting

behavioral risk factor surveys to establishing baseline data for successfully evaluating intervention and prevention activities. The TEC Program supports Tribal communities by providing technical training in public health practice and prevention-oriented research, and promoting public health career pathways for Tribal members. DEDP works with the National Institutes of Health and the Centers for Disease Control and Prevention to supplement the TECs, create stronger interagency partnerships, and prevent costly duplication of effort.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result/ Target for Recent Result/ (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
EPI-1: Health Status & Monitoring* **Measured by surveys, assessments, reports (Output)*	FY 2014 Final: 12 of 12 TECs Target: 12 of 12 TECs (Target Met)	12 of 12 TECs	Measure retired	N/A
EPI-2: Provide regional health profiles *(Output)*	FY 2014 Final: 12 of 12 TECs Target: 12 of 12 TECs (Target Met)	12 of 12 TECs	Measure retired	N/A
EPI-3: Tribal support - technical training in public health practice *(Output)*	FY 2014 Final: 12of 12 TECs Target: 12 of 12 TECs (Target Met)	12 of 12 TECs	Measure retired	N/A
EPI-4: Develop new EPI measure with Tribal Epidemiology Centers	N/A	Develop performance structure for this new measure	Measure implementation initiated along with any applicable database or performance structure	N/A

GRANTS AWARDS

CFDA 93.231 – Epidemiology Cooperative Agreements			
	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	12	12	12
Average Award*	$342,000	$360,000	$360,000
Range of Awards	$300,000 - $450,000	$350,000 - $500,000	$350,000 - $500,000

* Administrative and technical support of the TEC's is provided by the Division of Epidemiology and Disease Prevention (DEDP) and is included in the average award amount.

FY 2016 Tribal Epidemiology Centers Allocation			
1	Alaska Native Tribal Health Consortium	Anchorage, AK	$360,000
2	Albuquerque American Indian Health Board	Albuquerque, NM	$360,000
3	Great Lakes Inter-Tribal Council	Lac du Flambeau, WI	$360,000
4	Inter-Tribal Council of Arizona	Phoenix, AZ	$360,000
5	Montana/Wyoming Tribal Leaders Council	Billings, MT	$360,000
6	Navajo Nation Division of Health	Window Rock, AZ	$360,000
7	Northern Plains – Great Plains Area	Rapid City, SD	$360,000
8	Northwest Portland Area Indian Health Board	Portland, OR	$360,000
9	Oklahoma City Area Inter-Tribal Health Board	Oklahoma City, OK	$360,000
10	Seattle Indian Health Board	Seattle, WA	$360,000
11	United South and Eastern Tribes, Inc.	Nashville, TN	$360,000
12	California Rural Indian Health Board	Sacramento, CA	$360,000
	Administrative and technical support	IHS Headquarters	$359,000
	TOTAL		**$4,679,000**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Services: 75-0390-0-1-551
HOSPITALS AND HEALTH CLINICS
Health Information Technology

(Dollars in Thousands)

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$1,773,931	$1,836,789	$1,936,323	+$99,534
HIT	*$172,149*	*$172,149*	*$182,149*	*+$10,000*

Authorizing Legislation .....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended 2010

FY 2016 Authorization.....Permanent

Allocation Method .....Direct Federal; PL 93-638 Tribal Contracts/Compacts

PROGRAM DESCRIPTION and ACCOMPLISHMENTS

The Indian Health Service (IHS) Health Information Technology (HIT) Program uses secure and reliable information technology (IT) in innovative ways to improve health care delivery and quality, enhance access to care, reduce medical errors, and modernize administrative functions. IHS HIT provides critical support for the IHS, Tribal, and Urban (I/T/U) health care facilities that care for more than two million American Indian and Alaska Native (AI/AN) people across the Indian health system. IHS provides the technology infrastructure for a nationwide health care system, including a secure wide area network, enterprise e-mail services, and regional and national Help Desk support for approximately 20,000 users. IHS HIT also supports the mission-critical health care operations of the I/T/U with a comprehensive health information solution that includes a certified Electronic Health Record (EHR).

The IHS HIT Program is dedicated to providing the most innovative, effective, and cost-efficient HIT system in the federal government. The IHS HIT program is comprised of three major strategic IT investments: 1) the Resource and Patient Management System (RPMS); 2) Infrastructure, Office Automation, and Telecommunications (IOAT); and 3) the National Patient Information Reporting System (NPIRS). These investments are fully integrated with the Agency's programs and are critical to carrying out the IHS mission and priorities.

1) **RPMS** is the key IHS enterprise health information system that underlies the clinical, practice management and revenue cycle business processes at IHS, Tribal, and Urban (I/T/U) facilities across the country. The RPMS EHR is certified according to criteria published by the Office of the National Coordinator for Health Information Technology (ONC) and is in use at nearly 400 health care facilities across the country. Completion of the 2014 enhancements to the Certified RPMS EHR in August 2014 is paving the way for continued participation in the Meaningful Use (MU) incentive programs.
2) **IOAT** provides the technical infrastructure for IHS healthcare facilities and is the foundation upon which RPMS is delivered. The IOAT investment includes a highly available and secure wide-area network which includes locations with unique telecommunication challenges, a national e-mail and collaboration capability that is designed specifically to support health

care communication and data sharing, enterprise application services and supporting hardware including servers and end-user devices. The IHS IT infrastructure incorporates government and industry standards for the collection, processing, storage, and transmission of information and is poised to respond to new and pioneering opportunities, including cloud computing for flexible storage options and providing for the high availability for critical services.

3) **NPIRS** is an enterprise-wide data warehouse environment that produces reports required by statute and regulation and provides a broad range of clinical and administrative information, and associated analytical tools, to managers at all levels of the Indian health system. This investment, which resides in a private cloud, is evolving to become the data source for agency-level quality measurement, performance reporting, and enterprise analytics.

In addition, the IHS HIT Program includes mature Information Security, Capital Planning and Investment Control, and Enterprise Architecture Programs that support the three major strategic IT investments. These programs serve to promote compliance with federal laws and mandates and improve the efficiency and security of the IHS HIT investments.

FY 2013/14 Accomplishments

The IHS Office of Information Technology (OIT) has achieved numerous accomplishments during FY 2013 and 2014, including the following examples:

- Deployment of the 2011 Certified RPMS EHR throughout the IHS has resulted in substantial benefit to IHS hospitals and clinics through the collection of MU incentive payments. Through the second quarter of FY 2014, nearly $72.3 million was received as a result of adoption and/or meaningful use of the RPMS EHR by IHS eligible hospitals and providers.
- The RPMS EHR has completed testing against the 2014 EHR Certification criteria and received certification in August 2014. The RPMS EHR has been implemented at 279 facilities as of December 31, 2014.
- The IHS is on schedule to complete all development, testing and deployment of system changes necessary to implement the 10th edition of the International Classification of Diseases (ICD-10). The recent legislative postponement of the compliance date will allow additional time for testing with payers and continued improvements in clinical documentation as well as more time for facilities to implement the enhancements required for ICD-10.
- The IHS is deploying the IHS Personal Health Record (PHR), a secure portal that enables patients to view, download, and transmit demographic information, medications, lab results, problems, vital signs, immunizations, and other visit-related information. The PHR also facilitates secure communication between the patient and provider.
- The IHS has developed an enterprise-wide health information exchange (HIE) that will be used by IHS federal facilities and participating Tribal and Urban Indian health programs. The IHS also completed the requirements for the eHealth Exchange that will enable the secure sharing of patient information from the IHS HIE with other private or public national, state, or regional HIEs.
- The IHS has developed a Secure Messaging system based on the Direct protocol and Direct reference implementation specified by the ONC. This system will improve patient-to-provider communication and may improve patient care through a more effective referral process.
- The IHS completed the enterprise implementation of Microsoft Lync, an online collaboration and meeting tool, which reduces on-site meeting costs.
- The IHS completed the assessment, purchase and implementation of private cloud Storage Area Network expansion in support of the IHS Direct project, the Personal Health

Records/Health Information Exchange (PHR/HIE) projects, the NPIRS Data warehouse and the continued implementation of virtualization within the IHS Data Centers.

- The IHS provided a secure design and implementation guidance for Affordable Care Act (ACA) kiosk systems to be used throughout IHS healthcare facilities. The kiosks allow patients to access the ACA website while visiting the facility.
- The IHS developed the Agency's first Fiscal Year (FY) 2015-2017 OIT Human Capital Management Plan encompassing five strategic directions for IHS IT human capital management: integration of IT within IHS leadership & planning; IT employee recruitment; development; retention; and Human Capital and IHS performance processes.
- The IHS provided 333 OIT-sponsored EHR and RPMS training events (220 eLearning events, 113 on-site events) training 8,397 participants (6,459 eLearning participants, 1,938 on-site participants).
- The IHS modernized the FY14 Information Systems Security Awareness (ISSA) training using animated videos; the new training approach was well received by the HHS Training and Awareness Working Group. 29,000 I/T/U users have completed the training.
- Development of the RPMS Hardship Exemption Letter with a unique identifiers for each facility generated from within the EHR and given to the patient to indicate eligibility status.

Collaboration with Tribal health programs and other federal agencies is key to the success of the IHS HIT Program. IHS works closely with the Office of the National Coordinator for HIT, Centers for Medicare and Medicaid Services, Agency for Healthcare Research and Quality, Department of Veterans Affairs (VA), and other federal entities on IT initiatives to ensure that the direction of its HIT systems are consistent with other federal agencies. In addition, IHS has routinely shared HIT artifacts (e.g., design and requirement documents, clinical quality logic, etc.) with both public and private organizations. The IHS recently signed a collaborative agreement with the Open Source Electronic Health Record Alliance (OSEHRA), a private entity designated by the VA as the custodial agent for the VA health information system, VistA. IHS considers the RPMS suite to be a public utility and collaboration with OSEHRA will facilitate making the innovations and advances that IHS has made in HIT available to the broader public.

Immediate Priorities and Challenges

The IHS HIT Program will continue to face increased workload and costs going forward because of ever-growing and more complex requirements for health information technology capabilities. These requirements come from government and industry initiatives, program needs of the IHS, and operational requests of I/T/U health care facilities. Virtually any new program initiative has information technology requirements for data collection or reporting which then must be added to the IHS HIT portfolio. The IHS OIT forecasts the following to be major workload and cost drivers for IHS HIT in FY 2015, FY 2016 and beyond:

- **ICD-10 -** Completion, testing and rollout of the system enhancements required for ICD-10 that were delayed into FY 2015, with post-implementation costs beginning in FY 2016.
- **HIT Projects** - Numerous HIT enhancement projects, both those needed for system integrity, security and modernization as well as those demanded by IHS program offices and end users, were postponed by the 2014 Certification and ICD-10 initiatives, and need to be resumed as soon as time and funding become available.
- **Certified 2014 EHR** - FY 2015 will see new costs for operational support and training on new capabilities delivered with the 2014 Certified EHR. Operational costs in general will continue to rise and exceed historical levels because the breadth and complexity of IHS HIT systems. RPMS in particular, has been increasing exponentially over the past several years.

- **Enterprise Services** - Management and operations costs for enterprise services that have been developed to upgrade for MU and other initiatives, including at a minimum: HIE, Master Patient Index, the PHR patient portal, Electronic Prescribing, Terminology Services, centralized Pharmacy order checks, and more.
- **Quality Reporting** - Analytical and technical work to accomplish alignment of measurement and reporting processes for various clinical quality reporting mandates including Government Performance and Results Act (GPRA), MU Clinical Quality Measures, Inpatient Quality Reporting (IQR) and the Physician Quality Reporting Initiative (PQRI).
- **Certified 2015 EHR** - Analysis and development of the expected 2015 Certification standards for EHR must be completed by 2017 in order for IHS facilities to continue to participate in the MU initiative. This is expected to be no less costly than the 2014 Certification experience.
- **NPIRS expansion** - Continued expansion of the NPIRS national data warehouse to serve as the enterprise data analytics and performance measurement hub for IHS. NPIRS includes data from non-RPMS systems, which requires additional processing for data integration.
- **Data Center Consolidation** - IHS seeks to reduce data center footprints and share technical expertise in the field. Although this should save long term maintenance costs, there will be a start-up investment for these transitions especially with the move of IHS to 5600 Fishers Lane in FY2016.
- **Security Threats and Best Practices** - IHS HIT will be expected to continue to respond in a timely way to new security threats, regulatory mandates for government IT systems, and industry standards and best practices.
- **Affordable Care Act** - IHS HIT will be expected to support provisions of the Affordable Care Act (ACA) that call for new data or data systems to implement new business processes or reporting requirements. Many of these requirements are still evolving in the regulatory process so their impacts on IHS HIT are not fully known.
- **Network Reliability** - The IHS network will continue to require upgrades in order to achieve the necessary bandwidth and reliability recommended by the Federal Communications Commission (FCC) in order to support robust health information exchange required by MU and expanding telehealth initiatives.
- **Internet Protocol version 6 (IPv6)** - The Network Operations Support Center (NOSC) in coordination with Area IT staff will continue to make progress with the implementation of IPV6.
- **Active Directory** - IT Enterprise Services will continue to support collaboration with Tribal partners through the implementation of the Microsoft Active Directory Federation Services.

The IHS HIT Program will provide high quality support for existing and mandated health information technologies within available resources, and will continue to seek opportunities for reduced costs and efficiencies, including through cloud based solutions and virtualization.

FUNDING HISTORY

Fiscal Year	Amount
2011 Omnibus	$169,024,509
2012 Enacted	$172,149,000
2013 Enacted	$172,149,000
2014 Final	$172,149,000
2015 Enacted	$172,149,000

*This represents the total cost of HIT within IHS federal programs. The majority is from Hospitals & Health Clinics budget line with a small amount from Direct Operations for federal personnel and travel.

BUDGET REQUEST

The FY 2016 budget proposal for Health Information Technology within the Hospitals and Health Clinics Budget line is $182,149,000; this is an increase of $10,000,000 above the FY 2015 Enacted level.

FY 2015 Base Funding of $172,149,000 - The IHS HIT Program has continued to make progress in the past several years by keeping infrastructure costs as low as possible and maintaining a high level of productivity and commitment by both federal and contractor staff supporting the IHS-developed health information solutions. IHS uses open source tools where possible to minimize acquisition costs and is reducing use of more costly assisted acquisition providers such as the General Services Administration. The success of IHS HIT in completing the 2014 EHR certification initiative was the direct result of IHS Service Units contributing a portion of Stage 1 MU incentive payments to enable development for Stage 2. Diminution of the MU incentive programs, together with inflationary costs will constrain the ability of the IHS HIT investments to maintain current services or to enhance systems in response to the requirements described in the previous paragraphs. The IHS request includes funding to support the President's information technology initiatives and Departmental enterprise information technology initiatives identified through the HHS strategic planning process.

FY 2016 Funding Increase of $10,000,000 includes:

The program increase will be used to upgrade the RPMS EHR to comply with the requirements for 2015 version Certified EHR Technology (CEHRT) and Stage 3 MU.

The next major mandated EHR certification requirements will be released in late FY 2015 as the Final Rule for what is known as the 2015 version of the ONC certification program. This will launch a new major development project to upgrade RPMS. IHS expects that the costs for the new version of EHR certification will equal or exceed the cost for 2014 certification; the current estimate is $15 million. The project will need to begin in late FY 2015 and extend through FY 2017. While the FY 2014 certification was funded using an assessment of federal provider MU incentive payments, the amounts available in FY 2016 and beyond will be much smaller and not enough to sustain the efforts needed for certification; therefore this program increase is necessary for successful achievement of Stage 3 MU. Upgraded capabilities and services developed for and delivered with the 2015 version Certified EHR will require ongoing operational support and maintenance in subsequent years. Participation in MU is critical for the agency since penalties in Medicare payments will occur if IHS does not participate.

Projected Accomplishments Related to Program Increase:
Expected accomplishments will include analysis and documentation of technical and functional requirements for the enhancements to RPMS, completion of development of upgraded systems, testing and certification with ONC, and deployment/implementation. The ultimate accomplishment will be in achievement of Meaningful Use of the FY 2015 version Certified EHR across IHS.

Performance and project milestones will be monitored through normal Enterprise Performance Life Cycle processes.

IHS Investments

(Dollars in Thousands)

Program Name	IT Investment Title	Unique Investment Identifier	FY 2014 Final	FY 2015 Enacted	FY 2016 Pres. Budget
Hospitals & Health Clinics	IHS Resource and Patient Management System – Maintenance & Enhancements	009-17-01-02-01-1010-00	$96,625	$100,857	$110,857
Hospitals & Health Clinics	IHS National Patient Information and Reporting System – Maintenance & Enhancements	009-17-01-02-01-1020-00	$9,448	$ 9,761	$ 9,761
Hospitals & Health Clinics	IHS Infrastructure, Office Automation, & Telecommunications (IOAT)	009-17-02-00-01-1040-00	$56,218	$ 57,454	$ 57,454
Hospitals & Health Clinics	Non-major Investments including Security and Enterprise Architecture Programs	N/A	$9,858	$4,077	$ 4,077
Total			**$172,149**	**$172,149**	**$182,149**

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result/ Target for Recent Result (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
HIT-1: OMB IT Dashboard – All IHS Major Investments will maintain a score of 4/5 or greater	2014 (July 31) – RPMS 4, IOAT 5, NPIRS 5	≥4/5 for all investments	≥4/5 for all investments	Maintain
HIT-2: HHS CIO Work plan – The IHS will score 90% or greater on the annual scoring of the HHS CIO Work plan	2013 – 90.7%	>90%	>90%	Maintain
RPMS-2: Derive all clinical measures from RPMS and integrate with EHR (Clinical Measures/Areas) (RPMS Program Assessment)	FY 2014: 75/12 Target: 73/12 (Target Exceeded)	73/12	75/12	0

Information Technology is an enabler to virtually every operation and program that contributes to the overall mission of the Agency. Effective IT systems are necessary, although not sufficient, for successful Agency performance. Whether the IT required by the program is basic such as network and email, or the IT requirement is highly specialized and specific such electronic medical record and billing systems, the success of the IT organization, in terms of outcomes, is reflected in the success of the various programs of the Agency.

With respect to performance metrics that are specific to IHS HIT operations, IHS proposes two new measures as shown in the table above. These are existing metrics which compare IHS' performance against that of other HHS Operating Divisions (the HHS CIO Work plan) and

against other agencies government wide in terms of success of IT investment management (OMB IT Dashboard).

GRANTS AWARDS - IHS does not fund grants for health information technology.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Services: 75-0390-0-1-551
DENTAL HEALTH

(Dollars in Thousands)

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$165,260	$173,982	$181,459	+$7,477
FTE*	633	701	703	+2

*FTE numbers reflect only federal staff and do not include Tribal staff.

Authorizing Legislation .....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended 2010

FY 2016 Authorization.....Permanent

Allocation Method.....Direct Federal; P.L. 93-638 Self-Determination Contracts, Grants, and Self-Governance Compacts

PROGRAM DESCRIPTION and ACCOMPLISHMENTS

The purpose of the Indian Health Service (IHS) Dental Health Program (DHP) is to raise the oral health status of the American Indian/Alaska Native (AI/AN) population to the highest possible level through the provision of quality preventive and treatment services, at both community and clinic sites. The DHP is a service-oriented program providing basic dental services (e.g., diagnostic, emergency, preventive, and basic restorative care). Approximately 90 percent of the dental services provided fall into the basic dental services category. In FY 2014, the dental program provided a total of 3,693,104 documented basic dental services. More complex rehabilitative care (e.g., root canals, crown and bridge, dentures, and surgical extractions) is provided where resources allow and account for the additional 225,650 dental services provided in FY 2014.

The demand for dental treatment remains high due to the high incidence of dental caries in AI/AN children. Over 80 percent of AI/AN children ages 6-9 years suffer from dental caries, while less than 50 percent of the U.S. population ages 6-9 years have experienced cavities.[1] In addition to this disparity in prevalence, there is a significant disparity in severity of dental disease. AI/AN children ages 2-5 years exhibit an average of six decayed teeth, while the same age group in the U.S. population averages one decayed tooth.[2] A continuing emphasis on community oral health promotion/disease prevention is essential in order to address the current high prevalence, reduce the severity of oral disease and improve the oral health of AI/AN people. Prevention activities improve health and reduce the amount and cost of subsequent dental care. The IHS DHP measures performance through the delivery of preventive services.

[1] Phipps KR, Ricks TL, Blahut P. The oral health of 6-9 year old American Indian and Alaska Native children compared to the general U.S. population and Healthy People 2020 targets. Indian Health Service data brief. Rockville, MD: Indian Health Service. 2014[1]).
[2] Indian Health Service. The 2010 Indian Health Service Oral Health Survey of American Indian and Alaska Native Preschool Children. Rockville, M.D.: U.S. Department of Health and Human Services, Indian Health Service, 2014

The IHS DHP maintains data and tracks three key program objectives:

1) Increase the number of dental sealants placed in 2-15 year-olds;
2) Increase the number of patients that receive at least one topical fluoride application in 1-15 year-olds; and
3) Increase access to care.

Access to dental services is a prerequisite to the control of oral disease in susceptible or high-risk populations. The access to care Government Performance and Results Act (GPRA) objective is currently aligned with Healthy People 2020 methodology as a percentage of patients who have visited the dentist. The access to care performance was 28.8 percent in fiscal year (FY) 2014 and was within 1 percent of the 29.5 percent goal. This is an increase from the FY 2013 goal of 28.3 percent. Overall, seven of the 12 IHS Areas showed increases in access to care performance from 2013 to 2014.

Topical fluorides and dental sealants have been extensively researched and documented in the dental literature as safe and effective preventive interventions to reduce tooth decay. In FY 2013, the tracking of dental sealants and the tracking of patients receiving topical fluoride measures changed from simple counts of procedures or patients to estimates of the percentage of children receiving either sealants or topical fluorides. New annual targets were set for these two objectives as of July 1, 2013. The 27 percent FY 2014 topical fluoride goal for children ages 1 to 15 receiving one or more topical fluoride applications was met with a result of 27.9 percent. This is an increase from the 26.7 percent in FY 2013. Nine of the 12 IHS Areas showed increases from 2013 to 2014. The high number of sealants represents a notable accomplishment for the IHS DHP as significant numbers of susceptible tooth surfaces are now protected by dental sealants. In FY 2014, the 14.5 percent dental sealant performance goal was exceeded with a resultant 14.6 percent performance. This is also an increase from the 13.9 percent performance in FY 2013. Nine of the 12 IHS Areas showed increases in the proportion of patients with at least one or more intact dental sealants in the age 2 to 15 year-old age group.

The IHS Early Childhood Caries (ECC) Collaborative targeted to pre-school age children, ages 0 – 5 years, as it is in this age group that ECC originates. The 5-year IHS ECC Collaborative, aimed at preventing early childhood caries through increased preventive services, began in FY 2010 and ended September 30, 2014. A Basic Screening Survey (BSS) of approximately 12,000 AI/AN preschool children, identical to the 2010 BSS of 8,451 AI/AN preschool children, was completed November 30, 2014 and supplied data necessary for the final evaluation of the ECC Collaborative, which is currently under review. In FY 2015, the lessons learned will be developed and shared throughout IHS, Tribal, and Urban dental programs and will be emphasized in future IHS Continuing Dental Education (CDE) training to ensure identified effective ECC interventions continue.

In recent years, the IHS DHP has utilized field dental programs in conjunction with its Dental Clinical and Preventive Support Centers (DSC) to achieve national performance objectives and IHS Area initiatives. The DSCs were designed and implemented in FY 1999 and FY 2000 to augment the dental public health infrastructure necessary to best meet the oral health needs of AI/AN communities. Currently there are eight DSCs, four are funded by program awards and four are funded through grants. The primary purpose of a DSC is to provide technical support, training, and assistance in clinical and preventive aspects of dental programs providing care to AI/AN communities. As a direct result of the advocacy efforts of the DSCs, the number of key preventive procedures has increased significantly in recent years. For example, the number of dental sealants placed per year has tripled in the last decade, and the number of patients receiving

topical fluoride treatments has more than doubled in the last five years. In FY 2013, the DHP began tracking the coverage or prevalence of children and adolescents receiving sealants and topical fluoride, rather than simply counting procedures. These assessments allow improved comparisons with data from the U.S. population compiled by the Healthy People 2020 initiative.

Congressional appropriations created initial funding for the DSCs in FYs 1999 and 2000. In the ensuing years, these DSCs had an immediate positive impact on the direct delivery of dental care in a number of ways:

- All centers advocated for an appropriate focus on the dental GPRA performance objectives to increase specific clinical services.
- All centers provided continuing education opportunities to enhance the quality of care delivered.
- Several centers provided on-site clinical and community based program reviews to enhance the quality of care, assuring that field programs maintained a high level of expertise with respect to challenges such as infection control, The Joint Commission accreditation and certification preparedness, and patient scheduling practices aimed at maximizing access to care.
- Several centers provided an array of health education materials or designed materials customized to the specific needs of the IHS Areas they serve. These materials have increased the quality of IHS oral health education efforts throughout Indian Country.
- Several centers provided direct clinical services that otherwise would not have been provided.

The aggregate accomplishments of the DSCs have resulted in an increase in clinical preventive care, an increase in overall clinical services, and an enhancement of the quality of clinical and community based care delivered by the dental field programs.

The IHS DHP will continue efforts to recruit and retain dental providers to improve dental access, strengthen the IHS dental infrastructure and workforce, and to meet all annual performance objectives. Recent activities to support improvements in meeting annual performance objectives include:

- Overseeing an ongoing annual surveillance of oral health. In FY 2013, the program began an assessment of the DSCs project. During FY 2014, three support centers have undergone comprehensive, on-site evaluations, completing a long-term assessment of all eight centers. Additional ongoing feedback is provided to all centers via response to their quarterly reports by their project officer. Overall challenges include support for data analytic work needed to ensure timely feedback based on program data to field programs.
- Using the quarterly GPRA Dashboard and providing IHS Area-specific reports to each of the 12 IHS Area Dental Officers (ADO). Areas with performance measures that are not on target are provided assistance through a webinar to discuss measure performance as well as provide ideas and allow for brainstorming to improve measure performance.
- Monitor the oral health status of AI/ANs to determine disparities in oral disease burden and to serve as a foundation for prevention and treatment priorities in the IHS dental programs.
- Promote the adoption and meaningful use of health information technology through the IHS Electronic Dental Record (EDR).
- Promote evidence-based practices in health promotion and disease prevention, including the integration of oral and primary health care and improving oral health literacy.

FUNDING HISTORY

Fiscal Year	Amount
2011 Omnibus	$152,634,000
2012 Enacted	$159,440,000
2013 Enacted	$156,653,000
2014 Final	$165,290,000
2015 Enacted	$173,982,000

BUDGET REQUEST

The FY 2016 budget request for Dental Health Services of $181,459,000 is an increase of $7,477,000 above the FY 2015 Enacted level.

FY 2015 Base Funding of $173,982,000
The base funding is necessary to support the oral health care services provided by IHS and Tribal programs, maintain the program's progress in raising the quality of and access to oral care through continuing recruitment of oral health care professionals to meet workforce needs, and to meet or exceed agency targets.

FY 2016 Funding Increase of $7,477,000 includes:

- Inflation +$1,869,000 – to cover inflationary costs of providing health care services.

- Population Growth +$2,500,000 – to fund the additional services need arising from the growing AI/AN population. The growth rate is projected to be 1.8 percent in CY 2016 based on state births and deaths data.

- Pay Costs +$1,400,000 – to cover pay raises for federal and Tribal employees of which about 90 percent are working at the service unit level providing health care and related services.

- Staffing/Operating Cost Requirements for Newly Constructed Facilities +$1,708,000 – Dental funding is requested for two new and expanded healthcare facilities that are planned to open in FY 2016. Funding for two facilities allows IHS to expand provision of health care in those areas where capacity has been expanded to address critical health care needs.

Staff and Operating Costs for New Facility	Amount	FTE/Tribal Positions
Choctaw Alternative Rural Healthcare Center (JV), Choctaw, MS	$1,504,000	15
Ft. Yuma Health Center, Winterhaven, CA	$204,000	2
Grand Total:	**$1,708,000**	**17**

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result/ Target for Recent Result/ (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
12: **Topical Fluorides:** Percentage of American Indian and Alaska Native patients ages 1 to 15 years old receiving one or more topical fluoride applications.	FY 2014: 27.9% Target: 26.7% (Target Exceeded)	26.4%	28.3%	+1.9%
13: **Dental Access:** Percent of all American Indian/Alaska Native patients who receive dental services.	FY 2014: 28.8% Target: 29.2% (Target Not Met but Improved)	27.9%	29.3%	+1.4%
14: **Dental Sealants:** Percentage of American Indian/Alaska Native patients ages 2-15 years old with at least one or more intact dental sealant.	FY 2014: 14.6% Target: 13.9% (Target Exceeded)	14.1%	14.8%	+0.7%

Evidence based interventions are utilized to achieve all key outcomes (i.e., increased access to care, an increased number of children with dental sealants, and an increased number of children receiving topical fluoride applications). There is ample, well documented, and replicated evidence that strongly suggests dental sealants and applications of topical fluoride prevent dental decay.[3, 4] Likewise, there is well documented evidence of the efficacy of periodic oral examinations and access to clinical care in controlling the prevalence and severity of oral disease.[5, 6]

Observed trends over the past decade with regard to all three dental objectives are highly positive:

- The number of dental sealants placed per year and documented by the IHS GPRA program has increased by 34 percent since FY 2004.
- The number of patients receiving topical fluoride applications as documented by the IHS GPRA program has increased 99 percent since FY 2004, a virtual doubling of the number of individuals benefiting from this proven decay preventive measure.
- Approximately 24 percent of the user population accessed the dental program in FY 2006. As of FY 2014, approximately 28 percent have access to the dental program.

[3] Ripa, Louis W. Sealants Revisited: An Update of the Effectiveness of Pit and Fissure Sealants. Caries Research, vol. 27, Suppl. #1, 1993. Pp. 77-82.
[4] American Dental Association Council on Scientific Affairs. Professionally applied topical fluoride: Evidence based clinical recommendations. JADA 2006: vol. 137(8): p. 1151-9.
[5] National Institute of Dental and Craniofacial Research, National Institutes of Health. Oral Health in America: A Report of the Surgeon General. Rockville, M.D.: U.S. Department of Health and Human Services, NIDCR, NIH, 2000.
[6] National Institute of Dental and Craniofacial Research, National Institutes of Health. Office of the Surgeon General. A national call to action to promote oral health. Rockville, M.D.: U.S. Department of Health and Human Services, NIDCR, NIH, 2003.

GRANTS AWARDS

CFDA No. 93.933—Demonstration Projects for Indian Health			
	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	4	4	4
Average Award	$249,998	$249,998	$249,998
Range of Awards	$249,996-250,000	$249,996-250,000	$249,996-205,000
Total Awards	**$1,000,000**	**$1,000,000**	**$1,000,000**

AREA ALLOCATION

Dental Health

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2014 Final			FY 2015 Enacted			FY 2016 President's Budget			FY '16 +/- FY '15
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$6,061	$11,411	$17,472	$6,064	$12,330	$18,394	$6,224	$12,960	$19,184	$790
Albuquerque	6,609	12,444	19,054	6,613	13,446	20,059	6,788	14,134	20,921	862
Bemidji	2,949	5,553	8,502	2,951	6,000	8,950	3,029	6,306	9,335	385
Billings	1,510	2,844	4,354	1,511	3,073	4,584	1,551	3,230	4,781	197
California	2,639	4,968	7,607	2,640	5,368	8,008	2,710	5,643	8,352	344
Great Plains	693	1,305	1,998	693	1,410	2,103	712	1,482	2,194	90
Nashville	999	1,881	2,880	999	2,032	3,032	1,026	2,136	3,162	130
Navajo	10,418	19,615	30,033	10,424	21,195	31,619	10,699	22,278	32,977	1,359
Oklahoma	12,515	23,563	36,078	12,522	25,461	37,983	12,853	26,762	39,615	1,632
Phoenix	4,758	8,959	13,718	4,761	9,681	14,442	4,887	10,175	15,062	621
Portland	2,701	5,086	7,787	2,702	5,495	8,198	2,774	5,776	8,550	352
Tucson	657	1,237	1,893	657	1,336	1,993	674	1,404	2,079	86
Headquarters	4,817	9,069	13,886	4,819	9,799	14,619	4,947	10,300	15,247	628
Total, Dental	**$57,326**	**$107,934**	**$165,260**	**$57,356**	**$116,626**	**$173,982**	**$58,872**	**$122,587**	**$181,459**	**+$7,477**

Note: Allocation amounts are estimates.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Services: 75-0390-0-1-551
MENTAL HEALTH

(Dollars in Thousands)

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA*	$77,980	$81,145	$84,485	+$3,340
FTE**	196	222	223	+1

* New investments in behavioral health are listed under the Alcohol and Substance Abuse Programs section.
**FTE numbers reflect only federal staff and do not include Tribal staff.

Authorizing Legislation .....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended 2010

FY 2016 Authorization.....Permanent

Allocation Method.....Direct Federal; P.L. 93-638 Self-Determination compacts and contracts

PROGRAM DESCRIPTION and ACCOMPLISHMENTS

The IHS Mental Health/Social Services (MH/SS) Program is a community-based clinical and preventive service program that provides vital outpatient mental health counseling and access to dual diagnosis services, mental health crisis response and triage, case management services, community-based prevention programming, and outreach and health education activities. For information on the new youth focused Tribal Behavioral Health Initiative for Native Youth, please see the Methamphetamine and Suicide Prevention Initiative listed under the Alcohol and Substance Abuse Programs. The most common MH/SS Program model is an acute, crisis-oriented outpatient service staffed by one or more mental health professionals providing individual, family, and group psychotherapeutic services and case management. After hour emergency services are generally provided through local emergency departments, and service units will often contract with non-IHS hospitals and crisis centers for such services. Inpatient services are generally purchased from non-IHS hospitals or provided by state or county mental health hospitals. Intermediate level services such as group homes, transitional living support, intensive case management, and related activities are sometimes available, but generally are not reimbursable through IHS mechanisms. Therefore, access to intermediate level services is typically offered through state and local resources. Additionally, slightly more than one-half of the Tribes administer and deliver their own mental health programs. Therefore, the IHS MH/SS program assists Tribes in bringing programs and program collaborations to their own communities.

This aligns and integrates the Department's Strategic Goal 1: Strengthen Health Care under Objective E by ensuring AI/ANs have access to quality, culturally competent care. By focusing on the program's achievement of the Department's Strategic Plan, the agency's program integrity and performance management activities have been successfully integrated. Evaluating additional program risks for other metrics is currently under the planning phase.

Across Indian Country, the high incidence of alcohol and substance abuse, mental health disorders, suicide, violence, and behavior-related chronic diseases is well documented.[1] Each of these serious behavioral health issues has a profound impact on the health of individuals, public health, and community well-being both on- and off-reservations. The MH program supports the Department's performance goal to increase the proportion of adults ages 18 and over who are screened for depression in an effort to identify and treat symptoms before feelings of sadness, hopelessness, worthlessness, nervousness, or restlessness escalate into serious psychological distress or even suicide.

Specific focus areas for the IHS MH/SS Program are:

Suicide Prevention: During 2005–2007, the suicide rate for AI/AN was 1.7 times greater than the U.S. all-races rate for 2006 (19.0 vs. 10.9 per 100,000).[2]

IHS has developed a suicide surveillance reporting tool to document incidents of suicide in a standardized and systematic fashion. The suicide surveillance tool captures data related to a specific incident of suicide, including date and location of act, method, contributing factors, and other useful epidemiological information to better understand the issue or identified risk and target resources appropriately.

Information Systems Supporting Behavioral Health Care: The Resource and Patient Management System (RPMS) is the IHS enterprise health information system that underlies the clinical, practice management and revenue cycle business processes at IHS, Tribal, and Urban health care facilities across the country. RPMS includes functionality designed to meet the unique business processes of behavioral health (BH) providers and support BH-related initiatives. Standardized instruments and clinical decision support tools are available to support routine and effective screening for alcohol and substance use, depression, domestic violence and smoking status. Additionally, surveillance tools are available to capture suicide data at the point of care.

Aggregate national RPMS behavioral health data is maintained to support local, national and other program reporting requirements as well as quality performance measurement for numerous screening and prevention initiatives including alcohol and substance use, depression, domestic violence, and smoking, and suicide data collection.

Child/Family Protection: According to the National Child Abuse and Neglect Data System, an estimated 686,000 children were exposed to incidents of child abuse and neglect in 2012. These data translate to a rate of 9.2 occurrences of child abuse and neglect for every 1,000 children per year.[3] Family violence affects all members of the community, but AI/AN women and children are particularly vulnerable to abuse. To help victims of violence, IHS provides direct services, advocacy, interagency consultation, and collaboration with other federal agencies to provide AI/AN child and family protection services. Through its newly developed Tribal Forensic Healthcare Training Project, IHS provides critical training on family violence to IHS, Tribal, and Urban Indian health care providers through in-person and online courses, clinical skills training, and webinars.[4]

[1] U.S. Department of Health and Human Services. (2001). Mental Health: Culture, Race, Ethnicity Supplement to Mental Health: Report of the Surgeon General
[2] IHS Newsroom: Mortality Disparity Rates. *Available at* http://www.ihs.gov/newsroom/factsheets/disparities/.
[3] U.S. Department of Health & Human Services. Administration for Children and Families. (2012). Child Maltreatment. Available at http://www.acf.hss.gov/programs/cb/stats_research/index.htm#can
[4] Tribal Forensic Healthcare Training. *Available at* http://www.ihs.gov/forensichealthcare/training.

Partnerships: IHS has devoted considerable effort to develop and share effective programs throughout the Indian health system. The Agency believes developing programs that are collaborative, community driven, and nationally supported offer the most promising potential for long term success and sustainment. Through partnership and consultation, IHS and Tribes are working together to improve the health of AI/AN communities.

Strategies to address mental health and suicide include collaborations and partnerships with consumers and their families, Tribes and Tribal organizations, Urban Indian health programs, federal, state, and local agencies, as well as public and private organizations. IHS leads the AI/AN Task Force of the National Action Alliance for Suicide Prevention. This effort seeks to establish effective long-term strategic approaches to address mental health and suicide prevention in Indian Country.

Integration of Behavioral Health into Primary Care: In FY 2016, IHS will continue to focus on integration of behavioral health into primary care. IHS supports changing the paradigm of mental health and substance abuse disorder services from being episodic, fragmented, specialty, and/or disease focused to being a part of primary care and the medical home. The medical home is an accessible and patient-centered system of care that provides safe, timely, effective, efficient, and equitable care. This offers new opportunities for interventions that identify high-risk individuals before their actions or behavior becomes more clinically significant.

FUNDING HISTORY

Fiscal Year	Amount
2011 Omnibus	$72,786,000
2012 Enacted	$72,786,000
2013 Enacted	$74,131,000
2014 Final	$77,980,000
2015 Enacted	$81,145,000

BUDGET REQUEST

The FY 2016 budget request for Mental Health of $84,485,000 is an increase of $3,340,000 above the FY 2015 Enacted level.

FY 2015 Base Funding $81,145,000
The base funding is necessary to maintain the program's progress in addressing the behavioral health needs, including improving access to behavioral health services, addressing suicide prevention, intervention, and postvention in communities, supporting suicide surveillance, and clinical best practices.

FY 2016 Funding Increase of $3,340,000 includes:

- Inflation +$1,006,000 – to cover inflationary costs of providing health care services.

- Population Growth +$1,285,000 – to fund the additional services need arising from the growing AI/AN population. The growth rate is projected to be 1.8 percent in CY 2016 based on state births and deaths data.

- Pay Costs +$616,000 – to cover pay raises for federal and Tribal employees of which about 90 percent are working at the service unit level providing health care and related services.

- Staffing/Operating Cost Requirements for Newly Constructed Facilities +$433,000 – Mental health funding is requested for two new and expanded healthcare facilities that are planned to open in FY 2016. Mental health funding for 2 of these facilities allows IHS to expand provision of health care in those areas where capacity has been expanded to address critical health care needs.

Staff and Operating Costs for New Facility	Amount	FTE/Tribal Positions
Choctaw Alternative Rural Healthcare Center (JV), Choctaw, MS	$339,000	3
Ft. Yuma Health Center, Winterhaven, CA	$94,000	1
Grand Total:	**$433,000**	**4**

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result/ Target for Recent Result (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
29. **Suicide Surveillance:** Increase the incidence of suicidal behavior reporting by health care (or mental health) professionals.	FY 2014: 1,766 Target: 1,668 (Target Exceeded)	1,419	1,798	+379
18. **Behavioral Health:** Proportion of adults ages 18 and over who are screened for depression. IHS-All	FY 2014: 66.0% Target: 66.9% (Target Not Met but Improved)	64.3%	67.2%	+2.9%
18. Tribally Operated Health Programs	FY 2014: 61.1% Target: 61.5% (Target Not Met but Improved)	59.2%	62.2%	+3.0%

Depression is often an underlying component contributing to suicide, accidents, domestic/ intimate partner violence, and alcohol and substance abuse. Early identification of depression allows providers to plan interventions and treatment to improve the mental health and well-being of AI/AN people who experience depression. Tools have been selected to assess depression, monitor response, and track the response over time. The screening tools and results are incorporated into the IHS Electronic Health Record The system is now deployed and in operation in over 400 sites out of 657 IHS, Tribal, and urban Indian facilities across the country.

IHS made significant progress in improving performance results related to depression screening in recent years. During 2012–2013 and 2013–2014, the denominator increased 1.5 percent for a cumulative total of 16,490 new patients. This large increase in the denominator contributed the FY 2014 result of missing the higher target by 0.9 percent, and other contributing factors included staff turnover, recruitment of new staff unfamiliar with screening processes, and decreases in screening numbers among certain IHS Service Areas. To meet the FY 2016 target, the Agency

will provide standardized training on screening techniques and documentation in the electronic health record through the Tele-Behavioral Health Center of Excellence.

In FY 2016, IHS will continue to provide training on the Suicide Reporting Form (SRF) and emphasize the importance of suicide surveillance activities among providers, facility and Area managers, and administrators. Similarly, RPMS Site Managers and Electronic Health Record Clinical Application Coordinators will continue annual training on the SRF and the appropriate application set-up and exporting processes. IHS will continue to work with its public and private partners to implement the National Strategy for Suicide Prevention's fourth strategic direction, which addresses suicide prevention surveillance, research, and evaluation activities.

Fiscal Year 2013 and 2014 data for the SRF provided a more accurate benchmark for future target measures. The Agency anticipates the continued use of the SRF among providers in FY 2016 and anticipates meeting its target measure.

GRANTS AWARDS - The program does not anticipate any grant awards in FY 2016.

AREA ALLOCATION

Mental Health

(dollars in thousands)

DISCRETIONARY	FY 2014 Final			FY 2015 Enacted			FY 2016 President's Budget			FY '16 +/- FY '15
SERVICES	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$2,914	$6,894	$9,809	$2,914	$7,292	$10,207	$2,991	$7,636	$10,627	$420
Albuquerque	1,885	4,459	6,343	1,885	4,716	6,601	1,934	4,938	6,873	272
Bemidji	1,311	3,100	4,411	1,311	3,280	4,590	1,345	3,434	4,779	189
Billings	687	1,626	2,313	687	1,720	2,407	705	1,801	2,506	99
California	1,165	2,756	3,921	1,165	2,915	4,080	1,196	3,052	4,248	168
Great Plains	602	1,425	2,028	602	1,508	2,110	618	1,579	2,197	87
Nashville	525	1,242	1,768	525	1,314	1,839	539	1,376	1,915	76
Navajo	4,334	10,253	14,587	4,334	10,845	15,179	4,448	11,356	15,804	625
Oklahoma	4,089	9,672	13,761	4,089	10,231	14,320	4,197	10,713	14,909	589
Phoenix	2,275	5,382	7,657	2,275	5,693	7,968	2,335	5,961	8,296	328
Portland	1,242	2,937	4,178	1,242	3,106	4,348	1,274	3,253	4,527	179
Tucson	440	1,040	1,480	440	1,100	1,540	451	1,152	1,603	63
Headquarters	1,701	4,023	5,724	1,701	4,255	5,956	1,745	4,456	6,201	245
Total, MH	**$23,170**	**$54,810**	**$77,980**	**$23,170**	**$57,975**	**$81,145**	**$23,780**	**$60,705**	**$84,485**	**+$3,340**

Note: Allocation amounts are estimates.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Services: 75-0390-0-1-551

ALCOHOL AND SUBSTANCE ABUSE

(Dollars in Thousands)

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$186,378	$190,981	$227,062	+$36,081
FTE*	176	224	256	+32

*FTE numbers reflect federal staff only and do not include Tribal staff.

Authorizing Legislation .....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended 2010

FY 2016 Authorization.....Permanent

Allocation Method.....Direct Federal; P.L. 93-638 Self-Determination contracts and compacts

PROGRAM DESCRIPTION and ACCOMPLISHMENTS

Alcoholism, addiction, and alcohol and substance abuse are among the most severe public health and safety problems facing American Indian and Alaska Native (AI/AN) individuals, families, and communities. The purpose of the Indian Health Service (IHS) Alcohol and Substance Abuse Program (ASAP) is to raise the behavioral health status of AI/AN communities to the highest possible level through a comprehensive array of preventive, educational, and treatment services that are community-driven and culturally competent. The ASAP addresses the Agency's priorities to renew and strengthen our partnership with Tribes, improve the quality of and access to care through these collaborative activities, and works to integrate behavioral health into primary care. Additionally, the ASAP aligns and integrates the Department's Strategic Goal 1: Strengthen Health Care under Objective E by ensuring American Indians and Alaska Natives have access to quality, culturally competent care.

In general, AI/AN populations suffer disproportionately from substance abuse disorders compared with other racial groups in the United States. In a 2010 report from the National Survey on Drug Use and Health, the rates of past-month-binge alcohol use and illicit drug use were higher among AI/AN adults compared to national averages (30.6 percent vs. 24.5 percent and 11.2 percent vs. 7.9 percent, respectively) and the percentage of AI/AN adults who needed treatment for an alcohol or illicit drug use problem in the past year was nearly double the national average for adults (18.0 percent vs. 9.6 percent).[1]

Alcohol and substance abuse in AI/AN communities results in devastating intergenerational social, economic, physical, mental, and spiritual health disparities. Alcohol and substance abuse among the AI/AN populations contribute to high rates of mortality from liver disease, unintentional injury, and suicide. AI/AN communities suffer from some of the highest rates of Fetal Alcohol Spectrum Disorders (FASD) in the nation, and the damaging effects of alcohol use to the fetus during pregnancy are permanent and the leading cause of preventable intellectual

[1] Substance Abuse and Mental Health Services Administration, Office of Applied Studies (June 24, 2010). *The NSDUH Report: Substance Use among American Indian or Alaska Native Adults*, Rockville, MD.

disability. Methamphetamine and other drug abuse are becoming more serious problems among AI/AN people, compounding the current adverse effects of alcohol and substance abuse. For example, the age-adjusted[2] drug related death rate for AI/ANs is 15.0 per 100,000 population (2002-2004) and is 1.5 times greater than the U.S. all races rate of 9.9 per 100,000 population (2003).[3]

As alcohol and substance abuse treatment and prevention have transitioned from IHS direct care services to local community control via Tribal contracting and compacting, IHS' role has transitioned to providing support to enable communities to plan, develop, and implement culturally-informed programs. Organized to develop programs and program leadership, the major IHS ASAP activities and focus areas are:

Integrated Substance Abuse Treatment: IHS continues to support the integration of substance abuse treatment into primary care and emergency services through its activities to implement the National Drug Control Strategy. Integrating treatment into health care offers immediate and same-day opportunities for health care providers to identify patients with substance use disorders, provide them with medical advice, help them understand the health risks and consequences, obtain substance abuse consultations, and refer patients with more severe substance use-related problems to treatment.[4] One integration activity is Screening, Brief Intervention, Referral to Treatment (SBIRT), which is an early intervention and treatment service for people with substance use disorders and those at risk of developing these disorders. IHS is broadly promoting SBIRT as an integral part of a sustainable primary care-based behavioral health program through reimbursement from the Center for Medicare and Medicaid Services (CMS). Another activity is Medication Assisted Treatment (MAT) for opioid addiction, which is an approach that uses Food and Drug Administration approved pharmacological treatments, often in combination with psychosocial treatments, for patients with opioid use disorders.[5] IHS will continue to provide the necessary MAT training through its Tele-Behavioral Health Center of Excellence (TBHCE) for IHS, Tribal, and Urban Indian healthcare providers.

Youth Regional Treatment Centers (YRTCs): YRTCs provide residential substance abuse and mental health treatment services to AI/AN youth. Congress authorized the establishment of these YRTCs in each of the 12 IHS Areas, with two (northern and southern) specifically authorized for the California Area. The Southern California facility is expected to open in FY 2015. Some Tribes within certain IHS Areas (e.g., Bemidji and Billings) elected not to construct YRTCs but to contract for similar services. The Alaska Area divided their funds to provide residential treatment services for two programs.

Fetal Alcohol Spectrum Disorders (FASD): Since 1983, the IHS has funded the Fetal Alcohol and Drug Unit (FADU), located within the University of Washington's Alcohol and Drug Abuse Institute. Over 300 high-risk, substance-abusing pregnant and parenting women and their families have received evaluation, diagnosis, and referral services through the FADU. Additionally, the FADU has provided training and technical assistance to over 4,400 healthcare providers and AI/AN community members on FASD prevention and intervention topics. The IHS also has increased the alcohol screening rate nine-fold from seven percent in 2004 to 66 percent in 2014 through promoting and incorporating alcohol screening as a routine part of

[2] Rates have been adjusted to compensate for misreporting of AI/AN race on state death certificates.
[3] U.S. Department of Health and Human Services. Indian Health Service. Trends in Indian Health, 2002-2003 Edition. Washington: Government Printing Office, Released October 2009. ISSN 1095-2896. p. 195.
[4] U.S. Office of National Drug Control Policy. Integrating Treatment into Healthcare. *Available at* http://www.whitehouse.gov/ondcp/integrating-treatment-and-healthcare.
[5] U.S. Office of National Drug Control Policy. Medication Assisted Treatment for Opioid Addiction. *Available at* http://www.whitehouse.gov/sites/default/files/ondcp/recovery/medication_assisted_treatment_9-21-20121.pdf.

women's health care. Screening with intervention has been shown to be effective in reducing alcohol misuse during pregnancy and to reduce the incidence of FAS.

Methamphetamine and Suicide Prevention Initiative (MSPI): The MSPI is a nationally-coordinated demonstration/pilot program providing targeted methamphetamine and suicide prevention and intervention resources that are culturally appropriate to communities in Indian Country with the greatest need for these programs. The annual appropriation supports 130 pilot projects that support the use and development of innovative practice-based and evidence-based interventions administered by the communities themselves. These model projects are connected to the entire national network of recipients to share program, service, and evaluation information. All MSPI pilot projects are community developed and delivered and represent the growing support from IHS to help communities address the dual crises of methamphetamine abuse and suicide in Indian Country. The evaluation of the MSPI Program is showing progress in service provision, education, training and implementation of evidence based practices. National program evaluation is a central component to the MSPI and is the last phase of the demonstration project. The national evaluation is scheduled to be complete in FY 2016 and will be used to identify successful practice-based and evidenced interventions that can be replicated across the Indian health system. The MSPI program utilizes a data collection tool for IHS, tribal, and urban Indian projects to collect a rich and wide range of data informed by knowledge gained through process and outcome measurement. A new data has been completed and will replace the paper reporting form. It will eliminate the need for contract services to perform data collection and analytics.

Tele-Behavioral Health and Workforce Development: Workforce development is also an essential part of effectively addressing mental health and substance abuse issues in AI/AN communities. The ASAP incorporates tele-behavioral health technology as a means to increase access to behavioral health services. Established in 2008, the Telebehavioral Health Center of Excellence (TBHCE) in Albuquerque, New Mexico, provides a range of behavioral health services and technical assistance via televideo. Intra-Agency agreements continue between the TBHCE and Billings, Great Plains, Navajo, Phoenix, Nashville, and Tucson Areas. In FY 2014 over 8,200 patient encounters were provided nationally via tele-behavioral health. The TBHCE also provides a robust weekly schedule to meet the training needs of IHS, Tribal, and Urban Indian health care providers. In 2014, and in partnership with the University of New Mexico, the TBHCE conducted webinar training for over 8,600 participants on current and pressing behavioral health issues, including a concentrated focus on substance use disorders.

Information Systems Supporting Behavioral Health Care: The Resource and Patient Management System (RPMS) includes functionality designed to meet the unique business processes of behavioral health (BH) providers and support BH-related initiatives. Standardized instruments and clinical decision support tools are available to support routine and effective screening for alcohol and substance use, depression, domestic violence and smoking status. Additionally, surveillance tools are available to capture suicide data at the point of care. Aggregate national RPMS behavioral health data is maintained to support local, national and other program reporting requirements as well as quality performance measurement for numerous screening and prevention initiatives including screening for alcohol and substance use, depression, domestic violence, smoking, and suicide data collection.

Partnerships: IHS is collaborating with other agencies working in the field of substance disorders such as the Substance Abuse and Mental Health Services Administration (SAMHSA), Veterans Health Administration, Health Resources and Services Administration, Office of National Drug Control Policy, and CMS to ensure that the best available information, training, protocols,

evaluations, performance measures, data needs, and management skills are incorporated and shared with all agencies and organizations working on substance use disorders.

The Department of the Interior (DOI) through the Bureau of Indian Affairs (BIA), the Bureau of Indian Education (BIE), and the IHS have a Memorandum of Agreement (MOA) on Indian Alcohol and Substance Abuse Prevention, which was amended in 2011 as a result of the permanent reauthorization of the Indian Health Care Improvement Act. Through this MOA, BIA, BIE, and IHS coordinate and implement plans in cooperation with Tribes to assist Tribal governments in their efforts to address behavioral health issues. The MOA includes coordination of data collection, resources, and programs of IHS, BIA, and BIE.

The Tribal Law and Order Act (TLOA) requires interagency coordination and collaboration among HHS (IHS and SAMHSA), DOI (BIA/BIE), Department of Justice (Office of Justice Programs/Office of Tribal Justice), and the Office of the Attorney General. The leverage and coordination of Federal efforts and resources will assist in determining both the scope of alcohol and substance abuse problems as well as effective prevention and treatment programs. The MOA required by Section 241 of the TLOA was signed on July 29, 2011 by the Secretaries of the Departments of Health and Human Services and the Interior and the Attorney General to: (1) determine the scope of the alcohol and substance abuse problems faced by Tribes; (2) identify and delineate the resources each entity can bring to bear on the problem; (3) set standards for applying those resources to the problems; and (4) coordinate existing agency programs.

FUNDING HISTORY

Fiscal Year	Amount	MSPI
2011 Omnibus	$194,409,000	($16,332,045)
2012 Enacted	$194,297,000	($16,332,045)
2013 Enacted	$185,154,000	($15,512,557)
2014 Final	$186,378,000	($15,512,557)
2015 Enacted	$190,981,000	($15,512,557)

BUDGET REQUEST

The FY 2016 budget request for Alcohol and Substance Abuse of $227,062,000 is an increase of $36,081,000 above the FY 2015 Enacted level.

FY 2015 Base Funding of $190,981,000 - The base funding is necessary to maintain the program's progress in addressing alcohol and substance abuse needs by improving access to behavioral health services through tele-behavioral health efforts and providing a comprehensive array of preventive, educational, and treatment services.

FY 2016 Funding Increase of $27,990,000 includes:

- Inflation +$2,869,000 – to cover inflationary costs of providing health care services.

- Population Growth +$3,888,000 – to fund the additional services need arising from the growing AI/AN population. The growth rate is projected to be 1.8 percent in CY 2016 based on state births and deaths data.

- Pay Costs +$1,334,000 – to cover pay raises for federal and Tribal employees of which about 90 percent are working at the service unit level providing health care and related services.

- Staffing/Operating Cost Requirements for Newly Constructed Facilities +$2,990,000 – Alcohol and Substance Abuse funding is requested for one new and expanded health care facility and one youth regional treatment center that are planned to open in FY 2016. Funding for these facilities allows IHS to expand provision of health care in those areas where capacity has been expanded to address critical health care needs.

Staff and Operating Costs for New Facility	Amount	Tribal Positions
Southern California Youth Treatment Center, Hemet, CA	$2,888,000	32
Choctaw Alternative Rural Healthcare Center (JV), Choctaw, MS	$102,000	1
Grand Total:	**$2,990,000**	**33**

Tribal Behavioral Health Initiative for Native Youth – MSPI Expansion +$25,000,000 – Over 40 percent of AI/AN people are under the age of 24 and face negative health, education, and economic disparities in Indian Country in comparison to the general population.[6] These negative disparities are a high priority for Tribal leaders to address within their communities. In response, IHS and SAMHSA are collaborating on Tribal Behavioral Health Initiative for Native Youth (TBHINY) program to improve behavioral health outcomes for AI/AN communities as part of the government-wide Generation Indigenous initiative, created to remove the barriers to success for Native youth.

Specifically, the TBHINY responds to requests from Tribal leaders to: (1) improve access to behavioral health prevention efforts and treatment services for AI/AN youth; (2) address issues that lead to increased rates of suicide and substance abuse and opportunities to promote mental health; and (3) increase the number of behavioral health staff positions focused on child, adolescent, and family services.

IHS' successful MSPI provides an existing successful program to enhance and respond to the requests of Tribal leaders to improve behavioral health outcomes for Native youth. Through the original MSPI, developed in 2009, IHS funded 130 IHS, Tribal, and Urban Indian health programs to participate in a six year pilot demonstration project. This MSPI pilot demonstration phase promoted the use and development of evidence-based and practice-based models that represented culturally-appropriate prevention and treatment approaches to methamphetamine abuse and suicide prevention. Over 85 percent of these MSPI projects focused on positive development activities, prevention, behavioral health treatment, and wraparound aftercare services for AI/AN youth. Those projects provided over 500,000 evidence-based and practice-based youth encounters in the first five years of implementation. This early success of the MSPI revealed strength-based interventions, such as the protective role of culture, social connectedness, and cultural activities as being central to AI/AN wellness, especially for prevention of suicide and substance abuse efforts.

To further promote the successes of the MSPI, the TBHINY presents an opportunity to fund additional MSPI projects to focus on additional behavioral health prevention efforts in their communities, with a focus on additional supports and behavioral health providers for Native youth. IHS has found, through the MSPI pilots and through other work, that one of the fundamentals to helping Native youth is access to behavioral health professionals that are trained in culturally tailored interventions. The expansion of MSPI would offer Tribes the flexibility to address methamphetamine abuse, suicide prevention, evidence-based interventions for AI/AN youth, increasing the behavioral health workforce, or a combination of those services.

[6] Center for Native American Youth. Why We Exist. *Available at*: http://cnay.org/WhyWeAreHere.html.

- The FY 2016 increase of $25,000,000 will be used as follows: $22,000,000 for direct funding awards for 200 IHS, Tribal, and Urban Indian health care programs. IHS will administer a new competition for a 5-year funding cycle and selection of awardees will be based on the priority areas to increase behavioral health staff and AI/AN youth-focused programming through local IHS, Tribal, and Urban Indian health care facilities, school-based settings, or other youth-based programs.
- $3,000,000 for national management, information technology systems for data collection and reporting, training and technical assistance, including continuing education, and national evaluation.

The expected annual accomplishments are increased access to behavioral health services for AI/AN youth and a strengthened behavioral health workforce. The planned performance measures to assess progress are:

- Number of BH providers recruited and hired under the projects;
- Number of professional staff trained to deliver prevention, intervention, and treatment services to AI/AN youth;
- Number of youth screened for substance abuse, depression, and/or suicide risk; and
- Number of youth receiving behavioral health services.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result/ Target for Recent Result (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
10. **YRTC Improvement/ Accreditation:** Accreditation rate for Youth Regional Treatment Centers (in operation 18 months or more)	FY 2014: 90% Target: 100% (Target Not Met)	100%	100%	0
11**. Alcohol Screening (FAS Prevention):** Alcohol-use screening (to prevent Fetal Alcohol Syndrome) among appropriate female patients. IHS-All	FY 2014: 66.0% Target: 65.9% (Target Exceeded)	66.7%	70.3%	+3.6%
11. Tribally Operated Health Programs	FY 2014: 61.9% Target: 61.6% (Target Exceeded)	62.4%	65.9%	+3.5%
ASA-5: Increase Tele-Behavioral Health Encounters Nationally	FY 2014: 8,298 No Target: Historical Actual	8,600	8,901	+301
Methamphetamine and Suicide Prevention Initiative (MSPI)				
ASA – 1: The number of identified meth using patients who enter methamphetamine treatment program *(Output)*	FY 2014: 1,957 Target: 2,177 (Target Not Met)	2,583	2,837	+254
ASA – 2: The number of youth	FY 2014:	161,651	171,124	+9,473

Measure	Year and Most Recent Result/ Target for Recent Result (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
(ages 6 – 21) who participate in evidence-based and/or promising practice prevention or intervention programs *(Output)*	111,448 Target: 133,970 (Target Not Met)			
ASA – 3: The number of individuals trained in suicide crisis response *(Output)*	FY 2014: 2,558 Target: 2,857 (Target Not Met)	3,178	3,434	+256
ASA – 4: Increase tele-behavioral health encounters *(Output)**	FY 2014: 2,971 Target: 3,094 (Target Not Met)	3,261	Retire	N/A

*ASA-4 is a tele-behavioral health encounter measure specific to MSPI. In FY 2016, IHS is proposing to retire ASA-4 and begin reporting on a new national tele-behavioral health encounter measure (ASA-5).

YRTC accreditation: The accreditation measure for YRTCs reflects an evaluation of the quality of care by either the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities (CARF), or State licensure. The 100 percent accreditation performance measure was not met in FY 2014 as a result of the ongoing difficulties experienced by one Tribally-operated YRTC. However, significant progress was made by the YRTC at the completion of a CARF site visit on November 17-18, 2014, and final accreditation was received in December 2014.

MSPI: From 2009-2014, the MSPI resulted in 9,477 individuals entering treatment for methamphetamine abuse; 12,194 encounters via tele-behavioral health; 13,151 professionals and community members trained in suicide crisis response; and 528,306 encounters with youth provided as part of evidence-based and practice-based prevention activities. Despite the overall success of the MSPI, its targets were not met for FY 2014. The decreases were multifactorial and similar to the mature phases of other demonstration projects when high visibility, high-outreach events are held less often. The largest contributing factor in the decline of measures was attributable to staff vacancies, with turnover affecting more than half of the projects. Recruitment, training, and certification of new staff is required before clinical services can be resumed. The final evaluation for year 5 of the MSPI is set to be complete in March 2015 which will enable IHS to measure another year of progress and identify additional attributable causes and remedies if similar results are achieved.

GRANTS AWARDS

CFDA No. 93.933 Demonstration Projects for Indian Health			
	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget*
Number of Awards	14	14	214
Average Award	$100,000	$100,000	$109,345
Range of Awards	n/a	n/a	n/a
Total Awards	$1,388,7450	$1,400,00	$23,400,000

***Note: FY 2016 amounts include 200 planned, competitive MSPI grants under the TBHINY.**

AREA ALLOCATION

Alcohol and Substance Abuse

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2014 Final			FY 2015 Enacted			FY 2016 President's Budget			FY '16 +/- FY '15
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$2,681	$11,070	$13,751	$2,681	$11,410	$14,091	$3,010	$13,743	$16,753	$2,662
Albuquerque	5,826	24,055	29,881	5,826	24,793	30,619	6,541	29,863	36,404	5,785
Bemidji	2,333	9,631	11,963	2,333	9,926	12,259	2,619	11,956	14,575	2,316
Billings	1,926	7,952	9,878	1,926	8,196	10,122	2,162	9,872	12,034	1,912
California	2,123	8,767	10,891	2,123	9,036	11,159	2,384	10,884	13,268	2,108
Great Plains	2,091	8,634	10,725	2,091	8,899	10,990	2,348	10,719	13,067	2,076
Nashville	1,688	6,970	8,658	1,688	7,183	8,871	1,895	8,652	10,547	1,676
Navajo	3,622	14,954	18,576	3,622	15,413	19,035	4,066	18,565	22,631	3,596
Oklahoma	2,955	12,199	15,153	2,955	12,573	15,528	3,317	15,144	18,461	2,934
Phoenix	3,178	13,122	16,300	3,178	13,525	16,703	3,568	16,291	19,859	3,156
Portland	3,105	12,821	15,927	3,105	13,215	16,320	3,486	15,917	19,403	3,083
Tucson	599	2,471	3,070	599	2,547	3,146	672	3,068	3,740	594
Headquarters	4,212	17,392	21,605	4,212	17,926	22,138	4,729	21,592	26,321	4,182
Total, ASA	**$36,339**	**$150,039**	**$186,378**	**$36,339**	**$154,642**	**$190,981**	**$40,796**	**$186,266**	**$227,062**	**+$36,081**

Note: Allocation amounts are estimates.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Services: 75-0390-0-1-551
PURCHASED/REFERRED CARE

(Dollars in Thousands)

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$878,575	$914,139	$984,475	+$70,336
FTE	0	0	0	0

Authorizing Legislation .....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended 2010

FY 2016 Authorization.....Permanent

Allocation Method..... Direct Federal, PL 93-638 Tribal Contracts and Compacts

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The Snyder Act provides the formal legislative authority for the expenditure of funds for the "relief of distress and conservation of health of Indians."[1] In 1934, Congress provided the specific authority to enter into medical services contracts for American Indians and Alaska Natives.[2] These, among other authorities[3] established the basis for IHS and the Purchased/Referred Care (PRC) Program.[4]

The PRC Program is integral to providing comprehensive health care services to eligible American Indians and Alaska Natives (AI/AN). The Indian health system delivers care through direct care services provided in an IHS, Tribal or Urban Indian Health Program facility (e.g., hospitals, clinics) and through PRC services delivered by non-IHS providers. The general purpose of the PRC Program is for IHS and Tribal facilities to purchase services from private health care providers in situations where:

1) No IHS or Tribal direct care facility exists,
2) The direct care element is not capable of providing required emergency and/or specialty care
3) The direct care element has an overflow of medical care workload, and
4) Full expenditure of alternate resources (e.g., Medicare, private insurance) has been met and supplemental funds are necessary to provide comprehensive care to eligible Indian people.

In addition to meeting the eligibility requirements for direct services at an IHS or Tribal facility, PRC eligibility is determined based on proof of residency within the Service Unit or Tribal PRC delivery Area; authorization of payment for the individual recommended medical service by a PRC authorizing official; medical necessity of the service and inclusion within the established

[1] The Snyder Act, Public Law 67-85, November 2, 1921, 25 U.S.C § 13.
[2] The Johnson O'Malley Act of April 16, 1934, as amended, 25 U.S.C. § 452.
[3] Transfer Act, 42 U.S.C. § 2001; Indian Health Care Improvement Act, as amended, 25 U.S.C § 1601, et seq.
[4] The Consolidated Appropriation Act of 2014, Public Law 113-76, January 18, 2014, adopted a new name for the IHS Contract Health Services (CHS) program to Purchased/Referred Care (PRC). The IHS will administer PRC in accordance with all law applicable to CHS.

Area IHS/Tribal medical/dental priorities; and full expenditure of all alternate resources (i.e., Medicare, Medicaid, private insurance, state or other health programs, etc.). Alternate resources must pay for services first because the PRC Program is the payer of last resort.[5] Services purchased may include hospital, specialty physician, outpatient, laboratory, dental, radiological, pharmaceutical, or transportation services.

When funds are not sufficient to purchase the volume of PRC services needed by the eligible population residing in the PRC delivery area of the local facility, IHS PRC regulations require IHS- and Tribally-operated PRC programs to use a medical priority system to fund the most urgent referrals first. Medical priority (MP) levels of care are defined as follow:

MP Level I – Emergent or Acutely Urgent Care Services are defined as threats to life, limb and senses
MP Level II – Preventive Care Services are routine prenatal care, diagnostics procedures
MP Level III – Specialty Services are considered ambulatory care which include inpatient and outpatient care services
MP Level IV – Chronic Tertiary and Extended Care Services are defined as requiring rehabilitation services, skilled nursing facility care
MP Level V – Excluded Services are services and procedures that are considered purely cosmetic in nature, i.e., plastic surgery

A Medicare-like rate is used to purchase all hospital-based health care services and allows IHS to purchase care at a lower cost than if each service were negotiated individually. Physician and non-hospital provider based services are paid at a billed charges rate unless contracts are negotiated with individual providers of care. Program funds are administered and managed at IHS Headquarters, at each of the 12 IHS Areas, and at IHS and Tribal facilities across the nation.

The PRC Program also includes the Catastrophic Health Emergency Fund (CHEF). Created in 1988, CHEF was established for the sole purpose of meeting extraordinary medical costs associated with treatment of victims of disasters or catastrophic illnesses.[6] CHEF is used to reimburse PRC programs for high cost cases (e.g., burn victims, motor vehicle accidents, high risk obstetrics, cardiology, etc.) after a threshold payment amount of $25,000 is met. CHEF is centrally managed at IHS Headquarters and is available to IHS and Tribally-managed PRC programs annually on a first come basis.

The PRC Program contracts with a fiscal intermediary (FI), currently Blue Cross/Blue Shield of New Mexico, to ensure payments are made in accordance with IHS's payment policy, and coordinates benefits with other payers to maximize PRC resources. All IHS-managed PRC programs and some Tribally-managed PRC programs use the FI to ensure the use of Medicare-like rates for inpatient services.

PRC funding provides critical access to essential health care services and remains a top priority for Tribes in the budget formulation recommendations.

Accomplishments

Medicare-like Rates (MLR) – On December 5, 2014, the IHS published a notice of proposed rulemaking in the Federal Register to establish MLR for IHS payment for physician and other

[5] 25 U.S.C. § 1621e, 1623; 42 CFR 136.61 (2010)
[6] 25 U.S.C. § 1621a

non-hospital based services. This regulation is consistent with the recommendations from the Government Accountability Office (GAO)[7] and the HHS Office of Inspector General[8] and could potentially achieve substantial PRC savings that may be used to expand IHS beneficiary access to care. The IHS is seeking comment on how to establish reimbursement that is consistent across federal health care programs, aligns payment with inpatient services, and enables IHS to expand beneficiary access to medical care. In addition, the IHS is seeking comment on whether an ITU should be allowed to negotiate a higher rate than MLR so as not to have a detrimental financial impact to the most rural providers and potentially negatively impact access to care. The comment period closes on February 4, 2015, and IHS expects to take action on the comments by the end of calendar year 2015.

Purchased/Referred Care – Recent program funding increases have allowed some of the IHS and Tribally-managed PRC programs to approve referrals in priority categories other than Medical Priority I (life or limb), including some preventive care services, thus increasing access to patient care services. In FY 2013, 23 percent of IHS-operated PRC programs were able to purchase services beyond Medical Priority I – Emergent or Acutely Urgent Care Services. This number increased to 41 percent in FY 2014. Recent funding increases as well as alternate resources and increased third-party collections due to implementation of the Affordable Care Act ensure programs can purchase preventive care beyond emergency care services, such as mammograms or colonoscopies.

The IHS PRC Workgroup helped IHS developed a more accurate form for reporting denied and deferred PRC services each year. In FY 2013, PRC denied an estimated $760,855,000 for an estimated 146,928 services needed by eligible AI/ANs. Due to the fact that Tribally-managed programs are not required to report on denials, it is difficult to provide a verifiable and complete measure of the total unmet need for the entire system. Therefore, the denied services estimate is based on actual data from federal programs and estimated Tribal data. The unmet need data is collected at the end of each fiscal year; thus the FY 2014 unmet need data will be available in May 2015.

Catastrophic Health Emergency Fund (CHEF) – In FY 2014, 1,829 high cost cases were reimbursed from CHEF funds on a rolling basis at a total cost of $51,500,000. It is estimated that more cases may qualify for CHEF reimbursement but were not reported by the local IHS and Tribally-managed PRC programs due to the depletion of CHEF before the end of FY 2014. When CHEF funds are depleted, requests for reimbursements from IHS Headquarters are denied. Recent funding increases helped ensure CHEF funds were depleted later than in previous years; in FY 2014 funding was fully depleted in mid-September. The CHEF funds are part of the PRC unmet need data collection and the FY 2014 unfunded CHEF cases will be available in May 2015.

Evidence and Innovation Strategies

Since 2011, the GAO has published four reports on the PRC program.[9] The IHS PRC Workgroup has reviewed the recommendations and the Agency is implementing a majority of the GAO recommendations, including the MLR legislative proposal described above and many

[7] Government Accountability Office, *Indian Health Service: Capping Payment Rates for Nonhospital Services Could Save Millions of Dollars for Contract Health Services* (April 2013)

[8] Department of Health and Human Services, Office of Inspector General, *IHS Contract Health Services Program: Overpayments and Potential Savings* (Sept. 2009).

[9] GAO-11-767, "IHS Increased Oversight Needed to Ensure Accuracy of Data Used for Estimating Contract Health Service Need;" GAO-12-466, "Action Needed to Ensure Equitable Allocation of Resources for the Contract Health Services Program;" GAO-13-272, "Capping Payment Rates for Nonhospital Services Could Save Millions For Contract Health Services;" GAO-14-57, "Opportunities May Exist To Improve The Contract Health Services Program."

programmatic and policy improvements. In addition, the program has identified several risk categories and is working to ensure proper policies and procedures are in place to maintain programmatic consistency across all Areas. These ongoing activities continue to be monitored by PRC staff at the IHS Area office and Headquarters level.

In its 2013 report, the GAO recommended the PRC program modify the IHS GPRA measure on the timeframe for payment of referrals to track results for IHS authorized referrals and patient self-referrals separately. In the FY 2016 budget, IHS is adopting the GAO recommendation in recognition of the differences in payment processes for these two types of referrals and retiring the current PRC-1 measure "average days between service end and purchase order issued." The two new measures track IHS authorized referrals[10] and establish a timeframe for payment and track patient self-referrals[11] and establish a separate target timeframe for authorization and payment of referrals. The two new proposed measures better assess the timeliness of provider payments, ensuring continued access to care and program quality in monitoring timely payment to external providers and reinforce partnerships.

FUNDING HISTORY

Fiscal Year	PRC	CHEF	TOTAL
2011 Enacted	$731,347,000	$48,000,000	**$779,347,000**
2012 Enacted	$792,157,000	$51,418,000	**$843,575,000**
2013 Enacted	$752,420,000	$48,838,000	**$801,258,000**
2014 Final	$827,075,000	$51,500,000	**$878,575,000**
2015 Enacted	$863,139,000	$51,500,000	**$914,139,000**

BUDGET REQUEST

The FY 2016 budget request for Purchased/Referred Care of $984,475,000 is an increase of $70,336,000 over the FY 2015 Enacted level.

FY 2015 Base Funding of $914,139,000 provides funding to purchase:
- 36,500 Inpatient admissions
- 735,300 Outpatient visits
- 45,000 Patient travel trips
- $51,500,000 for CHEF high cost cases

In FY 2014 the CHEF program reimbursed 1,829 cases for a total amount of $51,500,000. If the PRC Program continues to receive $51,500,000 for CHEF the number of cases reimbursed will remain stable.

FY 2016 Funding Increase of $70,336,000 would provide funding for the following:

- Inflation + $35,240,000 – to inflationary costs of providing health care services.

- Population Growth +$8,362,000 – to fund the additional services need arising from the growing AI/AN population. The growth rate is projected to be 1.8 percent in CY 2016 based on state births and deaths data.

[10] As defined by the GAO, IHS referrals are "cases in which an IHS-funded provider refers a patient for care to an external provider."
[11] As defined by the GAO, self-referrals are "typically emergency situations where the patient receives services from external providers without first obtaining a referral from an IHS-funded provider."

- Staffing/Operating Costs for Newly Constructed Facilities +$1,208,000 – PRC funds are requested for one replacement health care facility planned to open in FY 2016. The overall request of $3,649,000 for Fort Yuma Health Center's staffing includes funding for Purchased/Referred Care of $1,208,000, because the new facility is replacing an inpatient facility with an outpatient facility which will require additional Purchased/Referred Care.

Staff and Operating Costs for New/Replacement Health Care Facility	Amount	FTE Positions
Ft. Yuma Health Center (Replacement), Winterhaven, CA	$1,208,000	0

Program Increase +$25,526,000 – to provide for the following additional services:
- 980 Hospital admissions
- 19,800 Outpatient visits
- 1,210 Patient travel trips

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
PRC-1: Average Days between Service End and Purchase Order Issued *(outcome)*	FY 2014 Final: 79.2 days Target: 74 days (Target Not Met)	74 days*	Measure Retired	N/A
PRC-2: Track IHS referrals	Under development		Baseline	N/A
PRC-3: Track self-referrals	Under development		Baseline	N/A

*PRC funds are used for patient care services; there is no funding for additional staff to process the additional PRC paperwork that the funding increase will allow. Therefore, the target remains the same as the previous year.

The PRC measures discussed above are under development by the agency to track and monitor the length of time it takes to pay a provider by 2 referral sources: IHS authorized referrals as the referral source; and patient self-referrals as the referral source.

GRANT AWARDS. This program does not award grants.

AREA ALLOCATION

Purchased/Referred Care
(dollars in thousands)

DISCRETIONARY SERVICES	Actual Base	FY 2014 Final			FY 2015 Enacted			FY 2016 President's Budget			FY '16 +/- FY '15
		Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$77,911	$30,173	$55,255	$85,429	$31,516	$57,371	$88,887	$33,989	$61,737	$95,726	$6,839
Albuquerque	38,271	14,822	27,142	41,964	15,481	28,181	43,662	16,696	30,326	47,022	3,359
Bemidji	54,154	20,973	38,407	59,380	21,906	39,877	61,783	23,625	42,912	66,537	4,754
Billings	56,677	21,950	40,196	62,146	22,927	41,735	64,662	24,726	44,912	69,637	4,975
California	42,691	16,534	30,277	46,811	17,269	31,437	48,706	18,624	33,829	52,453	3,748
Great Plains	79,859	30,928	56,637	87,565	32,304	58,806	91,110	34,839	63,281	98,120	7,010
Nashville	30,777	11,920	21,828	33,747	12,450	22,663	35,113	13,427	24,388	37,815	2,702
Navajo	87,232	33,783	61,866	95,650	35,287	64,235	99,521	38,055	69,123	107,179	7,657
Oklahoma	98,536	38,161	69,883	108,044	39,859	72,558	112,417	42,986	78,081	121,067	8,650
Phoenix	64,710	25,061	45,893	70,954	26,176	47,650	73,826	28,230	51,277	79,507	5,680
Portland	85,281	33,028	60,482	93,510	34,497	62,798	97,295	37,204	67,577	104,781	7,486
Tucson	17,034	6,597	12,081	18,678	6,891	12,543	19,434	7,431	13,498	20,929	1,495
Headquarters	68,124	26,383	48,314	74,698	27,557	50,164	77,721	29,719	53,982	83,701	5,980
Total, PRC	**$801,258**	**$310,313**	**$568,262**	**$878,575**	**$324,120**	**$590,019**	**$914,139**	**$349,551**	**$634,924**	**$984,475**	**+$70,336**

Note: Allocation amounts are estimates.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Services: 75-0390-0-1-551
PREVENTIVE HEALTH

(Dollars in Thousands)

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$147,476	$153,961	$163,025	+$9,064
FTE*	223	274	275	+1

*FTE numbers reflect only federal staff and do not include Tribal staff.

SUMMARY OF THE BUDGET REQUEST

The FY 2016 budget request for Preventive Health programs of $163,025,000 is an increase of $9,064,000 above the FY 2015 Enacted level.

- $79.6 million for **Public Health Nursing** (PHN) to support prevention-focused nursing care interventions for individuals, families, and community groups as well as improving health status by early detection through screening and disease case management. The PHN Program home visiting service provides primary, secondary, and tertiary prevention focused health interventions.
  - *Primary prevention* targets healthy populations with activities aimed at preventing the onset of disease in high risk populations through education, health awareness, immunizations, and risk reduction. PHNs provide childhood obesity prevention activities through breastfeeding promotion to the prenatal patient and during postpartum home visits to mother and baby after hospital discharge.
  - *Secondary prevention* detects and treats problems in the early stages of illness or disease. These interventions target disease before complications arise and before signs or symptoms appear and include health screening for diabetes and hypertension, fall risk assessments, and school health assessments.
  - *Tertiary prevention* reduces further complications from a disease or illness and restores the individual to their optimum level of health. Interventions include chronic disease care, self-management education, medication management, and care coordination. For example a PHN's make home visits after patients are discharged from the hospital to help reduce preventable complications and hospital readmissions.

- $19.1 million for **Health Education** to support the provision of community health, school health, worksite health promotion, and patient education. The Health Education Program standardizes, coordinates, and integrates education initiatives within IHS, including health literacy for American Indian/Alaska Native (AI/AN) individuals and communities, provision of professional education and training, and developing educational materials for staff, patients, families, and communities.

- $62.4 million for **Community Health Representatives** (CHRs) to help to bridge the gap between AI/AN individuals and health care resources through outreach by specially trained indigenous community members. CHRs use local community knowledge to help integrate and disseminate basic information about health promotion/disease prevention and self-management support to patients. With more pilot sites participating in the Agency's

Improving Patient Care and Partnership for Patients efforts, several are reporting how valuable the input and services provided by CHRs are to improving patient care.

- $1.95 million for **Hepatitis B and Haemophilus Immunization Programs (Alaska)** will support the provision of vaccines for preventable diseases, immunization consultation/ education, research, and liver disease treatment and management through direct patient care, surveillance, and education. The Hepatitis B and Haemophilus Immunization Programs (Alaska) budget supports these priorities through direct patient care, surveillance, and educating AI/AN patients.

These **Preventive Health** services contribute widely to the performance measures that fall under the auspices of Hospitals & Health Clinics. PHN clinical services directly contribute to community health and wellness through immunizations, case management, and patient education. CHRs are also community-based and contribute to follow up care and lay health education. Health Education activities permeate the Indian health system and are integral to the fulfillment of the performance screening measures. The Immunization Alaska Program plays a key role by tracking immunization rates through specific immunization registries throughout the State of Alaska, and such efforts contribute to the national immunization rates.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Services: 75-0390-0-1-551
PUBLIC HEALTH NURSING

(Dollars in Thousands)

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$70,829	$75,640	$79,576	+$3,936
FTE*	190	223	224	+1

*FTE numbers reflect only federal staff and do not include Tribal staff.

Authorizing Legislation .....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended 2010

FY 2016 Authorization.....Permanent

Allocation Method..... Direct Federal, P.L. 93-638 Tribal Contracts and & Compacts, Grants

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The IHS Public Health Nursing (PHN) Program is a community health nursing program that focuses on the goals of promoting health and quality of life, and preventing disease and disability. The PHN Program provides quality, culturally sensitive health promotion and disease prevention nursing care services through primary, secondary and tertiary prevention services to individuals, families, and community groups.

- *Primary prevention interventions* aim to prevent disease and include such services as health education/behavioral counseling for health promotion, risk reduction, and immunizations.
- *Secondary prevention interventions* detect and treat problems in their early stages. Examples include health screening of high-risk populations, screening for diabetes and hypertension, fall risk assessments, and school health assessments.
- *Tertiary prevention interventions* prevent or limit complications and disability in persons with an existing disease. The goal of tertiary prevention is to prevent the progression and complications associated with chronic and acute illness by providing optimal care for the patient. Examples include chronic disease case management, self-management education, medication management, and care coordination.

Public Health Nurses are licensed, professional nursing staff available to improve care transitions by providing patients with tools and support that promote knowledge and self-management of their condition as they transition from the hospital to home. Public Health Nurses play a critical role in the surveillance and early efforts to halt the spread of communicable diseases. The PHN expertise in communicable disease assessment, outreach, investigation, surveillance and monitoring interventions helps to manage and prevent the spread of communicable diseases. The PHNs contribute to the agency's primary prevention efforts by providing community immunization clinics and immunizations to homebound American Indian/Alaska Natives (AI/AN).

Public Health Nurses conduct home visiting services for:

- Maternal and pediatric populations, including childhood obesity prevention through breastfeeding promotion, screening for early identification of developmental problems, and parenting education;
- Elder care services including safety and health maintenance care;
- Chronic disease care management; and
- Communicable disease investigation and treatment.

The PHN Program aligns with the Agency's priorities and contributes to the sustained progress towards meeting all GPRA measures and integrates the Department's Strategic Goal to strengthen health care by ensuring AI/AN have access to quality, culturally competent care that aims to promote health and quality of life through a community-population focused nurse visiting program.

The PHN Program participates in the IHS's initiative to decrease childhood obesity and prevent diabetes by performing the following activities: providing patient education, assessment and referral services for prenatal and postpartum clients during home visits; developing a PHN electronic health record template to standardize this intervention; and monitoring these interventions by use of the PHN data mart to evaluate this evidence-based prevention practice of promoting breastfeeding during the nurse home visit.

Public Health Nurses also contributed to increasing breastfeeding rates and supporting childhood obesity prevention efforts by helping all eligible IHS obstetric facilities to receive the "Baby Friendly" designation in 2014. Breastfeeding assistance is an important service to AI/AN families in at-risk communities and help to prevent childhood obesity and diabetes. This program also supports the *Let's Move! In Indian Country* program and has become an official standard of care for AI/AN mothers and babies within the IHS health care system.

FUNDING HISTORY

Fiscal Year	Amount
2011 Omnibus	$63,943,000
2012 Enacted	$66,632,000
2013 Enacted	$66,282,000
2014 Final	$70,909,000
2015 Enacted	$75,640,000

BUDGET REQUEST

They FY 2016 budget request for Public Health Nursing of $79,576,000 is an increase of $3,936, 000 above the FY 2015 Enacted level.

FY 2015 Base Funding of $79,576,000 – The base funding is necessary to support the public health nursing services provided by IHS and Tribal programs, maintain the programs progress in raising the quality of and access to public health nursing care through continuing recruitment of nursing professionals to meet workforce needs, and to meet or exceed agency targets.

FY 2016 Funding Increase of $3,936,000 includes:

- Inflation +1,755,000 – to cover inflationary costs of providing health care services.

- Population Growth +$1,076,000 – to fund the additional services need arising from the growing AI/AN population. The growth rate is projected to be 1.8 percent in CY 2016 based on state births and deaths data.

- Pay Costs +$605,000 – to cover pay raises for federal and Tribal employees of which about 90 percent working at the service unit level providing health care and related services.

- Staffing/Operating Cost Requirements for Newly Constructed Facilities +$500,000 – Public Health Nursing funding is requested for two new and expanded healthcare facilities that are planned to open in FY 2016. Funding these facilities allows IHS to expand provision of health care in those areas where capacity has been expanded to address critical health care needs.

Staff and Operating Costs for New Facility	**Amount**	**FTE/Tribal Positions**
Choctaw Alternative Rural Healthcare Center (JV), Choctaw, MS	$378,000	3
Ft. Yuma Health Center, Winterhaven, CA	$122,000	1
Grand Total:	**$500,000**	**4**

With the FY 2016 budget proposal, the PHN Program will continue working towards providing services and achieving its performance targets:

1. Providing approximately 390,556 individual patient encounters for health activities and nursing services to AI/AN patients;
2. Continuing to support national measures of maternal-child health, such as childhood immunizations, prenatal visits, postpartum visits, childhood obesity prevention through breastfeeding promotion and the Baby Friendly Hospital Initiative, and domestic violence screening through collaboration with related federal, state, local, and private programs;
3. Continued progress on other GPRA measures including tobacco screening, depression screening, adult pneumococcal vaccinations;
4. Continued provision of community immunizations and immunizations to homebound individuals and elderly (support increasing Influenza vaccination coverage rates to meet the Healthy People 2020 goal of 70 percent);
5. Integration of PHN Case Management best practices into the cooperative agreement grant and program awards;
6. Continued support of injury prevention; and
7. Other services will be sustained with minimal expansion.

All PHN programs will be encouraged to implement a new program in their community activities in FY 2015 that is based on a partnership with the Department of Veterans Affairs (VA) and provides community-based support for family caregivers of Native Veterans with dementia. This successful program, called the Resource to Enhance All Caregivers Health (REACH) program, is an evidence-based program that provides a structured intervention to support caregivers of individuals suffering from dementia. Caregivers supported by the REACH-VA program show improvement in depression, the effect of depression on daily life, and caregiver burden and frustration. Veterans with dementia whose caregivers are supported by REACH-VA have improved behavioral health outcomes.

Public health nursing programs will continue to report on clinical performance measures for hospital readmissions that will be aligned with national quality measurements, such as the

measurements stated in the President's Partnership for Patients initiative. IHS will continue focusing on reducing preventable complications during transition from one care setting to another, thereby reducing overall hospital readmissions. Sustaining these efforts will improve patient recovery from illness without incidence of preventable complications requiring re-hospitalization.

The PHN Program will continue to work closely with other federal, state, local, and private agencies to foster high-quality, well-coordinated home visiting programs for AI/AN families in at-risk communities. Local PHN programs take advantage of opportunities to partner with other programs, such as the Maternal, Infant and Early Childhood Home Visiting Program and other programs funded under the Affordable Care Act.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
23: **Public Health Nursing:** Total number of public health activities captured by the PHN data system; emphasis on primary, secondary and tertiary prevention activities to individuals, families and community groups.	FY 2014: 386,307 Target: 425,679 (Target Not Met)	425,679	390,556	-35,123

Note: Allocation amounts are estimates.

The FY 2014 target result of 35,123 encounters is less than the target. The FY 2014 performance decrease continues to be a result of the changes in the data exporting and collection process. Several large Tribal programs have migrated away from the IHS Resource Patient Management System (RPMS) to purchase a commercial off the shelf electronic health record package which changed the way the PHN visits were coded and resulted in less visits being exported to the agency's National Data Warehouse (NDW) database. This has continued to result in a decrease in the overall national PHN Program performance report. Despite these issues and the impact on the performance targets, the NDW continues to be the reliable source of data reporting and the PHN program will continue to monitor, track and improve its reporting activities based upon the export of data to the database. The PHN program staff continues to work to resolve this issue so as to report the most accurate data and describe the important services provided by the PHN Program.

The FY 2016 target is set at 390,556 encounters as data collection efforts continue to identify issues in collecting the PHN Provider code in data exports of the entities that migrate away from the traditional IHS RPMS. The PHN Provider Productivity report includes a critical element, the PHN Provider code of 13, to complete this report. As sites decide to use off the shelf software and opt for "simplified" data exports to the NDW which include only the bare bones record and contain just enough data to be used for workload purposes, these simplified records affects the PHN Productivity report since these basic records may not contain the PHN Provider code. The resolution of this issue will take some additional time due to the various entities that must be included and the collaboration to change the export reports to include the PHN Provider code; therefore, this work is ongoing and continues with revisions to be reflected in 2017 the targets. In the interim, in FY 2016, IHS will seek to standardize various PHN documentation templates to improve the capturing of those PHN initiatives that target Agency initiatives such as increasing

breastfeeding rates, decreasing hospital re-admissions and improving quality and access to care especially in the community. With the use of the PHN data mart, in FY 2016, the PHN Program will post various PHN data briefs to follow the activity in meeting specific Agency targets. This will provide an avenue to monitor the PHN Programs' support of health care delivery services in the home and benchmarks. Nurse home visiting is an important service to AI/AN families in at-risk communities and a proven prevention strategy. Early investments in home visiting programs have been shown to reduce the costs caused by foster care placements, hospitalizations and emergency visits, unintended pregnancies, and other more costly interventions.

GRANTS AWARDS

The PHN Program awarded 10 grants and 5 program awards in calendar year (CY) 2013 with continuation funding through CY 2017. These grants and program awards provide funding to increase local nursing services through public health nursing case management programs for high risk and vulnerable patients and families. Research indicates nurse case management is a cost effective approach to maximize health outcomes. Case management involves the client, family, and the health care team to support appropriate and timely interventions. In addition to reducing the cost of health care, nurse case management has proven its worth in terms of improving client self-determination. The intent of this program is to make available an array of PHN Best Practices/Promising Practices to support a PHN Case Management Program through the cooperative agreement grants to Tribes and Urban programs and the federal program award process.

CFDA No. 93.933/Community Based Model of PHN Case Management Services			
	FY 2014 Enacted	FY 2015 Pres. Budget	FY 2016 Request
Number of Awards	4	4	4
Average Award	$249,998	$249,998	$249,998
Range of Awards	$249,996-250,000	$249,996-250,000	$249,996-205,000
Total Awards	**$1,000,000**	**$1,000,000**	**$1,000,000**

AREA ALLOCATION

Public Health Nursing

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2014 Final			FY 2015 Enacted			FY 2016 President's Budget			FY'16 +/- FY'15
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$2,910	$6,670	$9,581	$2,921	$7,310	$10,232	$3,055	$7,709	$10,764	$532
Albuquerque	1,191	2,731	3,922	1,196	2,993	4,188	1,251	3,156	4,406	218
Bemidji	1,067	2,445	3,512	1,071	2,680	3,751	1,120	2,826	3,946	195
Billings	682	1,563	2,246	685	1,713	2,398	716	1,807	2,523	125
California	1,315	3,015	4,330	1,320	3,304	4,625	1,381	3,484	4,865	241
Great Plains	289	661	950	290	725	1,015	303	764	1,067	53
Nashville	333	763	1,097	334	837	1,171	350	882	1,232	61
Navajo	4,172	9,562	13,734	4,188	10,479	14,667	4,380	11,050	15,430	763
Oklahoma	3,954	9,062	13,016	3,969	9,932	13,900	4,151	10,473	14,624	723
Phoenix	2,211	5,068	7,280	2,220	5,555	7,774	2,321	5,857	8,179	405
Portland	923	2,117	3,040	927	2,320	3,246	969	2,446	3,415	169
Tucson	318	730	1,048	320	800	1,119	334	843	1,177	58
Headquarters	2,149	4,925	7,073	2,157	5,397	7,554	2,256	5,691	7,947	393
Total, PHN	**$21,516**	**$49,313**	**$70,829**	**$21,596**	**$54,044**	**$75,640**	**$22,587**	**$56,989**	**$79,576**	**+$3,936**

Note: Allocation amounts are estimates.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Services: 75-0390-0-1-551
HEALTH EDUCATION

(Dollars in Thousands)

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$16,926	$18,026	$19,136	+$1,110
FTE*	34	42	42	0

*FTE numbers reflect only federal staff and do not include Tribal staff.

Authorizing Legislation .....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended 2010

FY 2016 Authorization.....Permanent

Allocation Method.....Direct Federal, P.L. 93-638 Self-Determination Contracts and Self-Governance Compacts

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The IHS Health Education Program has been in existence since 1955 to educate American Indian/Alaska Native (AI/AN) clients and communities about their health. The program continues to focus on the importance of educating AI/AN clients in a manner that empowers them to make better choices in their lifestyles and how they utilize health services. Accreditation requirements at all IHS and tribal facilities specifically require the provision of and documentation of patient education as evidence of the delivery of quality care.

The IHS Health Education Program aligns and integrates the Department's Strategic Goal 3.D. to promote prevention and wellness across the lifespan. This is accomplished by working in partnership with individuals, groups, and communities in the provision of health education services and providing assistance to AI/ANs in the determination and improvement of their health status through incorporation of cultural beliefs, practices and traditions into patient health education. Continued investment in the IHS Health Education Program demonstrates IHS' commitment to integrate education and prevention services with clinical services to improve healthcare services for AI/AN people.

The Health Education Program also supports the IHS' performance goals to report the number of visits with Health/Patient Education, and the proportion of tobacco-using patients that receive tobacco cessation intervention. The IHS Health Education Program continues to meet, and in some cases exceed, its performance measures as documented in the outputs and outcomes table. Educational services provided by IHS, Tribal and Urban staff demonstrate a steady increase in the number of AI/AN clients that have a documented educational encounter. The number of visits in which education was provided has increased from approximately 3,657,235 visits in 2013 to 3,840,886 visits in 2014, an increase of 183,651 visits.

The Health Education Program partners with other IHS disciplines and programs to ensure that the education of IHS clients continues to occur, even at those sites without a full-time health educator. The Headquarters Health Education Program provides technical assistance and

guidance on educational issues to all disciplines and programs. All educational encounters are documented and coded in the Resource and Patient Management System (RPMS) electronic health record for the documentation of patient health education as well as tobacco cessation intervention, and the results are analyzed in the National Patient Information Reporting System and Clinical Reporting System to report patient education provided to clients and tobacco cessation intervention results. Health Education provides leadership in the integration of Healthy People 2020 Objectives with goals that integrate plain language, health literacy, patient-provider communications and electronic health information opportunities for our clients.

The Health Education Program demonstrates accountability through the development of the Patient Education Protocols and Codes, which is an IHS-wide reporting system providing local, on-demand education data reports documenting a broad range of clinical and administrative information to managers at all levels of the Indian health system. In 2014, there have been 1,355 updates to patient education protocols out of 4,208 total protocols. The Health Education Program has promoted participation in reporting to ensure program integrity by focusing on the program's achievement of the Department's Strategic Plan and by successfully integrating the agency's program integrity and performance management activities in all work performed within the program.

The Health Education program maintains data tracking of a key program objective: the number of clients who received health education services. IHS Health Education maintains IHS-wide statistics on educational encounters. Examples of data available from educational encounters include: the number of clients who received health education services; presenter credentials; location; information provided; amount of time spent on health education; patient comprehension; and behavior goals.

In partnership with all IHS programs, disciplines and staff, the Health Education Program staff continues to:

(1) Communicate the importance and on-going need for comprehensive clinical and community health education services to AI/AN clients;
(2) Provide these services both as individual one-on-one counseling education sessions and in group encounters in the community;
(3) Promote health literacy through the standardization, coordination and integration within IHS of health education for clients, professional education and training, and educational materials for staff, patients, families and communities; and
(4) Assist in transforming the health care system to increase access to high quality, effective health care that is predictably safe.

FUNDING HISTORY

Fiscal Year	Amount
2011 Omnibus	$16,649,000
2012 Enacted	$17,057,000
2013 Enacted	$16,552,000
2014 Final	$17,001,000
2015 Enacted	$18,026,000

BUDGET REQUEST

The FY 2016 budget request for Health Education of $19,136,000 is an increase of $1,110,000 above the FY 2015 Enacted level.

FY 2015 Base Funding of $18,026,000 is necessary to maintain the progress in addressing the health education needs, improving access to health information, developing standardized nationwide patient health education programs and ensuring that health information is quality assured and culturally and linguistically appropriate.

FY 2016 Funding Increase of $1,110,000 includes:

- Medical Inflation +$547,000 to cover inflationary costs of providing health care services.
- Population Growth $334,000 – to fund the additional services need arising from the growing AI/AN population. The growth rate is projected to be 1.8 percent in CY 2016 based on state births and deaths data.
- Pay Costs +$133,000 to cover pay raises for federal and Tribal employees of which about 90 percent are working at the service unit level providing health care and related services.
- Additional Staffing and Operating Costs for Newly-Constructed Healthcare Facilities - +$96,000 – Health Education funding is requested for one new and expanded healthcare facility that is planned to open in FY 2016. Health Education funding is included for the Choctaw Alternative Rural Healthcare Center and will allows IHS to expand provision of health care in this facility where capacity has been expanded to address critical health care needs.

Staff and Operating Costs for New Facility	**Amount**	**Tribal Positions**
Choctaw Alternative Rural Healthcare Center (JV), Choctaw, MS	$96,000	1
Grand Total:	**$96,000**	**1**

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
HE-1 Number of Visits with Health/Patient Education *(Output)*	FY 2014: 3,840,886 Target: 2,874,290 (Target Exceeded)	3,430,486	3,894,658	+464,172

The Health Education Program demonstrated its effectiveness by exceeding its target by 33.6 percent in FY 2014. The Health Education Program will strive for continued success in 2015 and 2016 by maintaining or exceeding its level of services through the continued development and integration of Patient Education Protocols and Provider Codes into all IHS software packages including the Electronic Health Record (EHR). The EHR is widely deployed and may partially account for the fulfillment of the Health Education target by more accurately capturing the number of visits. The Health Education Program will also continue to provide training for providers on the use of these protocols and codes.

The Health Education Program will strive for continued success by maintaining or exceeding the level of services provided in FY 2015 and will continue to work towards strengthening the following areas:

- The development of standardized, nationwide patient and health education programs through the integration of the IHS Patient Education Protocols into all IHS software packages including the Patient Care Component and the EHR;
- Provide ongoing training to IHS and Tribal staff on the documentation and coding of patient and health education.
- Achievement in the areas of the Healthy People 2020 Objectives through health communications by:
  - increasing the proportion of AI/ANs with access to health information;
  - improving the health literacy of AI/ANs with inadequate or marginal literacy skills;
  - increasing the health information contained on www.ihs.gov and ensuring that information disclosed is quality-assured and culturally and linguistically appropriate for AI/AN clients;
  - improving patient-provider communication skills; and
  - improving the use of plain language in written health communications materials.

GRANT AWARDS – The Health Education budget does not fund grants.

AREA ALLOCATION

Health Education

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2014 Final			FY 2015 Enacted			FY 2016 President's Budget			FY '16 +/- FY '15
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$372	$1,536	$1,908	$380	$1,652	$2,032	$397	$1,760	$2,157	$125
Albuquerque	360	1,485	1,845	368	1,597	1,965	384	1,701	2,086	121
Bemidji	231	955	1,186	236	1,026	1,263	247	1,094	1,341	78
Billings	120	495	614	122	532	654	128	567	695	40
California	232	959	1,191	237	1,031	1,269	248	1,099	1,347	78
Great Plains	49	201	250	50	216	266	52	230	282	16
Nashville	98	404	502	100	434	534	105	463	567	33
Navajo	443	1,831	2,275	453	1,969	2,423	474	2,098	2,572	149
Oklahoma	525	2,169	2,694	537	2,332	2,869	561	2,484	3,045	177
Phoenix	345	1,423	1,768	352	1,530	1,882	368	1,630	1,998	116
Portland	180	743	923	184	799	982	192	851	1,043	60
Tucson	42	174	216	43	187	230	45	199	244	14
Headquarters	303	1,253	1,556	310	1,347	1,657	324	1,435	1,759	102
Total, Health Ed	**$3,299**	**$13,627**	**$16,926**	**$3,374**	**$14,652**	**$18,026**	**$3,526**	**$15,610**	**$19,136**	**+$1,110**

Note: Allocation amounts are estimates.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Services: 75-0390-0-1-551

COMMUNITY HEALTH REPRESENTATIVES

(Dollars in Thousands)

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$57,895	$58,469	$62,363	+$3,894
FTE*	9	9	9	0

*FTE numbers reflect only Federal staff and do not include increases in Tribal staff.

Authorizing Legislation .....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended 2010

FY 2016 Authorization.....Permanent

Allocation Method.....Direct Federal, P.L. 93-638 Self-Determination Contracts and Self-Governance Compacts

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

Community Health Representatives (CHRs) are a critical part of the Indian public health system as they link available health programs to the American Indian and Alaska Native (AI/AN) patients and communities. This is accomplished by utilizing indigenous community members as health paraprofessionals with local community knowledge to help integrate and disseminate basic information about health promotion and disease prevention to Indian communities and Tribal members, expand lay health education services, support patient self-management efforts, and initiate community change. Funds are distributed through Area allocations to the Tribes that employ approximately 1,600 CHRs.

CHRs provide a critical link in the continuity of care across settings that support patient care and monitoring and self-management, which are especially important in geographically remote and rural reservations. These services help prevent avoidable hospital readmissions and emergency department visits. Training is a key tool to provide laypersons with the comprehensive health education, skills, and competencies needed to perform the wide variety of culturally sensitive job responsibilities the various Tribes assign to their CHRs. Training improves public health workforce skills and equips CHRs with the knowledge needed to provide 16 categories of services that patients report make a difference in their lives and that also contribute to Agency performance measures. Research indicates that community health workers such as CHRs improve patient access to quality health care and contribute to greater patient satisfaction with health services.[1] CHRs are a vital part of the Indian health system care team and help provide needed public health services to the community.

The CHR program aligns and integrates the Department's Strategic Goal 3, Objective D to promote prevention and wellness across the lifespan. The program also supports the Secretary's

[1] *Patient-Centered Community Health Worker Intervention to Improve Post hospital Outcomes: A Randomized Clinical Trial*, JAMA Intern Med (2014).

Initiatives to: promote early childhood health and development; promote community living for older adults and people with disabilities; and foster a 21st century health workforce. The IHS does not have authority to direct tribally-managed CHR health programs on their utilization of health information technologies. However, Tribal CHR programs that use RPMS are encouraged to use the CHR Patient Care Component (PCC) to document patient care services which provides a mechanism for Tribal CHR programs to export their data to the IHS national data collection system. This data identifies what types of patient care services CHRs provide within the community and supports a demand for increased CHR services. By focusing on the program's achievement of elements within the Department's Strategic Plan, the agency's program integrity and performance management activities will be successfully integrated.

For FY 2014, 41 percent of CHR programs reported on the types of services provided. This data demonstrated that:

- 19 percent of services involved collection of patient data (e.g., taking vital signs, delivering medication, delivering medical equipment and providing emotional support).
- 17.9 percent of services were collecting case findings or screenings.
- 114.7 percent of services were performing case management activities.
- 11.7 percent of services were providing health education to individuals and communities.
- 9.3 percent of services were providing transportation for coordination of care.
- 3.6 percent of services were providing other necessary patient and family support services, such as making or assisting with funeral arrangements and completing CHR PCC.

FUNDING HISTORY

Fiscal Year	Amount
2011 Omnibus	$61,505,000
2012 Enacted	$61,407,000
2013 Enacted	$58,304,000
2014 Final	$57,895,000
2015 Enacted	$58,469,000

BUDGET REQUEST

The FY 2016 budget request for Community Health Representatives of $62,363,000 is an increase of $3,894,000 above the FY 2015 Enacted level.

Base Funding for Community Health Representatives is $58,469,000.

FY 2016 Funding Increase of $3,894,000 includes:

- Inflation +$2,223,000 – to cover inflationary costs of providing health care services.

- Population Growth +$1,234,000 – to fund the additional services need arising from the growing AI/AN population. The growth rate is projected to be 1.8 percent in FY 2016 based on state births and deaths data.

- Pay Costs +$437,000 - to cover pay raises for Federal and Tribal employees of which about 90 percent are working at the service unit level providing health care and related services.

Funding will be used as follows:

- For contracting, compacting, and direct service Tribes to provide direct health care, health promotion and disease prevention services in homes and other community-based settings as identified in Tribal Annual Funding Agreements and scope of work to 2.2 million AI/AN population throughout 12 Areas.
- For training, information technology costs, and special projects. Approximately 68 percent of this amount represents shares for Tribally-administered funds. The remaining 32 percent of federally retained funds will support the following plans for FY 2016, but are not limited to:
    - CHR Basic training on-line modules and support to the IHS Areas to check CHR skills and competencies. Online CHR Basic training will reduce travel and per diem expenses for CHRs. Funds will be used to develop, test, implement and sustain an Advanced CHR Training which are cost effective and culturally appropriate.
    - Use funds to pay for online training development, testing, implementation and maintenance.
    - Provide training, web management, listserv, and other program administrative, technical and logistical assistance to Tribes and Areas.
    - Continue health information technology development, refinement, and data support to enhance the CHR data application in RPMS and integration into the EHR.
    - Train CHRs nationally on the CHR PCC data system.
    - Continue efforts to provide CHR education on the IPC Initiative and integrate CHR's into the patient's health care team and medical home.
    - Share information on the use and benefits of the CHR Data Mart, an online tracking system which allows authorized local CHR Program staff to monitor exported CHR PCC patient data and workload management.
    - Finalize the updated CHR Resource Requirements Methodology module, part of the system IHS uses to prepare staffing estimates based on workload information for each discipline to Congress and Tribes

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
CHR-2: CHR patient contacts for Chronic Disease Services [1, 2, 3]	FY 2014: 422,629 Target: 362,951 (Target Exceeded)	347,848	429,814	+81,966
CHR-1: Number of patient contacts [3, 4]	FY 2014: 975,874 Target: 831,333 (Target Exceeded)	796,740	992,464	+195,724
CHR-3: Number of CHRs trained [5]	FY 2014: 3,950 Target: 414 (Target Exceeded)	400	800	+400

[1, 3]128 of 309, about 41 percent, CHR Programs assigned Program Codes reported and exported data in RPMS CHR PCC during FY 2013, as reported in the CHR Data Mart, the only way IHS Headquarters can track CHR specific data for CHR-1 and CHR-2 program measures (38 per cent reported in FY 2012; 47 percent reported in 2011; 42 percent in 2009; 55 percent in 2008).
[2]The Program Performance target above represents an effort by the IHS national CHR Program to obtain specific number of patient contacts provided in the categories of diabetes, heart, hypertension, nutrition, cancer, other chronic, dialysis, obesity, depression, renal failure, and liver disease related to IHS GPRA indicators and drawn from the CHR PCC software application.
[3]Training conducted on CHR PCC suggests that CHRs routinely under-report the services they provide. Typically they report 2-3 services, but when queried further they identify 5-7 additional services that regularly are unreported (checking homes for hazards as part of injury prevention efforts, providing homemaker services, providing health information on/checking medications, coordinating appointments, interpreting/translating, health education).
[4]Patient contacts are the number of services multiplied by number served. The methodology to establish CHR-1 and CHR-2 targets was changed in FY 2013 from using extrapolated data and service hours to actual services.
[5]In FY2013 changes to the formats and venues to provide CHR National Education Training, Basic and Refresher training and CHR PCC trainings began in response to the Efficient Spending Policy.

The CHR program will to continue to work toward improving access to care, decreasing cost and improving the patient experience with the budget proposed for FY 2016. The CHR program measures: (1) number of patient contacts; (2) patient contacts for chronic disease services and (3) number of CHRs trained contribute to improving access to care for underserved AI/communities. The third measure is a statutory requirement that IHS provide CHR Basic and Advanced training and RPMS CHR PCC training. IHS also leverages other Agency Webinar trainings to provide additional CHR training and updates on chronic diseases.

The CHR Program will strive to maintain the level of services provided in FY 2015 and will continue to work towards addressing the following challenges:

1) Enhancement to the IHS online training system for CHRs;
2) Coordinating data validations, and promoting on-going use of the RPMS CHR PCC, data application by Tribes. The CHR PCC is the mechanism by which CHRs report services provided to patients and communities. The CHR PCC also provides verifiable documentation for budget justification and program performance.
3) Education on necessary federal security requirements for Tribal CHRs to request and maintain access to RPMS.

GRANTS AWARDS – No grant awards are anticipated for FY 2016.

AREA ALLOCATION

Community Health Representatives

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2014 Final			FY 2015 Enacted			FY 2016 President's Budget			FY '16 +/- FY '15
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$488	$6,372	$6,860	$541	$6,387	$6,928	$547	$6,843	$7,389	$461
Albuquerque	297	3,876	4,173	329	3,885	4,214	333	4,162	4,495	281
Bemidji	236	3,077	3,313	261	3,085	3,346	264	3,305	3,569	223
Billings	324	4,230	4,554	359	4,240	4,599	363	4,542	4,905	306
California	300	3,914	4,214	332	3,923	4,256	336	4,203	4,539	283
Great Plains	135	1,760	1,895	150	1,765	1,914	151	1,890	2,042	127
Nashville	233	3,043	3,276	258	3,050	3,308	261	3,267	3,528	220
Navajo	463	6,054	6,518	514	6,068	6,582	519	6,501	7,021	438
Oklahoma	602	7,867	8,469	668	7,885	8,553	675	8,448	9,123	570
Phoenix	421	5,493	5,914	466	5,506	5,972	471	5,899	6,370	398
Portland	315	4,116	4,431	350	4,125	4,475	353	4,420	4,773	298
Tucson	132	1,729	1,861	147	1,733	1,880	148	1,856	2,005	125
Headquarters	172	2,247	2,419	191	2,252	2,443	193	2,412	2,605	163
Total, CHR	**$4,117**	**$53,778**	**$57,895**	**$4,567**	**$53,902**	**$58,469**	**$4,614**	**$57,749**	**$62,363**	**+$3,894**

Note: Allocation amounts are estimates.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Services: 75-0390-0-1-551

HEPATITIS B AND HAEMOPHILUS IMMUNIZATION PROGRAMS (ALASKA)

(Dollars in Thousands)

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$1,826	$1,826	$1,950	+$124
FTE*	0	0	0	0

*Program is operated by tribal staff.

Authorizing Legislation .....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended 2010

FY 2016 Authorization.....Permanent

Allocation Method ..... Self-Governance Compact

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

Hepatitis B Program – The Hepatitis B Program was initiated in 1983 because of the need to prevent and monitor hepatitis B infection among a large population of Alaska Natives with or susceptible to the disease. It continues to provide this service in addition to evaluation of vaccine effectiveness and the medical management of persons with hepatitis and liver disease.

Haemophilus Immunization (Hib) Program – The Hib Program started in 1989 with a targeted Haemophilus Influenzae type b prevention project in the Yukon Kuskokwim Delta and now maintains high vaccine coverage by providing resources, training, and coordination to Tribal facilities throughout Alaska. Regular meetings are held with regional Immunization Coordinators, Clinical Directors, Community Health Aide Program, IHS Immunization Coordinators, and the State of Alaska Immunization Program. The Program works with Tribal public relations to address parental immunization hesitancy and highlight the importance of vaccines.

The Hepatitis B Program and the Haemophilus Immunization (Hib) Program of the Alaska Native Tribal Health Consortium (ANTHC) in collaboration with Alaska Tribal Health Care System partners provide clinical expertise and consultation, trainings, research, evaluation and surveillance with the goal to reduce the occurrence of infectious disease and improve access to healthcare in the Alaska Native population. The programs support the HHS Strategic Plan (Goal 1, Objective F and Goal 3, Objective E) through its activities: immunization; patient screening, development of electronic health record reminders and systems, providing an infrastructure to maintain high immunization coverage and high clinical management coverage of hepatitis B and C in Alaska Natives. The programs' activities support IHS priorities by improving the quality of and access to care for Alaska Natives.

The Immunization Alaska program has several performance measures to monitor progress in achieving the goal of high vaccine coverage for Alaska Natives as described below:

Hepatitis B Program

The Hepatitis B program continues to prevent and monitor for hepatitis B infection among a large population of Alaska Natives with or susceptible to the disease. The program evaluates hepatitis A and hepatitis B vaccination coverage of Alaska Natives, and the total number of Alaska Native patients targeted for screening and the total number of patients screened for hepatitis B and hepatitis C as well as other liver disease that disproportionately affect the Alaska Native population.

- In FY 2014, hepatitis A and hepatitis B vaccination coverage exceeded the target. Hepatitis A vaccination coverage was 93 percent (90 percent Target) and hepatitis B vaccination coverage was 97 percent (90 percent Target).
- For FY 2014, at least 64 percent of AI/ANs with chronic hepatitis B or C infection were screened for liver cancer and for liver aminotransferase levels (60 percent and 68 percent of the population, respectively).
- Continuing in FY 2014, the program maintains its practice of encouraging hepatitis patients to have regular, bi-annual screening, this percentage is an increase from previous years.

In FY14, non-alcoholic fatty liver disease was excluded from target data, affecting outcome data to reflect new target populations.

Haemophilus Immunization (Hib) Program

The Hib program continues to provide resources, training and coordination to tribes in Alaska to maintain high vaccine coverage amongst Alaska Natives. Vaccine coverage data is collected for each tribal region and measured in collaboration with local tribal immunization coordinators. Consultation for the varying electronic health record systems within each tribal health organization is provided to improve vaccine coverage for all tribes. Statewide Alaska Native immunization coverage rates are reported to IHS Headquarters for infants 3-27 months, 19-35 months, adolescents, and older adults and flu vaccine immunization rates are reported for all ages

In FY 2014:

- Immunization Coverage for Alaska Native 19-35 month olds was 77 percent, which is close to the Healthy People 2020 goal of 80 percent for child vaccine coverage with 4:3:1:3:3:1:4 series (4 DTaP, 3 IPV, 1 MMR, 3 Hib, 3 Hep B, 1Var, 4 PCV).
- Achieved coverage with full series Haemophilus influenza type b (Hib) vaccine in 19-35 month olds (94 percent), which is much higher than the US all-races 2012 rate of 80.9 percent.
- Achieved increased Tdap vaccine coverage in 19-64 year olds from 71 percent to 82 percent.
- Assisted tribal facilities using the RPMS immunization package in achieving interface to share vaccine records with the Alaska State Immunization Information System (SIIS).
- Provided consultation with 3 facilities who were implementing new Electronic Health Records (EHR) on immunization documentation and SIIS interface implementation of new EHR at 4 tribal facilities and the development of alternative reminder-recall systems and reporting of vaccine coverage using the SIIS.

A summary of immunization results is included below:

Immunization Measure	Age Group	Alaska Native coverage as of 09/30/2014
4:3:1:3:3:1:4	19-35 months	77%
4:3:1:3:3:1	19-35 months	84%
3 Hib vaccines doses		94%
3 PCV (pneumococcal conjugate vaccine)	19-35 months	96%
1+ HPV	13-17 years female	84%
Pneumococcal vaccine	65+ years	93%
Tdap	19-64 years	82%

The program continues to collaborate with Centers for Disease Control and Prevention in developing media materials and networking with IHS and other agencies to provide technical assistance regarding EHRs. Challenges include the diversity of EHRs employed by Tribal agencies that may result in a temporary loss or delay of Area-wide reporting of immunization coverage. This will continue to be addressed through coordinated efforts by the Hib program, IHS and Tribes, such as providing technical support to Tribal agencies developing EHRs to meet meaningful use requirements. Vaccine and immunization coverage are measured as well as consults provided to tribal partners.

FUNDING HISTORY

Fiscal Year	Amount
2011 Omnibus	$1,930,000
2012 Enacted	$1,927,000
2013 Enacted	$1,826,000
2014 Final	$1,826,000
2015 Enacted	$1,826,000

BUDGET REQUEST

The FY 2016 budget request for the Hepatitis B Program and the *Haemophilus* Immunization (Hib) Program of $1,950,000 is $124,000 above the FY 2015 Enacted level.

FY 2015 Base Funding of $1,826,000 – Funding will continue to provide coordination of vaccine coverage reporting for Tribal facilities, training of Tribal immunization coordinators, and clinic staff in vaccine recommendations and documentation, consultation in the migration to EHRs, and regular notification to hepatitis patients of the need to complete liver function screenings so that program clinicians can identify serious liver disease or liver cancer when it is at an early and treatable stage.

Hepatitis B Program – The program will continue to conduct three days of outpatient clinics at the Alaska Native Medical Center, travel to regional health centers to conduct outpatient clinics (13 site visits/year) and will continue its web-based application for video-conferencing (Adobe Connect) that is accessible to the statewide Alaska Tribal Health System (ATHS) audience to provide relevant clinical information to assist in the care and management of hepatitis and liver disease patients. Annual field clinics (13 visits/year) will continue to be conducted across Alaska to provide direct patient care, clinical updates to ATHS staff, and to recruit and conduct follow-up on participants enrolled in the program's research studies. Hepatitis A and Hepatitis B vaccine coverage for all Alaska Natives will continue to be measured. In addition, the total number of

Alaska Native patients targeted and screened will be measured for hepatitis B, hepatitis C and other liver disease that affects Alaska Natives.

Haemophilus Immunization (Hib) Program – The budget request will be used for staff travel to provide program support for regional Tribal programs and limited printing of media materials. Funding of these activities allows maintenance of current program support of Alaska Tribal immunization activities, statewide and national immunization advocacy and technical support, and Area reporting to IHS Headquarters. Statewide Alaska Native immunization coverage rates are reported to IHS Headquarters for infants 3-27 months, 19-35 months, adolescents, and older adults and flu vaccine immunization rates are reported for all ages. In addition, the number of consultations and trainings offered to tribal facilities is also reported.

FY 2016 Funding Increase of $124,000 includes:

- Inflation +$70,000 – to cover inflationary costs of providing immunization services in Alaska.

- Population Growth +$39,000 – to fund the additional services need arising from the growing AI/AN population. The growth rate is projected to be 1.8 percent in FY 2016 based on state births and deaths data.

- Pay Costs +$15,000 – to cover pay raises for Tribal employees, of which about 90 percent are working at the service unit level providing health care and related services.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result/ (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
Hepatitis Program (Targeted/Known Cases = T and Screened = S)				
Sum of Hepatitis Patients Targeted for Screening	FY 2014 Final Result: 2,706 Target: 3,327 (Target Not Met; see notes **)	3,327	3,327	0
AK-1: Chronic Hepatitis B Patients Screened/Targeted*	FY 2014 Final Result: T=1,061, S=637 Target: T=1,060, S=628 (T Target Exceeded and S Target Exceeded)	T=1,060 S=628	T=1,060 S=628	T= 0 S= 0
AK-2: Chronic Hepatitis C Patients Screened/Targeted	FY 2014 Final Result: T=1,443, S=985 Target: T=1,600, S=976 (T Target Not Met and S Target Exceeded)	T=1,600 S=976	T=1,600 S=976	T= 0 S= 0
AK-3: Other Liver Disease Patients Screened/Targeted**	FY 2014 Final Result: T=202, S=191 Target:	T=667 S=501	T=667 S=501	T= 0 S= 0

Measure	Year and Most Recent Result / Target for Recent Result/ (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
	T=667, S=501 (T Target Not Met and S Target Not Met; see note **)			
AK-4: Hepatitis A vaccinations***	FY 2014 Final Result: HepA=93% Target: HepA=90% (Target Exceeded)	90%	90%	0
AK-5: Hepatitis B vaccinations***	FY 2014 Final Result: HepB=97% Target: HepB=90% (Target Exceeded)	90%	90%	0

* Decline in hepatitis B cases due to an aging cohort and their deaths; discovery of new cases is rare given hepatitis B vaccinations.
** Other liver disease includes autoimmune hepatitis and primary biliary cirrhosis. Nonalcoholic fatty liver disease has been dropped from the report as of FY15 CJ given new criteria for clinical follow-up.
***Hepatitis A/B Immunization rates for Alaska Native children who achieve Hepatitis A 1-dose completion and Hepatitis B 3-dose completion aged 19-35 months are compiled and reported throughout the Alaska Native Tribal Health System on a quarterly basis. The rates reported herein represent an average for the reporting period. The established target immunization rate for each vaccine is 90%.
†Criteria for determining hepatitis C cases modified to exclude persons with two negative PCR tests.
All data reported is that which is available to the Alaska Native Tribal Health Consortium.

There have been relatively the same funding levels over the past three years allowing us to maintain and grow our efforts to screen hepatitis patients and monitor and assist tribes in achieving their immunization targets. The general trend shows most output measure targets are not met or exceeded; targets not met were due primarily to new clinical follow-up criteria for other liver diseases and the exclusion of hepatitis C cases which are no longer classified as chronic. In FY 2014, 117 new cases of hepatitis C infection were identified and as clinically indicated these patients will be targeted and screened. New drug regimens for treating hepatitis C have very high cure rates and we anticipate some degree of leveling in number of hepatitis C patients targeted once those who have been cured no longer need clinical follow-up. Patients with chronic hepatitis B infection continue to require screening given their high risk of liver cancer. For FY 2015, we are developing new strategies to encourage screening in hepatitis B patients who have not been screened in the last 18 months. Patients with other liver diseases (i.e., autoimmune liver diseases) continue to be monitored given their risk of more serious liver disease and/or drug toxicity resulting from their treatment. These liver diseases are one of many autoimmune diseases having a significant impact the Alaska Native population[1].

GRANTS AWARDS -- The program does not award any grants.

[1] Ferucci et al. Semin Arthritis Rheum. 2005 Feb;34(4):662-7; Hurlburt et al. Am J Gastroenterol, 2002 Sep;97(9):2402-7

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Services: 75-0390-0-1-551
URBAN INDIAN HEALTH

(Dollars in Thousands)

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$40,729	$43,604	$43,604	$0
FTE*	5	5	5	0

*FTE numbers reflect only federal staff and do not include urban staff.

Authorizing Legislation .....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended 2010

FY 2016 Authorization.....Permanent

Allocation Method.....Formula Contracts and Competitive Formula Grants awarded to Urban Indian Organizations

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The Urban Indian Health Programs (UIHP) was established in 1976 to make health services more accessible to urban Indians. The IHS enters into limited, competing contracts and grants with 35 urban Indian 501(c)(3) non-profit organizations to provide health care and referral services for urban Indians residing in 57 sites throughout the United States. Urban Indian Organizations (UIO), define their scope of work and services based upon the service population, health status, and documented unmet needs of the urban Indian community they serve. Each UIO is governed by a Board of Directors that must be made up of at least 51 percent urban American Indians and Alaska Natives (AI/AN). UIO provide unique access to culturally appropriate and quality health care to urban AI/AN.

The UIO provide primary medical care and public health case management services for approximately 54,000 urban Indians who do not have access to the resources offered through IHS and Tribally operated health care facilities because they do not live on or near a reservation. The UIO health program sizes and services vary.

- Twenty-one are full ambulatory programs providing direct medical care to the population served for 40 or more hours per week.
- Seven are limited ambulatory programs providing direct medical care to the population served for less than 40 hours per week.
- Five are outreach and referral programs providing behavioral health counseling and education services, health promotion/disease prevention education, and immunization counseling but not direct medical care services.
- One is a residential treatment facility.
- Another provides national education and research services for UIO and the Office of Urban Indian Health Program (OUIHP).
- In addition to the 35 UIO, funding is also provided for dental services through the Albuquerque Area IHS Dental Program.

The UIO are evaluated in accordance with the Indian Health Care Improvement Act (IHCIA) requirements. The program is administered by the OUIHP in IHS Headquarters. The OUIHP integrates Strategic Planning, Performance and Program Integrity by annually reviewing UIO progress with set goals and objectives. The IHS Urban Indian Health Program Review Manual is used by the IHS Area Urban Coordinators to conduct annual onsite reviews of the IHS funded UIO to monitor compliance with contractual requirements that are established through legislation. The results are submitted to OUIHP for review and follow-up to ensure that corrective action plans are successfully completed prior to continuation funding.

Accomplishments – The UIO fulfill IHS data reporting requirements including the IHS Government Performance and Results Act (GPRA) report and the Diabetes Non-Clinical Audit report. Eight UIO currently participate in the IHS Improving Patient Care (IPC) initiative. Twenty-five UIO have completed the IPC collaborative and are now in the Quality and Innovation Learning Network (QILN) implementing what they have learned across a wider variety of clinical and administrative options.

From July 1, 2012 to June 30, 2013, the UIO 2013 GPRA cycle accomplishments included:
- 100 percent of the UIO reported on 20 of the 20 performance measures,
- 24 UIO reported through the Clinical Reporting System (CRS),
- 9 UIO reported using 100 percent review of appropriate data source (as opposed to sampling a smaller percentage of records), and
- One UIO met 100% of the 2013 GPRA measures that were established for UIO.

Through the Uniform Data System (UDS), the UIO report amounts and purposes for which funding is used, identify the number of eligible urban AI/AN for whom services are provided, and the number and type of services provided to urban AI/AN. The 2013 UDS report is the most recent year for which data is available. The UDS captures access to care, clinical status and quality of care, continuity of care, efficiency, provider productivity, cost effectiveness and financial sustainability. In addition, five UIO are accredited by the Accreditation Association for Ambulatory Healthcare. One UIO is accredited by the Joint Commission. One UIO is accredited by the Commission on Accreditation of Rehabilitation Facilities and six UIO have achieved Patient Centered Medical Home (PCMH) status.

As of March 2014, twenty-seven UIO have implemented the IHS Resource and Patient Management System (RPMS)/Electronic Health Record (EHR) (19 of the 27 implemented EHR) and six UIO utilize non-RPMS health information technology systems. Nineteen UIO had providers that registered and attested for meaningful use and ten UIO received CMS incentive payments. OUIHP works collaboratively with IHS Headquarters and Area Offices to provide support and deliver information technology technical assistance to twenty-seven UIO.

IHS is completing development of a national performance data mart. During FY 2015, IHS will evaluate and validate the new performance data mart which contains urban program data submitted to the National Data Warehouse. The plan is to report performance data from the data mart in FY 2016. With the addition of UIO data, the IHS will report aggregated results in FY 2016 from federal, tribal and urban sites. Currently, aggregated performance results include only federal and tribal sites.

Five significant program challenges exist:
1. Recruitment and retention of UIO health professionals;
2. Increased demand for health information technology training and technical assistance;

3. Increased need for training and technical assistance on third party billing and ICD-10;
4. Responding to UIO facilities maintenance and repair improvement needs at the current funding level; and
5. Implementation of new program authorities with the reauthorization of IHCIA including: 25 U.S.C. § 1659 Facilities Renovation; Sec. 163. Requirement to Confer with Urban Indian Organizations {25 U.S.C. § 1660d}; 25 U.S.C. § 1660e Expanded Program Authority for Urban Indian Organizations; 25 U.S.C. § 1660f Community Health Representatives; and 25 U.S.C. § 1660h Health Information Technology.

Tribal leadership consistently demonstrates support of increased funding levels for urban Indian health programs to serve their members who reside away from their Tribal communities. The UIO often provide the only affordable, culturally competent healthcare services available in these urban areas.

FUNDING HISTORY

Fiscal Year	Amount
2011 Omnibus	$43,139,000
2012 Enacted	$43,053,000
2013 Enacted	$40,729,000
2014 Final	$40,729,000
2015 Enacted	$43,604,000

BUDGET REQUEST

The FY 2016 budget request for the UIHP of $43,604,000 is the same level of the FY 2015 Enacted level.

Base Funding of $43,604,000 – The base funding is necessary to support the UIO funding and accomplishments to strengthen and enhance the HHS Strategic Plan for Fiscal Years 2014-2018. The funding addresses Goal 1-Strengthen Health Care; Goal 2-Advance Scientific Knowledge and Innovation; Goal 3-Advance the Health, Safety, and Well-Being of the American People; Goal 4-Ensure Efficiency, Transparency, Accountability, and Effectiveness of Health and Human Service programs by:

- Providing outreach, information and assistance to assure that eligible urban Indians are enrolled in the Health Insurance Marketplace (Output and Outcome UIHP-7);
- Enhancing third party revenue, implementing payment reforms such as the transition to a new prospective payment system, and increasing quality improvement efforts (Output and Outcome UIHP-2, 3, 6, and 7);
- Increasing the number of accredited or patient centered medical homes for urban Indians. Seven UIO are currently accredited. Six have achieved PCMH status and four are working towards achieving PCMH recognition. Twenty-five UIO have participated in the Improving Patient Care Initiative (Output and Outcome UIHP-7);
- Emphasizing preventive health including evaluation, dissemination, and promotion of effective clinical preventive services (Output and Outcomes UIHP-2, 3, 6, and 7);
- Applying innovative solutions to public health challenges to increase understanding of what works in public health;
- Implementing and utilizing health information technology (Output and Outcomes UIHP-2, 3, 6, and 7);

- Expanding access to quality, culturally competent care for urban Indians through collaboration with HHS;
- Investing in the number of health care providers to provide quality health services for urban Indians and to meet the increased workload demands;
- Implementing the new IHCIA authority to confer with Urban Indian Organizations.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
UIHP-2: Percent of AI/AN patients with diagnosed diabetes served by urban health programs that achieve good blood sugar control. (Outcome)	FY 2014: 47.1% Target: 48.3% (Target Not Met)	47.7%	49.5%	+1.8%
UIHP-3: Proportion of children, ages 2-5 years, with a BMI of 95 percent or higher (Outcome[1]) *Goal is a lower percentage*	FY 2014: 27.7% FY 2014 Target: N/A(Target Exceeded)	N/A	22.8%	N/A
UIHP-6: Increase the number of diabetic AI/ANs that achieve ideal blood pressure control (Outcome)	FY 2014: 67.7% Target: 71.0% (Target Not Met)	70.1%	68.9%	-1.2%
UIHP-7: Number of AI/ANs served at Urban Indian Clinics. (Outcome)	FY 2013: 53,408 Target: 51,832 (Target Exceeded)	51,167	53,408	+2,241

The UIHP targets for the glycemic control measure (UIHP-2) and blood pressure control measure (UIHP-3) reflect a merging of UIHP targets with the IHS clinical budget measures.

[1] Long-term measure, reportable in 2010, 2013 and 2016.

UIHP-3: For the past 24 years, one UIO has provided a youth summer camp for children aged 5-12. Youth participate in activities such as swimming, horseback riding, zip-line and rock wall, mountain/road biking, archery, hiking, and cultural activities such as drumming, singing, dancing, storytelling, and shawl making. Targeted goals are improved physical health and well-being, enhanced mental health and individual functioning, improved socialization skills, and youth workers. To address childhood obesity through nutrition, a detailed camp menu is developed and reviewed by a Registered Dietitian.

Affecting lifestyle changes among urban AI/AN families requires a culturally sensitive approach. The existing UIO have operated culturally appropriate initiatives to reduce childhood obesity, prevent diabetes and its complications, and reduce risk factors related to heart disease and cancer. Their continued efforts to target behavioral or lifestyle changes offer the best hope for impacting the major health challenges of the urban AI/AN population.

The initiative *Let's Move! in Indian Country* (LMIC) seeks to improve the health of AI/AN children, who are affected by childhood obesity at some of the highest rates in the country. UIO actively participate to advance the LMIC initiative by developing and implementing program activities at the local level to achieve the LMIC goals to raise the next generation of healthy Native children, create a healthy start on life, develop healthy learning communities, increase opportunities for physical activity, and ensure families have access to healthy affordable foods.

GRANTS AWARDS - Funding for UIOs for FY 2014 included both grants and contracts awarded to the programs.

CFDA No. 93.193 – Urban Indian Health Services			
	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	33	34	35
Average Award	$227,856	$246,856	$246,856
Range of Awards	$122,832 - $626,765	$122,832 - $626,765	$122,832 - $800,000

Area Allocation

Urban Indian Health

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2014 Final			FY 2015 Enacted			FY 2016 President's Budget			FY '16 +/- FY '15
	Federal	Urban	Total	Federal	Urban	Total	Federal	Urban	Total	Total
Alaska	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Albuquerque	945	1,473	2,418	1,002	1,587	2,589	1,002	1,587	2,589	0
Bemidji	1,615	2,520	4,135	1,713	2,713	4,427	1,713	2,713	4,427	0
Billings	889	1,387	2,276	943	1,494	2,437	943	1,494	2,437	0
California	2,550	3,977	6,527	2,705	4,283	6,988	2,705	4,283	6,988	0
Great Plains	595	929	1,524	632	1,000	1,632	632	1,000	1,632	0
Nashville	367	572	939	389	616	1,005	389	616	1,005	0
Navajo	281	439	720	298	472	771	298	472	771	0
Oklahoma	806	1,256	2,062	854	1,353	2,208	854	1,353	2,208	0
Phoenix	967	1,508	2,475	1,026	1,624	2,650	1,026	1,624	2,650	0
Portland	2,155	3,362	5,517	2,286	3,620	5,906	2,286	3,620	5,906	0
Tucson	201	313	514	213	337	550	213	337	550	0
Headquarters	4,540	7,082	11,622	4,816	7,627	12,442	4,816	7,627	12,442	0
Total, Urban Health	**$15,911**	**$24,818**	**$40,729**	**$16,877**	**$26,727**	**$43,604**	**$16,877**	**$26,727**	**$43,604**	**$0**

Note: Allocation amounts are estimates.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Services: 75-0390-0-1-551

INDIAN HEALTH PROFESSIONS

(Dollars in Thousands)

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$28,466	$48,342	$48,342	$0
FTE*	19	19	19	0

*FTE numbers reflect only federal staff and do not include tribal staff.

Authorizing Legislation .....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended 2010

FY 2016 Authorization.....Permanent

Allocation Method..... Direct Federal, Grants and Contracts

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The Indian Health Care Improvement Act (IHCIA) P.L. 94-437, as amended, authorizes the Indian Health Service (IHS) Indian Health Professions (IHP) Program which manages the Scholarship program, Loan Repayment program (LRP), health professions training related grants, and recruitment and retention activities for IHS. The IHS made its first Scholarship program awards in 1978 when Congress appropriated funds for the IHP program.

The IHP programs work synergistically to recruit and retain health professionals to provide high-quality primary care and clinical preventive services to American Indian and Alaska Native (AI/AN) communities. The IHP programs align with the Department of Health and Human Services (HHS) Strategic Plan Strategic Goal 1E, ensure access to quality, culturally competent care, including long-term services and supports, for vulnerable populations. The IHP programs consult with tribes to determine which health professions are needed in AI/AN communities. The IHP programs also work with IHS, tribal facilities and Urban Indian Programs and the Health Resources and Services Administration to increase the number of sites eligible to participate as National Health Service Corps (NHSC) approved sites for the NHSC Scholarship program and LRP. Both of these activities align with the HHS Strategic Goal 1E and the IHS Priorities 1 and 3 to strengthen tribal partnerships and improve the quality of and access to care.

The IHP program has seen much success throughout the years including, but not limited to, the following:

- Enabling AI/ANs to enter the health care professions through a carefully designed system of preparatory, professional, and continuing educational assistance programs.
- Serving as a catalyst in developing AI/AN communities by providing educational opportunities and enabling AI/AN health care professionals to further Indian self-determination in the delivery of health care.
- Developing and maintaining American Indian psychology career recruitment programs as a means of encouraging AI/ANs to enter the mental health field.
- Assisting AI/AN health programs to recruit and retain qualified health professionals.

While the IHP programs have seen successes, we continue to strive to improve our performance and identify areas of risk. Placement of new scholars within 90 days of completing their training

continues to be a challenge. The use of online manuals, e-Newsletters, emails, and referral of graduates to recruiters have all been used to facilitate the 90 day scholar placement. In FY 2014, 56.7 percent of scholars had a hire letter within 90 days (target was 78 percent). Failure to meet this goal was primarily due to nursing scholars not completing their boards and finding positions within the 90 day period. The Scholarship program continues to look for new ways to assist our scholars in meeting this requirement. Assuring scholars and loan repayment recipients meet their service obligation is another critical component of the IHP programs. Annual employment verification through personnel rosters and certification by tribal employers assist in this process. Scholarship program and LRP databases allow staff to identify when health professionals are expected to complete their service obligation and allow for timely follow-up.

Loan Repayment Program (Section 108): The LRP is an invaluable tool for recruiting and retaining healthcare professionals, offers health care professionals the opportunity to reduce their student loan debts through service to Indian health programs with critical staffing needs. Applicants agree to serve two years at an Indian health program in exchange for up to $20,000 per year in loan repayment funding and up to an additional $5,000 per year to offset tax liability. Loan repayment recipients can extend their initial two-year contract on an annual basis until their original approved educational loan debt is paid.

Applicants who apply for funding and do not receive it, are identified as either "matched unfunded" or "unmatched unfunded." The "matched unfunded" applicants are health professionals employed in an Indian health program. The "unmatched unfunded" applicants are health professionals that either decline a job offer because they did not receive loan repayment funding or those unable to find a suitable assignment meeting their personal or professional needs. In FY 2014, there were 118 "matched unfunded" applicants (including 5 physicians, 5 behavioral health providers, 9 dentists, and 42 nurses) and 468 "unmatched unfunded" health professionals (including 13 physicians, 34 behavioral health providers, 34 dentists, and 237 nurses). The inability to fund these 586 health professional applicants is a significant challenge for the recruitment efforts of the agency. It is estimated that an additional $29.94 million would be needed to fund the 586 unfunded health professional applicants from FY 2014. A more detailed breakout of loan repayment awards in FY 2014 by discipline is included in a table at the end of the narrative.

The $5 million increase in LRP funding in FY 2015 is estimated to allow IHS to offer an additional 115 new loan repayment awards.

Sections 103 and 104 of the Scholarship Program – Section 103 scholarships include the preparatory and pre-graduate scholarship programs that prepare students for health professions training programs. Graduate students and junior- and senior-level undergraduate students are given priority for funding for programs under Section 103, unless the section specifies otherwise. Section 104 includes the Health Professions Scholarship program, which provides financial support consisting of tuition, fees and a monthly stipend for AI/AN students from federally recognized Tribes enrolled in health profession or allied health profession programs. Students accepting funding for programs under Section 104 incur a service obligation and payback requirement. A detailed breakout of scholarships awarded by discipline in FY 2014 is included in a table at the end of the narrative.

In 2013, the IHS Scholarship program provided retention metrics for inclusion in a system design guide for the revision of the Scholarship Management System. When completed, the system will provide annual reports on retention of scholarship recipients employed by IHS beyond the obligated service period.

FUNDING HISTORY

Fiscal Year	Amount
2011 Omnibus	$40,661,000
2012 Enacted	$40,596,000
2013 Enacted	$38,467,000
2014 Final*	$28,466,000
2015 Enacted**	$48,342,000

* In order to fully fund IHS Contract Support Costs in FY 2014, IHS reduced base funding for several programs, including Indian Health Professions ($10 million total IHP reduction) during the fiscal year.
** The FY 2015 Enacted restores IHP cuts, includes a $5 million LRP increase and a $4.8 million transfer of LRP funds from the Hospital and Health Clinics (H&HC) budget line.

BUDGET REQUEST

The FY 2016 budget request for the Indian Health Professions program of $48,342,000 is the same as the FY 2015 Enacted level.

Base Funding of $48,342,000 – The base funding is necessary to enable AI/ANs to enter the health care professions through a carefully designed system of preparatory, professional, and continuing educational assistance programs; serve as a catalyst in developing AI/AN communities by providing educational opportunities and enabling AI/AN health care professionals to further Indian self-determination in the delivery of health care; and assist Indian health programs to recruit and retain qualified health professionals.

The FY 2016 budget request also includes a legislative proposal for tax relief for the IHS Scholarship and LRP recipients to allow tax relief similar to the NHSC Scholarship and LRP.

The table below specifies the expected performance of each budget proposal by section.

Sec	Title	FY 2014 Final Level	FY 2015 Enacted Level	FY 2016 President's Budget	FY 2016 +/- FY 2015	Expected Performance*
103	Health Professions Preparatory and Pre-Graduate Scholarships	$2,302,494	$3,687,137	$3,687,137	0	52 continuing and 37 new student agreements
104	Health Professions Scholarship	$5,034,760	$10,034,760	$10,034,760	0	171 continuing and 52 new student contracts
105	Extern Program	$0	$1,115,357	$1,115,357	0	135 temporary clinical assignments
108	Loan Repayment Program	$17,646,607	$30,022,607	$30,022,607	0	360 contract extensions and 465 new contracts.
112	Quentin N. Burdick American Indians Into Nursing Program	$1,669,697	$1,669,697	$1,669,697	0	4 grants
114	Indians into Medicine (INMED) Program	$1,097,364	$1,097,364	$1,097,364	0	3 grants
217	American Indians Into Psychology Program	$715,078	$715,078	$715,078	0	3 grants
	TOTAL	**$28,466,000**	**$48,342,000**	**$48,342,000**	**0**	

In FY 2014, the LRP received $4,875,597 in H&HC funds, which continues the funding support for loan repayment awards first appropriated in FY 2001. The LRP awarded 112 new LRP contracts to various health professionals, including nurses, dentists, pharmacists, and mid-level practitioners with H&HC funding. In FY 2015, these funds were rolled into the Indian Health Professions line item from H&HC to be used for the LRP and the FY 2016 budget carries forward this policy.

GRANTS AWARDS – The IHP administers three grant programs which fund colleges and universities to train students for health professions: Quentin N. Burdick American Indians into Nursing Program (Section 112), Indians into Medicine Program (Section 114), and American Indians into Psychology Program (Section 217). These programs provide critical support to students during their health career professional pathway and encourage students to practice in the Indian health system.

CFDA No. 93.970 - Health Professions Recruitment Program for Indians			
	FY 2014 Final Level	FY 2015 Enacted Level	FY 2016 President's Budget
***Quentin N. Burdick American Indians Into Nursing Program (Section 112) – CFDA No. 93.970**			
Number of Awards	4	4	4
Average Award	$414,924	$414,924	$414,924
Range of Awards	$414,924	$414,924	$414,924
Indians Into Medicine Program (Section 114) – CFDA No. 93.970			
Number of Awards	3	3	3
Average Award	$356,083	$356,083	$356,083
Range of Awards	$170,000 - $728,250	$170,000 - $691,837	$170,000 - $691,837
American Indians Into Psychology Program (Section 217) – CFDA No. 93.970			
Number of Awards	3	3	3
Average Award	$238,359	$238,359	$238,359
Range of Awards	$200,000-$253,000	$238,259	$238,359

* A new grant cycle in FY 2014 changed all 4 awards to the same level of funding, $414,924 per award.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2015 Target*	FY 2016 Target*	FY 2016 Target +/- FY 2015 Target
42: Scholarships: Proportion of Health Professionals Scholarship recipients placed in Indian health settings within 90 days of graduation.	FY 2014 Final: 56.7% Target:78% (Target Not Met)	78%	78%	0
Number of Scholarship Awards – Total				
IHP-1: Section 103: Health Professions Preparatory and Pre-Graduate Scholarships *(Outputs)*	FY 2014 Final: 84 Target:23 (Target Exceeded)	85	89	+4
IHP-2: Section 104: Health Professions Scholarship *(Outputs)*	FY 2014 Final: 260 Target: 228 (Target Exceeded)	228	223	-5
IHP—3: Number of Externs (Section 105) *(Outputs)*	FY 2014 Final: 111 Target: 0	135	135	0

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2015 Target*	FY 2016 Target*	FY 2016 Target +/- FY 2015 Target
	(Target Exceeded)			
Number of Loan Repayments Awarded – Total (Section 108)** *(Outputs)*	FY 2014 Final: 1,229 Target: 440 (Target Exceeded)	503	1,185	+682
IHP-4: New Awards (2 Year Awards) *(Outputs)*	FY 2014 Final: 379 Target: 180 (Target Exceeded)	243	465	+222
IHP-5: Contract Extensions (1 Year Awards) *(Outputs)*	FY 2014 Final: 331 Target: 260 (Target Exceeded)	260	360	+100
IHP-6: Continuation Awards (Funded in Previous Fiscal Year) (*Outputs)*	FY 2014 Final: 519 Target: 500 (Target Exceeded)	180	360	+180

* FY 2015 and FY 2016 "Targets" include estimates based on complete FY 2014 funding cycle data and additional Loan Repayment Program funding received in the FY 2015 budget.
** The "Number of Loan Repayments – Total" includes New Awards, Contract Extensions and Continuation Awards. The FY 2014 figures include awards funded with Hospital & Health Clinics funds.

The IHS performance goal is to place scholars within 90 days from when they complete their health profession degree or training. The IHS hiring reforms and improved tracking of placements should result in improved performance and meeting the objective.

The proposed budget level will allow the IHS to graduate and recruit hundreds of new health professionals and retain health professionals already in service. Most new LRP contracts go to newly hired health professionals serving in IHS, Tribal or Urban Indian Programs. These new providers allow for additional patients to be seen in clinics and hospitals and allow new and preventive services to be provided. Retaining current employees is also essential to continuity of care for our patients and necessary for sites to maintain essential health care services to patients.

Scholarship Program Awards – In FY 2014, students in the following disciplines received IHS Scholarship Program funding:

Section 103 Pre-professional - 30 students				
Pharmacy	10		Clinical Psychology	3
Nursing	15		Social Work	2
Section 103 Pre-graduate – 54 students				
Medicine	44		Optometry	2
Dentistry	8			
Section 104 Health Professions - 260 students				
Physician (Doctor of Osteopathic Medicine and Doctor of Medicine)	33		Medical Technology	2
Nurse (Associate Degree Nurse, Bachelor and Master)	65		Social Work	9
Pharmacist	40		Sanitarian	1
Dentist	41		Chemical Abuse Counseling	3
Physical Therapist	12		Nurse Midwife	1
Physician Assistant	6		Podiatrist	1
Clinical Psychologist	6		Health Records	6
Optometrist	12		X-Ray Technology	4
Nurse Practitioner	18			

Loan Repayment Program Awards – In FY 2014, the IHS LRP made awards to the following disciplines:

Awards by Profession	Total Awards**	New Awards	Contract Extensions	Matched Not Awarded
Nurses	147	131	16	42
Dental*	96	46	50	9
Pharmacists	182	45	137	22
Physicians	72	35	37	5
Physician Assistants/Advanced Practice Nurses	53	33	20	17
Behavioral Health	33	21	12	5
Optometrists	31	6	25	3
Podiatrists	13	3	10	1
Rehabilitative Services	29	11	18	3
Other Professions	54	48	6	11
TOTAL	**710**	**379**	**331**	**118**

***** Includes Dentists, Dental Hygienists, and Dental Assistants.
**Includes awards funded with Hospitals & Health Clinics funds.

Other Professions	Total Awards	Matched Not Awarded	By Pay System	Awards
Medical Lab Scientist	6	4	Tribal Employees	373
Dietician	10	0	Civil Service	209
Medical Technician	2	2	Commissioned Corps	119
Engineer	5	0	Urban Health Employees	8
Diagnostic Radiology Technician	14	4	Buy Indian	1
Sanitarian	5	0		
Respiratory Therapist	4	1		
Chiropractor	7	0		
Health Records	1	0		
TOTAL	**54**	**11**	**Total**	**710**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Services: 75-0390-0-1-551

TRIBAL MANAGEMENT GRANT PROGRAM

(Dollars in Thousands)

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$1,442	$2,442	$2,442	$0
FTE*	0	0	0	0

*Tribal Management Grant funds are not used to support FTEs.

Authorizing Legislation ..... 25 U.S.C. 450, Indian Self-Determination and Education Assistance Act, as amended 2010

FY 2016 Authorization.....Permanent

Allocation Method ..... Discretionary competitive grants to Tribes and Tribal organizations

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The Tribal Management Grant (TMG) program was authorized in 1975 under Sections 103(b)(2) and 103(e) of Public Law (P.L.) 93-638, Indian Self-Determination and Education Assistance Act (ISDEAA), as amended. It was established to assist all federally-recognized Indian Tribes and Tribally-sanctioned Tribal organizations (T/TO) to plan, prepare, or decide to assume of all or part of existing Indian Health Service (IHS) programs, functions, services, and activities (PFSA) under the authority of the ISDEAA and to further develop and enhance their health program management capability and capacity. The TMG program provides discretionary competitive grants to T/TO, to establish goals and performance measures for current health programs, assess current management capacity to determine if new components are appropriate, analyze programs to determine if T/TO management is practicable, and develop and enhance infrastructure systems to manage or organize PFSA. The nature of the TMG program allows T/TO the option to enter or not enter into ISDEAA contracts/compact agreements which are equal expressions of self-determination. If a Title I Tribe exercises their right of self-determination by assuming operations and management of programs, then they will be prepared to compact services under Title V Self Governance.

The TMG program has established three funding priorities. The first priority is for any Tribe that has received federal recognition or restoration within the last five years. The TMG program recognizes that newly recognized or restored Tribes need assistance implementing or developing management and infrastructure systems for their organization. The second priority focuses on T/TO that need to improve financial management systems to address audit material weaknesses. This priority recognizes the importance of addressing audit capacity in order to strengthen infrastructure to provide additional or improved services. The third priority includes all other projects and T/TO.

The TMG program offers four project types with three different award amounts and project periods:

(1) Planning - fund up to $50,000 with project periods not to exceed 12 months. A Planning Project allows establishment of goals and performance measures for current health programs or to design their health programs and management systems.

(2) Evaluation - fund up to $50,000 with project periods not to exceed 12 months. An Evaluation Study Project determines the effectiveness and efficiency of a program or if new components are needed to assist the T/TO improve its health care delivery system.

(3) Feasibility - fund up to $70,000 with project periods not to exceed 12 months. A Feasibility study analyzes programs to determine if T/TO management is practicable.

(4) Health Management Structure (HMS) grants are funded up to $300,000 with project periods not to exceed 36 months. HMS projects include the design and implementation of systems to manage PFSA, such as Electronic Health Records (EHR) systems or billing and accounting systems, health accreditation, as well as correction of audit material weaknesses.

This budget request provides critical funding support for the above listed activities to strengthen T/TO health care (HHS Strategic Goal 1: Objective E). The TMG program develops and enhances the management and financial infrastructure of T/TO by preparing and assisting T/TOs in assuming PFSA of the IHS under Title I contracting. The T/TO services will provide comprehensive primary and preventive services for historically underserved areas. This budget request represents the need for continued TMG funding as identified during the Budget Formulation and Tribal Consultation processes.

Approximately 338 T/TO have successfully taken over PFSA from the IHS either through a contract or compact as a result of having their management and financial infrastructure improved or developed.

For almost 40 years, the TMG program has assisted many of the 566 federally-recognized T/TO (75 percent) to evolve organizationally with good health management infrastructure to the point of being able to compete for other grant programs under HHS as well as other federal agencies. The feasibility funds are critical in helping T/TOs conduct planning to assess if it is feasible to assume an IHS PFSA. T/TO develop their health management structure by developing policies and procedures, addressing audit weaknesses and deficiencies, perform accreditation for the Joint Commission. They evaluate programs they have taken over under P.L. 93-638 contracting such as Community Health Representatives or Alcohol Substance Abuse or Mental Health and others.

Approximately 3 percent of TMG funding is used for overall administration of the program; these funds provide program requirements training, grant writing workshops and general technical assistance. These efforts assist T/TO in developing proposals that fully address the TMG project cycle and are responsive to the program announcement. Past performance has demonstrated that T/TOs who participate in TMG training and technical assistance sessions score higher in the objective review than those with no grant training.

Throughout the program's history, staff continue to build upon and identify best practices. In FY 2016, TMG will continue to strengthen program policies and procedures and expand on what works well for T/TOs. Based on the results of training and technical assistance sessions, the TMG program will continue to implement and improve upon training and technical assistance efforts.

FUNDING HISTORY

Fiscal Year	Amount
2011 Omnibus	$2,581,000
2012 Enacted	$2,577,000
2013 Enacted	$2,442,000
2014 Final	$1,442,000
2015 Enacted	$2,442,000

BUDGET REQUEST

The FY 2016 budget request for the TMG Program of $2,442,000 is the same as the FY 2015 Enacted level.

Base Funding of $2,442,000 – The base funding is necessary to maintain the TMG program in:

- The building of health management infrastructure for T/TOs including, but not limited to, EHR conversion, third-party billing, and health accreditation, all of which impacts the provision of health care.
- Increasing the T/TOs ability to compete for other grant programs as the management capability of the applicant organization plays an important role in securing federal funding from other federal agencies on a broader scale.
- Enhancement of a Tribe's ability to assume PFSA from the IHS under the ISDEAA, P.L. 93-638 contracts.
- The incorporation of newly federally-recognized or federally-restored Tribes for IHS assistance and consideration to provide technical assistance and develop their management capacity and capability to achieve and eventually exercise their government-to-government relationship as sovereign nations under the ISDEAA and eventually assume PFSA, if they choose to do so.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
Planning Grants	FY 2014: 1 Target: 2 (Target Not Met)	2	2	0
Health Management Structure (HMS) Grants	FY 2014: 15 Target: 28 (Target Not Met)	26	26	0

Performance was less in 2014 due to a decrease of funds – TMG funds in the amount of $1,000,000 were utilized for funding/augmenting Contract Support Costs (CSC) shortfall payments as required by the Supreme Court decision in *Salazar v. Ramah*, which stated that the IHS is required to fully fund CSC from its Services appropriation.

GRANTS AWARDS

FY 2014 funding was distributed to Tribes for individual grant awards as follows: 88 percent of the available funding was distributed for grant awards that focused on Health Management Structure; 8 percent of funding was distributed for planning grants; and 4 percent of funding was distributed for Evaluation studies. Estimate percentages for FYs 2014, 2015 and 2016 will likely remain the same.

CFDA No. 93.228 – CFDA Tribal Management Grant			
	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards[1]	$1,442,000 13 Noncompeting Continuations and 3 New	$2,442,000 10 Noncompeting Continuations and 17 New	$2,442,000 10 Noncompeting Continuations and 17 New
Average Award	$90,125	$95,444	$95,444
Range of Awards	$50,000 - $150,000	$50,000 - $150,000	$50,000 - $150,000

[1] Includes partial awards

AREA ALLOCATION

Tribal Management Grants

Discretionary SERVICES	**FY 2014 Final**	**FY 2015 Enacted**	**FY 2016 President's Budget**	**FY 2016 +/- FY 2015**
Headquarters	$1,442	$2,442	$2,442	$0
Total, TMG	**$1,442**	**$2,442**	**$2,442**	**$0**

Note: Funds are not allocated on a recurring basis to Areas but awarded on a competitive basis to T/TO directly from IHS Headquarters.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Services: 75-0390-0-1-551
DIRECT OPERATIONS

(Dollars in Thousands)

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$65,894	$68,065	$68,338	+$273
FTE*	268	268	268	0

*FTE numbers reflect only federal staff and do not include tribal staff.

Authorizing Legislation .....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended 2010

FY 2016 Authorization.....Permanent

Allocation Method.....Direct Federal, P.L. 93-638 Self-Determination Contracts, and Self-Governance Compacts

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The Direct Operations budget supports the Indian Health Service (IHS) in providing Agency-wide leadership, oversight, and executive direction for the comprehensive public and personal health care provided to American Indians and Alaska Natives (AI/AN) by the IHS. IHS Headquarters administers the Agency in the context of Administration goals, HHS goals, and the IHS mission and priorities while simultaneously maintaining the special Tribal-Federal relationship based in treaty and law. Agency administration includes oversight of national functions such as: human resources, financial resources, acquisitions, internal controls, health care and facilities planning, health information technology, and other administrative support resources and systems' accountability. With more than half of the IHS budget managed by Tribes, the IHS continues to function as a large, comprehensive, primary health care system that benefits from many efficiencies through common administrative systems and consistent business practices. The role of Tribes and Tribal organizations in managing the delivery of health care facilities has also increased an Agency focus and responsibility on addressing Contract Disputes Act claims and the authorities for settlement analyses and negotiation are conducted at the highest levels.

The IHS Headquarters provides overall program direction, authorities and oversight for the 12 IHS Areas and 168 Service Units; formulates policy and distributes resources; provides technical expertise to all components of the Indian health care system, which includes IHS direct, Tribally operated programs, and Urban Indian health programs (I/T/U); maintains national statistics and public health surveillance; identifies trends; and projects future needs. The IHS Headquarters actively works with HHS to formulate and implement national health care priorities, goals, and objectives for AI/ANs within the framework of its mission. The IHS Headquarters works with HHS to formulate the annual budget and necessary legislative proposals. In addition, it responds to congressional inquiries and interacts with other governmental entities to enhance and support health care services for AI/ANs.

The Direct Operations budget also supports the 12 Area Offices, which, by delegation from the IHS Director, distribute resources, monitor and evaluate the full range of comprehensive health care and community oriented public health programs, and provide technical support to local

Service Units and I/T/U staff. They ensure the delivery of quality health care through the 168 Service Units and participate in the development and demonstration of alternative means and improvement techniques of health services management and delivery to promote the optimal provision of health services to Indian people through the Indian health system.

The Direct Operations budget is critical to continue making progress in addressing the agency priority to reform the IHS. One example of reform is implementation of the Affordable Care Act (ACA) and the Indian Health Care Improvement Act (IHCIA) within the IHS. In FY 2014, implementation has focused on helping IHS beneficiaries during the Health Insurance Marketplace open enrollment period, continuing to help Tribal members who can enroll monthly throughout the entire year as a special benefit of the ACA, helping with Medicaid and CHIP enrollment throughout the year, and helping Tribal members and those eligible for IHS with the application for an exemption or waiver from the tax penalty. IHS and its Tribal partners have continued outreach, education, and enrollment activities as well as focusing on enhanced business office and health care delivery system improvements necessary to fully implement ACA and IHCIA provisions in the IHS. IHS recently worked on guidance for the business office, local contracting with Qualified Health Plans from the Marketplace, and training on how to incorporate the new plans and their requirements into the IHS Purchased Referred Care program. As the ACA is implemented, IHS's ability to show that it is improving and providing quality care will help encourage its current patients to continue using its facilities, even if they take advantage of the health coverage options offered by the ACA. This could mean more third-party resources that will help improve access to services for all patients served at IHS facilities.

Another example of agency reform is improving Human Resource Management and Servicing systems. The FY 2015 performance goal for IHS executives across the IHS is to have an IHS average overall hiring time of fewer than 80 days. The focus of improvements in the hiring process is ensuring a high quality of applicants on selection certificates and expediting on-boarding through expanded direct hiring authorities. In addition the agency has made improvements in utilization of pay systems for more competitive salaries because historically it has been difficult for IHS to recruit and retain healthcare personnel due to remote locations and noncompetitive salaries. IHS continues the collaborative work with the Health Resources and Services Administration, which has resulted in approval of 650 IHS, Tribal and Urban Indian health care delivery sites for placement of National Health Service Corps health care providers and the number of placements has increased to 381 providers as of December 2014. The progress was made possible by collaboratively developing a process for a pre-approved method for site eligibility. Finally, the IHS is implementing a Veterans Hiring Initiative (VHI), announced in FY 2014, to increase the number of veterans employed at the IHS. The goal is to increase the percent of new hires who are veterans from 6 percent to 9 percent in 2 years. The IHS Initiative includes a marketing campaign to IHS and Tribal facilities about participation in the VHI; development of a pilot program to hire qualified veterans with Intermediate Care Technician experience; partnering with the Department of Labor Employment and Training Service Office on veteran employment opportunities; and collaborating with the HHS Veterans Outreach lead on coordinating activities with the Department of Veterans Affairs in the "VA for Vets" program. The Initiative is also involved in other activities locally and regionally.

One important performance goal for IHS is that IHS ensures that 100 percent of all IHS-operated health care facilities achieve or maintain accreditation or certification by a national health care organization. For example, when Centers for Medicare and Medicaid Services (CMS) survey in 2014 identified a specific facility was at risk of losing accreditation, IHS acted immediately by putting a corrective action plan in place, and in one case by deploying, staff from headquarters and, several health care providers to help at the hospital. This response addressed the survey

findings and passed a follow-up survey with no further findings. The IHS is also taking a system-wide approach to certification/accreditation with funding support from CMS through the development of an IHS Hospital Consortium which is working on directives to federal health care sites to implement consistent accreditation practices. The accreditation/certification performance measure is critical to IHS operations and is one of the six performance measures IHS contributes to in the HHS Strategic Plan. In total, IHS has six representative performance measures for which progress is tracked in meeting defined targets and reported and monitored as part of the HHS Annual Performance Plan and Report which details performance progress for the HHS. The Direct Operations budget request will help provide the oversight needed to measure, track and report performance outcomes.

FUNDING HISTORY

Fiscal Year	Amount
2011 Omnibus	$68,583,000
2012 Enacted	$71,653,000
2013 Enacted	$67,894,000
2014 Final	$65,894,000
2015 Enacted	$68,065,000

BUDGET REQUEST

The FY 2016 budget request for Direct Operations of $68,338,000 is $273,000 above the FY 2015 Enacted level.

Base Funding of $68,065,000 – Funding is necessary for Direct Operations to continue to fund system-wide administrative, management and oversight priorities at the discretion of the IHS Director that include:

- Continuing investments to maintain improvements and reforms made to date and to continue enhancements in the IHS' capacity for providing comprehensive oversight and accountability in key administrative areas such as: human resources, property, financial management, Information Technology, program and personnel performance management and Purchased Referred Care (PRC) program improvements developed through PRC consultation recommendations on improving business practices related to PRC and third-party reimbursements.
- Addressing recent Congressional oversight and reports issued by the General Accountability Office (GAO) and the Office of Inspector General (OIG) to make improvements in management of IHS programs, such as the PRC program.
- Addressing requirements for national initiatives associated with privacy requirements, facilities, and personnel security.
- Continuing to settle and negotiate Tribal contracting and compacting Contract Support Costs claims and establish policies and procedures to accurately determine CSC needs in the future.
- Improving responsiveness to external authorities such as Congress, GAO, and OIG on questions related to oversight recommendations and the implementation and continuing accountability for new permanent authorities of the reauthorization of the IHCIA. The IHS has placed a high priority on the issues raised in the Senate Committee on Indian Affairs (SCIA) investigation of the IHS Aberdeen Area (now the Great Plains Area), and, in addition to implementing a corrective action plan to address findings in the Great Plains Area, IHS established a schedule to conduct comprehensive reviews of all IHS Areas to ensure that the findings of the investigation are not global IHS issues. In 2013, IHS completed Area Oversight Reviews for all 12 Areas and provided a report to the SCIA summarizing each

Area's Assessment including Findings and Actions. IHS will continue to implement and monitor improvements and corrective actions related to the findings of the Area reviews, internal and external reviews.

Current Services Increase of $273,000 includes:

- Pay Costs +$273,000 – to cover pay raises for Federal employees, which improve the ability of the agency to retain high performing employees. A funding increase is necessary to mitigate the impact of higher payroll costs on base budgets as the result of pay raises.

Direct Operations Headquarters and Area Offices – Estimated Distribution: The distribution of funds includes Headquarters operations (excluding Urban and Self-Governance programs), 12 Area Offices operations, and Tribal shares as indicated by the table below:

	FY 2014 Final	FY 2015 Enacted	FY 2016 Pres. Budget
Headquarters (58.7%)	$38,679,778	$39,959,677	$40,119,950
Title I Contracts (non-add)	*2,124,052*	*2,129,402*	*2,137,943*
Title V Compacts (non-add)	*6,354,796*	*6,370,801*	*6,396,353*
Area Offices (12) (41.3%)	27,214,222	28,105,323	28,218,050
Title I Contracts (non-add)	*537,195*	*538,548*	*540,708*
Title V Compacts (non-add)	*8,541,937*	*8,563,451*	*8,597,798*
BA	**$65,894,000**	**$68,065,000**	**$68,338,000**

Area Allocation

Direct Operations
(dollars in thousands)

DISCRETIONARY SERVICES	FY 2014 Final			FY 2015 Enacted			FY 2016 President's Budget			FY '16 +/- FY '15
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$3,330	$1,342	$4,672	$3,472	$1,354	$4,826	$3,487	$1,358	$4,845	$19
Albuquerque	922	372	1,294	962	375	1,337	966	376	1,342	5
Bemidji	989	399	1,388	1,032	402	1,434	1,036	403	1,439	6
Billings	1,581	637	2,218	1,648	643	2,291	1,656	645	2,300	9
California	1,044	421	1,465	1,089	425	1,513	1,093	426	1,519	6
Great Plains	1,726	696	2,422	1,800	702	2,502	1,808	704	2,512	10
Nashville	1,204	485	1,689	1,255	489	1,745	1,261	491	1,752	7
Navajo	2,169	874	3,043	2,261	882	3,143	2,271	885	3,156	13
Oklahoma	2,528	1,019	3,547	2,636	1,028	3,664	2,647	1,031	3,679	15
Phoenix	2,162	871	3,033	2,254	879	3,133	2,264	882	3,145	13
Portland	1,822	734	2,556	1,900	741	2,640	1,908	743	2,651	11
Tucson	481	194	675	502	196	697	504	196	700	3
Headquarters	27,010	10,882	37,892	28,161	10,980	39,140	28,282	11,015	39,297	157
Total, Direct Ops	**$46,971**	**$18,923**	**$65,894**	**$48,971**	**$19,094**	**$68,065**	**$49,183**	**$19,155**	**$68,338**	**+$273**

DEPARTMENT OF HEALTH & HUMAN SERVICES
Indian Health Service
Services: 75-0390-0-1-551
SELF-GOVERNANCE

(Dollars in Thousands)

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$4,227	$5,727	$5,735	+$8
FTE*	13	13	13	0

*FTE numbers reflect only federal staff and do not include tribal staff.

Authorizing Legislation ..... Title V of the Indian Self-Determination and Education Assistance Act (ISDEAA), as amended 25 U.S.C. § 458aaa et seq., 42 C.F.R. Part 137

FY 2016 Authorization.....Permanent

Allocation Method ..... Direct Federal, Cooperative Agreements, and Self-Governance Funding Agreements

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The Office of Tribal Self-Governance (OTSG) is responsible for a wide range of agency functions that are critical to the IHS' relationship with American Indian and Alaska Native (AI/AN) nations, Tribal organizations, and other AI/AN groups. The budget supports OTSG activities to comply with the President's Memorandum for the Heads of Executive Departments and Agencies of November 5, 2009, on Tribal Consultation.[1] OTSG activities support self-governance in the context of the Agency priorities: renew and strengthen our partnership with Tribes; reform the IHS; improve the quality of and access to care; and ensure that all work is transparent, accountable, fair, and inclusive.

Since 1993, the IHS, in cooperation with Tribal representatives, developed formula methodologies for identification of Tribal shares for all Indian Tribes. Tribal shares are those program and administrative funds that Tribes are eligible to assume through self-determination contracts and self-governance compacts.[2] Today approximately 60 percent of the IHS budget appropriation is transferred to Tribes and Tribal organizations through these agreements. The IHS Tribal Self-Governance program has grown dramatically since the initial 14 compacts and funding agreements were signed in 1994. As of September 2014, the IHS negotiated a total of 84 self-governance compacts and 109 funding agreements with Indian Tribes and Tribal organizations. In FY 2015, approximately $1.8 billion, over one-third of the total IHS budget appropriation, will be transferred to Tribes to support 89 ISDEAA Title V compacts and 114 funding agreements.[3]

[1] *Available at* http://www.whitehouse.gov/sites/default/files/omb/memoranda/2010/m10-33.pdf
[2] The ISDEAA provides two mechanisms for Tribes and Tribal organizations to assume responsibility for health care formerly provided by the Federal government. The IHS Tribal Self-Governance Program is authorized under Title V of the Act. Tribes may also contract with the IHS through self-determination contracts and annual funding agreements authorized under Title I of the Act.
[3] For FY 2015, the IHS estimates an additional five Tribes entering into Title V ISDEAA compacts and funding agreements. This estimate corresponds to the number of Self-Governance Negotiation Cooperative Agreements available each fiscal year. Eligibility requirements for these agreements mirror the statutory requirements that Tribes must meet to participate in the IHS Tribal Self-Governance Program (25 U.S.C. § 458aaa–2; 42 C.F.R. Part 137, Subpart C). For this pool, an average estimate of $5 million per Tribe is used to project estimates for Tribes entering into a Title V ISDEAA compacts and funding agreements, inclusive of both Tribal shares and contract support costs.

The Self-Governance budget supports activities, including but not limited to: government-to-government negotiation of self-governance compacts and funding agreements; oversight of the IHS Director's Agency Lead Negotiators; technical assistance on Tribal consultation activities; analysis of Indian Health Care Improvement Act (IHCIA) authorities; and supporting the activities of the IHS Director's Tribal Self-Governance Advisory Committee.

The Self-Governance budget strengthens and renews partnerships with Tribes through several activities:

- Develops and oversees the implementation of Tribal self-governance legislation and authorities in the IHS.
- Reviews eligibility requirements for Tribes to participate in the Tribal Self-Governance Program and to receive Self-Governance Planning and Negotiation Cooperative Agreements.
- Provides resources and technical assistance to Tribes and Tribal organizations for the implementation of Tribal self-governance.
- Provides Tribal Self-Governance program training to Tribes, Tribal organizations, and Tribal groups.
- Coordinates national Tribal self-governance meetings, including an annual conference in partnership with the Department of the Interior, to promote the participation by all AI/AN Tribes in the IHS Tribal Self-Governance program activities and program direction.
- Develops, publishes, and presents information related to the IHS Tribal Self-Governance program activities to Tribes, Tribal organizations, state and local governmental agencies, and other interested parties.
- Coordinates self-governance Tribal Delegation Meetings for HHS, the IHS Headquarters, and Area Senior officials.

The Self-Governance budget supports health innovation and reform activities by:

- Overseeing the negotiation of Tribal self-governance compacts and funding agreements;
- Supporting authorities available to Tribes under the IHCIA, as amended; and
- Providing support for projects that improve Tribally-operated health programs, Government Performance and Results Act (GPRA) reporting, and facility accreditation.

The Self-Governance budget improves the quality of and access to care by:

- Providing support for projects that assist Tribally-operated health programs to enhance information technology infrastructure and prepare for meaningful use and other federal reporting standards;
- Providing support for negotiation for Title V construction project agreements to assist Tribes to expand and to modernize health care facilities; and
- Collaborating on crosscutting issues and processes including, but not limited to: budget formulation; program management issues; self-determination issues; Tribal shares methodologies; and emergency preparedness, response and security.

The Self-Governance budget ensures all work is transparent, accountable, fair and inclusive by:

- Maintaining, improving, and updating a Title V database containing Tribal compacts and all funding agreement documents. The database provides 24/7 access to Tribes and IHS staff. It also meets all Federal Funding Accountability and Transparency Act requirements and

reports all Title V compact and funding agreement amounts to the HHS Tracking Accountability in Government Grants System;
- Coordinating and reporting IHS Tribal Consultation activities with Tribes, HHS, and other federal agencies in accordance with law, executive orders, and policy; and
- Publishing and disseminating self-governance information nationally to Tribes and Tribal organizations.

These services are deployed in accordance with strategic planning, are data driven, and support program integrity through adherence to reporting requirements. Upgrades to the Title V database will support the Strategic Planning, Performance, and Program Integrity Integration Initiative by providing improved access to data to evaluate performance and identify areas of process improvement. Funding the Tribal Self-Governance program supports program integrity by providing the necessary resources to carry out core activities, including technical assistance to federal staff and Tribes, conducting outreach and education activities, and facilitating the introduction of additional Tribes and Tribal organizations into the IHS Tribal Self-Governance program.

FUNDING HISTORY

Fiscal Year	Amount
2011 Omnibus	$6,054,000
2012 Enacted	$6,044,000
2013 Enacted	$5,727,000
2014 Final	$4,227,000
2015 Enacted	$5,727,000

BUDGET REQUEST

The FY 2016 budget request for the Tribal Self-Governance program of $5,735,000 is an increase of $8,000 above the FY 2015 Enacted level.

FY 2015 Base Funding of $5,727,000 – The base funding is necessary to support further implementation of the IHS Tribal Self-Governance program, to continue funding for Planning and Negotiation Cooperative Agreements to assist Indian Tribes to prepare and enter into the IHS Tribal Self-Governance program, to continue to fund performance projects, and to fund Tribal shares needs in IHS Areas and Headquarters for any Indian Tribes that have decided to participate in the IHS Tribal Self-Governance program**.**

Current Services +$8,000 Increase includes:

- Pay costs +$8,000 – to cover pay raises for OTSG employees. Pay increases are necessary for maintaining the base program funds that support Tribes entering into Self-Governance.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result/ (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
TOHP-1: Percentage of TOHP clinical user population included in GPRA data.	FY 2014: 57.7% Target: 55.3% (Target Exceeded)	55.3%	57.7%	+2.4
TOHP-SP: Implement recommendations from Tribes annually to improve the Tribal consultation process.	FY 2014: 9 Target: 3 (Target Exceeded)	3	3	0

The IHS is required to report to Congress each year on the quality of health care it provides to its patients. Government Performance and Results Act (GPRA) measures to demonstrate the quality of care are reported using the Resource and Patient Management System (RPMS) via the Clinical Reporting System (CRS) application. All federal health care facilities are required to use RPMS/CRS and must report GPRA data. However, Tribal sites running non-RPMS data systems are still encouraged to run and submit GPRA reports to track their progress. The Self-Governance budget supports demonstration projects to improve GPRA reporting by Tribally operated health programs.

Consultation is considered an essential element for a sound and productive relationship with Tribes. The IHS is committed to regular and meaningful consultation and collaboration with Tribal governments and this budget line supports the OTSG to facilitate the Tribal consultation activities and process. The increased involvement of Tribes in advising and participating in the decision-making process of the Agency will result in stronger collaborations between the federal government and Tribal governments, innovation in the management of programs and important issues being brought forward for consideration by the IHS, the Administration, and Congress in a timely fashion.

GRANT AWARDS

CFDA No. 93.444 – Tribal Self-Governance Program: Planning and Negotiation Cooperative Agreement			
	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Planning Cooperative Agreements			
Number of Awards	3	5	5
Award Amount	$120,000	$120,000	$120,000
Negotiation Cooperative Agreements			
Number of Awards	3	5	5
Award Amount	$48,000	$48,000	$48,000

AREA ALLOCATION

Self-Governance

Discretionary SERVICES	**FY 2014 Final**	**FY 2015 Enacted**	**FY 2016 President's Budget**	**FY 2016 +/- FY 2015**
Headquarters	$4,727	$5,727	$5,735	+$8,000
Total, SELF-GOV	**$4,727**	**$5,727**	**$5,735**	**+$8,000**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Services: 75-3920-0-1-551

CONTRACT SUPPORT COSTS

(Dollars in Thousands)

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$612,484	$662,970	$717,970	+$55,000
FTE	0	0	0	0

Authorizing Legislation ..... 25 U.S.C. §§ 450 et seq., Indian Self-Determination and Education Assistance Act, P.L. 93-638, as amended

FY 2016 Authorization.....Permanent

Allocation Method ..... P.L. 93-638 Self-Determination Contracts and Compacts

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The 1975 Indian Self-Determination and Education Assistance Act (ISDEAA), Public Law 93-638, provides Indian Tribes and Tribal organizations (T/TO) the authority to contract with the Federal government to operate programs serving eligible persons and to receive not less than the amount of program funding that the Secretary would have otherwise provided for the direct operation of the program. The 1988 amendments to the Act identified Contract Support Costs (CSC) be paid in addition to the program amount. CSC are defined as reasonable costs for administrative activities that T/TO must carry out but that the Secretary either did not carry out in her direct operation of the program or provided from resources other than those under contract. In FY 2014 more than $2.5 billion of the IHS appropriations was administered by T/TO through ISDEAA contracts and compacts.

Elements of CSC include:

- Pre-award costs (e.g., consultant and proposal planning services)
- Start-up costs (e.g., purchase of administrative computer hardware and software)
- Direct CSC (e.g., unemployment taxes on direct program salaries)
- Indirect CSC (e.g., pooled costs), which are a subset of the T/TO's overall indirect costs

The IHS CSC policy was established in 1992 and most recently revised in 2007[1] to provide guidance in the administration of CSC. It was developed through extensive consultation and input from Tribes. The IHS continues to work on improving its management of CSC payments to T/TO to ensure consistency with the ISDEAA and IHS CSC Policy.

With regard to CSC need and payments in FY 2014, the FY 2014 Consolidated Appropriations Act did not specify a limit on the total amount of funds available for the payment of CSC and that the Services appropriation had to be used to cover CSC. IHS submitted an operating plan to Congress, as required by the Appropriations Act that

[1] *Indian Health Manual*, Part 6 – Services to Tribal Governments and Organizations, Chapter 3 – Contract Support Costs, *available at* http://www.ihs.gov/ihm/index.cfm?module=dsp_ihm_pc_p6c3.

identified IHS's plan to fully fund the CSC need as estimated at that time, which required a $10 million reduction in other items in the budget. At that time, IHS indicated that additional funds would need to be reallocated if the CSC need exceeded the $587 million initially identified in the operating plan. Additional need was likely, given the various updates and adjustments in CSC need that were expected later in the year and given that Tribes could also decide to enter into ISDEAA negotiations later in the year for new or expanded programs, functions, services, or activities, which would also generate new CSC need. As a result, IHS reprogrammed $25 million from the Services budget to CSC.

In FY 2014, IHS made tremendous progress in resolving Contract Disputes Act claims for CSC owed for past funding years. As of January 16, 2015, the IHS has extended settlement offers on 1,211 claims (over 90 percent of the 1,325 claims received after the Ramah decision) and settled 861 claims for a value of approximately $679 million from the Judgment Fund. This is a significant accomplishment when compared to the three CSC claims that were settled between the Supreme Court's June 2012 decision in *Salazar v. Ramah Navajo Chapter* and November 2013.

FUNDING HISTORY

Fiscal Year	Amount
2011 Omnibus	$397,693,000
2012 Enacted	$471,437,000
2013 Enacted	$447,788,000
2014 Final	$612,484,000
2015 Enacted	$662,970,000

BUDGET REQUEST

The FY 2016 budget request for Contract Support Costs of $717,970,000 is an increase of $55,000,000 above the FY 2015 Enacted level. This request will fully fund the current estimate of CSC need in FY 2016.

Long-Term Solution

As demonstrated in FY 2014 estimating CSC need is difficult because 1) now that CSC is fully funded, Tribes are showing more interest in contracting and compacting, 2) Tribes can request new and expanded programs at any time of the year, and 3) Tribes that currently contract and compact can request to renegotiate direct and indirect-type CSC at any point in the year. Because CSC is part of the Services budget, when the amount identified for CSC is not sufficient to satisfy new, expanded and renegotiated CSC, the funds must be taken from other programs in the Services budget.

In the FY 2014 Omnibus bill, Congress requested that both the Bureau of Indian Affairs and IHS consult with Tribes develop a long-term approach to fund CSC. The leading Tribal recommendation was to make CSC a mandatory appropriation. This budget proposes to reclassify CSC from annual discretionary appropriations to a mandatory appropriation beginning in FY 2017, which will allow time for Tribal consultation in FY 2016 on operational details. The budget proposes to lower the discretionary budget caps to reflect the reclassification.

Mandatory Specifications for FY2016 Budget Proposal:

1) Three year mandatory appropriation, which provides a specified amount for each year as displayed in the table below.

(Dollars in Millions)

	FY 2017	FY 2018	FY 2019	3-Year Mandatory
CSC	$800	$925	$1,100	$2,825

2) Funding is no year and is therefore available to be carried over in future years. For instance, if CSC was to reach $700 million in FY 2017, the remaining $100 could be carried over into FY 2018. Under this scenario, $1,025 million ($925 million plus the $100 million carried forward) would be available for CSC in FY 2018.
3) New CSC estimates will be provided on a three year cycle as part of the reauthorization process.
4) In addition to amounts already dedicated to program administration, up to 2% of CSC totals can be used for administrative capacity and program management.

Area Allocation

Contract Support Costs

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2014 Final			FY 2015 Enacted			FY 2016 President's Budget			FY '16 +/- FY '15
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$0	$204,190	$204,190	$0	$221,021	$221,021	$0	$239,357	$239,357	$18,336
Albuquerque	0	19,629	19,629	0	21,247	21,247	0	23,010	23,010	1,763
Bemidji	0	35,837	35,837	0	38,791	38,791	0	42,009	42,009	3,218
Billings	0	11,323	11,323	0	12,256	12,256	0	13,273	13,273	1,017
California	0	58,237	58,237	0	63,037	63,037	0	68,267	68,267	5,230
Great Plains	0	20,528	20,528	0	22,220	22,220	0	24,063	24,063	1,843
Nashville	0	23,107	23,107	0	25,011	25,011	0	27,086	27,086	2,075
Navajo	0	59,119	59,119	0	63,992	63,992	0	69,301	69,301	5,309
Oklahoma	0	94,630	94,630	0	102,431	102,431	0	110,928	110,928	8,498
Phoenix	0	27,593	27,593	0	29,868	29,868	0	32,346	32,346	2,478
Portland	0	56,070	56,070	0	60,692	60,692	0	65,727	65,727	5,035
Tucson	0	2,221	2,221	0	2,404	2,404	0	2,604	2,604	199
Headquarters	0	0	0	0	0	0	0	0	0	0
Total, CSC	**$0**	**$612,484**	**$612,484**	**$0**	**$662,970**	**$662,970**	**$0**	**$717,970**	**$717,970**	**+$55,000**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Services: 75-0390-0-1-551

PUBLIC AND PRIVATE COLLECTIONS

(Dollars in Thousands)

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Medicare:				
Federal	$160,935	$162,108	$162,108	$0
Tribal[1]	6,986	6,986	6,986	0
Tribal[2]	57,244	57,244	57,244	0
Subtotal:	225,165	226,338	226,338	0
Medicaid:				
Federal	$591,324	$620,046	$628,046	+$8,000
Tribal[1]	22,217	22,932	23,232	+300
Tribal[2]	124,203	128,201	129,901	+1,700
Subtotal:	737,744	771,179	781,179	+10,000
M/M Total:	**$962,909**	**$997,517**	**$1,007,517**	**+$10,000**
Private Insurance	90,246	90,303	95,303	+5,000
VA Reimbursements[3]	$6,622	$18,244	$28,062	+$9,818
TOTAL:	**$1,059,777**	**$1,106,064**	**$1,130,882**	**+$24,818**
FTE[4]	6,278	6,278	6,278	0

[1] Represents CMS tribal collection estimates as last provided.
[2] Represents estimates of tribal collections due to direct billing between FY 2002 – FY 2014.
[3] The FY 2015 President's Budget estimates VA Reimbursements at $39 million and $36 million for FY 2014; total for federal and tribal reimbursements. The FY 2014, FY 2015 and FY 2016 collections reflect the revised agreed upon estimates with VA staff; these estimates more accurately reflect current trends and future expectations. The VA and IHS will continue to work together to re-evaluate future growth estimates based on FY 2014 and FY 2015 actual collections.
[4] FTE numbers reflect only federal staff and do not include increases in tribal staff.

Authorizing Legislation…….. Indian Health Care Improvement Act, Pub. L. 94-437, as amended by Pub. L. 111-148, title X, §10221(a), Mar. 23, 2010, 124 Stat. 935); the Social Security Act sec. 1880 & 1911, 42 U.S.C 1395qq &1396j and the Economy Act (31 U.S.C 1535).

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

In 1976, the Indian Health Care Improvement Act (IHCIA) authorized the IHS to collect Medicare and Medicaid (M&M) reimbursements for services provided in IHS facilities to patients with M&M eligibility. The IHCIA was later amended to allow IHS to collect Private Insurance (PI) reimbursements for services provided in IHS facilities for patients with PI.

In fiscal year (FY) 2014, $1.060 billion was collected from third party insurers, of which an estimated $752 million was Federal M&M collections and $90.2 million, or 8.5 percent was from private insurers. The estimates above are based on the FY 2014 actual collections, current M&M rates available and published in the Federal Register on April 8, 2014 for the 2014 calendar year (CY), increased Medicaid enrollment estimated related to the Affordable Care Act (ACA) for FY 2015 and FY 2016 and recent agreement with VA staff on reimbursement estimates from the VA.

Collections support HHS strategic goal 1 – Strengthen Health Care and support the IHS Priority to improve the quality of and access to care – and public and private collections are a significant part of IHS and Tribal budgets in improving health care services.

Accreditation - In accordance with IHCIA authorization for collections, the IHS places the highest priority on meeting accreditation and certification standards for its healthcare facilities. Third party revenue is essential to maintaining facility accreditation, certification and standards of health care through organizations such as the Joint Commission or the Accreditation Association for Ambulatory Health Care. Collection funds are used to maintain facility certification and accreditation and to improve the delivery and access to healthcare for American Indian and Alaska Native (AI/AN) people.

Monitoring - IHS has developed and implemented a data system to identify deficiencies and monitor the third party collections process for IHS operated facilities. The Third Party Internal Control Self-Assessment online data tool provides necessary information for local managers and Headquarters staff to monitor compliance with applicable policies and procedures during the collections process so they can take necessary corrective actions and improve overall program activity. Over the past year, the Agency has had 100 percent of all IHS federal facilities participate in completing the online tool and 100 percent of all facilities with identified red flags have established a corrective action plan and are working towards compliance.

During FY 2016, IHS will continue the development of a third party interface with the Unified Financial Management System and enhance systems, reports, and processes to meet legislative requirements for IHS operated facilities. The IHS will also work on initiatives such as the Electronic Health Record (EHR) and implementing ICD-10 codes. The IHS will continue to strengthen its business office policies and management practices, including internal controls, patient benefits coordination, provider documentation training, certified procedural coding training, electronic claims processing and debt management. Priority activities include continued development of third party billing and accounts receivable software to improve effectiveness and to ensure system integration with its business processes, compliance with M&M regulations, and industry standards and changes in operational processes. Improvements for IHS operated facilities are coordinated with concurrent enhancements in Purchased and Referred Care business practices related to alternate resources.

In addition, IHS is working to incorporate legislative rules and regulations that impact third party collections directly and indirectly. Some rules such as meaningful use of the EHR by providers and facilities will have a direct impact on improving availability of data used in revenue generation over the next few years. IHS has formed workgroups to maximize impact for all IHS, Tribal, and Urban Indian health program facilities, such as the National Business Office Coordinators ACA subcommittee whose focus is to identify ACA revenue impacts and provide guidance and direction.

Partnerships - In partnership with its health programs, IHS is working to develop and enhance partnerships with federal and State agencies. IHS continues to work with CMS and the State Medicaid agencies to identify patients who are eligible to enroll in M&M and the State Children's Health Insurance Programs and in the implementation of provisions in the ACA/IHCIA, and the Children's Health Insurance Program Reauthorization Act. Implementing Medicaid Expansion and enrolling patients in the Health Insurance Marketplaces continues to be a major focus. Enrollment and collections depend, in large part, on IHS' successful partnerships/relationships, State participation in Medicaid expansion, and awareness and willingness of IHS users to enroll in Medicaid in States where the program has been expanded or in Health Insurance Marketplace plans.

IHS continues to provide resources and education related to the changes under the ACA. Areas have developed and shared their Area Business Plan Templates with Tribes in the Areas and

continue to monitor implementation progress. IHS anticipates that in-network contracting with qualified health plans in the Marketplace may work for many facilities and is working with CMS to identify ways to encourage and monitor implementation. In FY 2014, IHS issued enrollment process and contracting guidance to Areas, this information is also shared with Tribes and urban programs, and helps ensure the health system is aware of and prepared for changes. IHS continues to monitor ACA implementation progress, provides technical assistance, and works with CMS to resolve issues related to AI/ANs and ACA implementation.

IHS collaborates with CMS and the Tribes on a number of issues, including implementation of recent legislative changes, third party coverage, claims processing, denials, training and placement of State Medicaid eligibility workers at IHS and Tribal sites to increase the enrollment of Medicaid eligible AI/AN patients. IHS is coordinating outreach, education, and training efforts in order to avoid duplication of efforts. IHS has partnered with CMS to provide a number of training sessions for Tribal and IHS employees, focusing on outreach and improving access to M&M programs.

In December 2012, IHS and the Department of Veterans Affairs (VA) signed the VA/IHS National Reimbursement Agreement that facilitates reimbursement by the VA to the IHS and Tribal facilities for direct health care services provided to eligible AI/AN veterans. This was a significant step forward in ensuring implementation of Section 405 of the IHCIA[1]. The agreement represents a positive partnership to support improved coordination of care between IHS federal facilities and the VA and paves the way for future agreements negotiated between VA and tribal health programs. IHS will continue to work directly with the VA to implement billing practices to ensure IHS receives proper payment for care provided at IHS and Tribal facilities to AI/AN veterans. Monitoring, auditing, and compliance with the agreement will become a focus for FY 2015 and FY 2016. Implementation plans have been developed to bill the VA and collect at all IHS federal sites serving eligible Veterans. Currently, 100 percent of federal sites are billing the VA for services. Tribal health programs currently have over 65 agreements with the VA.

Annually, IHS trains health care facility staff in areas related to coding, third party billing and other aspects of the revenue cycle. Area I/T/U staff are highly encouraged to participate in annual CMS trainings. IHS hosts a Partnerships conference to provide the most current information related to finance, information technology, Purchased/Referred Care, and business office functions; special emphasis is also provided for the specific management needs of Tribes and urban programs. In 2014, IHS hosted an ACA webinar with updated information for I/T/U staff on outreach and education for enrolling patients in the Marketplaces, including help with purchasing insurance and enrolling in Medicaid.

Claims Processing Improvements - During FY 2016, IHS will continue to work to enhance each IHS operated facility's capability to identify patients who have private insurance coverage and improve claims processing. The local service units utilize private insurance funds to improve services, purchase medical supplies and equipment, and to improve local service unit business management practices in support of maintaining accreditation. The IHS continues to make use of private contractors to pursue collections on outstanding claims from private payers.

[1] 25 U.S.C. § 1645(c), "Reimbursement. The Service, Indian tribe, or tribal organization shall be reimbursed by the Department of Veterans Affairs or the Department of Defense (as the case may be) where services are provided through the Service, an Indian tribe, or a tribal organization to beneficiaries eligible for services from either such Department, notwithstanding any other provision of law.

FY 2014 - 2016 Collections Estimates
Medicare and Medicaid (M&M): The FY 2016 M&M estimate includes an increase of $10 million over the FY 2015 level, which is anticipated from increased Medicaid enrollment related to current and future ACA implementation.

The FY 2015 revised level totals $997.517 million and includes an increase of $34.608 million over the FY 2014 actual level of $962.909 million. The FY 2015 increase includes an increase of $22 million related to increased patient enrollment in Medicaid primarily due to ACA implementation and an increase of $12.608 million associated with the FY 2014 impact of the CY 2014 M&M rate changes

All M&M rate changes are calculated utilizing the IHS Medicare cost reports submitted to CMS and the Medicare Administrative Contractor. Accurate and complete cost reports will continue to be a priority since they provide valuable information in setting the Agency's future M&M rates.

Medicaid – The FY 2016 Medicaid collections estimate totals $781.179 million and includes an increase of $10 million over the FY 2015 level as we expect to continue progress in Medicaid expansion during FY 2016.

The FY 2015 revised estimate totals $771.179 million and includes an increase of $33.435 million over the FY 2014 actual level of $737.744 million. The FY 2015 increase includes $22 million for related to increased enrollment through Medicaid expansion and $12.608 million related to the impact of the CY 2014 rate increases published in the Federal Register on April 8, 2014.

IHS is making progress in ACA implementation and increased Medicaid enrollments. IHS is continuing to monitor its user population and insurance coverage and is making all possible efforts to maximize Medicaid enrollment in all States, including those that have not yet implemented Medicaid expansion.

Medicare – For FY 2016, this proposal recommends a continuation of the FY 2015 revised estimate of $226.338 million. The FY 2015 revised level includes an increase of $1.173 million over the FY 2014 actual level due to the impact of the CY 2014 rate increases published in the Federal Register on April 8, 2014.

Private Insurance – For FY 2016, this proposal includes a total of $95.303 million, an increase of $5 million over the FY 2015 estimate $90.303 million as we continue implementation of ACA and expect increases in private insurance coverage among AI/AN populations.

In addition to the premium subsidies that the general American public receives to purchase insurance, the ACA includes special benefits for AI/ANs. The ACA has specific subsidies for cost sharing for members of federally recognized tribes and individuals may choose to enroll in private insurance plans that can be billed through the Indian health system. While health insurance subsidies will continue in FY 2015, the purchase of health insurance is voluntary for many AI/ANs. I/T/U delivery of health care is not contingent on the purchase of health insurance and our patients will continue to have access to health care offered in I/T/U facilities regardless of their insurance status.

VA/IHS National Reimbursement Agreement– In FY 2014, the VA reimbursements totaled $6.622 million for IHS federally operated facilities; Tribes are not required to report collections to IHS. The FY 2015 President's Budget estimated that Federal and Tribal sites would collect $36 million in FY 2014 and $39 million in FY 2015. As stated in the FY 2015 President's Budget, these collection estimates were overestimated and needed to be adjusted for future years based on

actual collections and other factors. During FY2014, IHS and VA agreed to revise reimbursement estimates to $18.244 million for FY 2015 and $28.062 million for FY 2016. Estimates are based on the assumption that the number of AI/AN Veterans who are dually eligible for IHS and VA services will increase from FY 2014 to FY 2016 to approximately 29,000 by the end of FY 2015 and 29,400 during FY 2016. The FY 2016 estimate of $28.062 million is an increase of $9.818 million over the FY 2015 revised estimate of $18.244 million.

IHS and VA have agreed to continue to monitor actual reimbursements and will update estimates based on FY 2014 and FY 2015 actual collections. Estimating the true level of FY 2015 through FY 2016 collections is primarily impacted by the actual number of eligible AI/AN Veterans using IHS services and their individual eligibility for VA benefits. IHS continues to work with the VA in identifying the actual number of AI/ANs with VA benefits eligibility and, of those, how many receive direct care from IHS. IHS and the VA continue to work in partnership to identify and resolve billing and reimbursement issues and provide sites with on-going support and training. Currently, all IHS sites have signed implementation plans and have the ability to bill the VA for Veterans Services.

Third Party Collections Improvement – the $10 million increase in the H&HC budget will be used to increase reimbursements by improving the IHS Business Office activities through centralizing and increasing training, outreach & education, systems enhancement and program monitoring that focuses on patient enrollment in alternate resources and implementing overall best practices. Increased enrollment in alternate resources will result in maximizing revenue through third party collections to be used at the facility level. Enrolling patients in Medicaid expansion and Federal/State Exchange programs authorized under the Affordable Care Act will be a central focus.

The following table shows third party collections estimated distributions:

(Dollars in Thousands)

Type of Obligation	FY 2014 Enacted	FY 2015 Pres. Budget	FY 2016 Request
Personnel Benefits & Compensation	$417,527	$421,699	$425,915
Travel & Transportation	5,217	5,512	5,638
Non-Patient Transportation	3,117	3,280	3,363
Comm./Util./Rent	18,140	19,216	19,542
Printing & Reproduction	280	292	299
Other Contractual Services	197,711	209,654	213,809
Supplies	165,813	175,956	179,338
Equipment	12,567	13,382	13,625
Land & Structures	6,128	6,560	6,669
Grants	15,627	16,524	16,865
Insurance / Indemnities	378	382	394
Interest/Dividends	0	0	0
Subtotal	$842,505	$872,457	$885,457
Tribal Collections (est)	210,650	215,363	217,363
Sub-Total Collections	**1,053,155**	**1,087,820**	**1,102,820**
VA	6,622	18,244	28,062
Total, Collections	**$1,059,777**	**$1,106,064**	**$1,130,882**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Services: 75-0390-0-1-551

SPECIAL DIABETES PROGRAM FOR INDIANS

(Dollars in Thousands)

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$147,000	$150,000	$150,000	0
FTE*	0	0	0	0

*SDPI funds are not used to support FTE.

Authorizing Legislation ..... 111 Stat. 574, 1997 Balanced Budget Act (P.L. 105-33), Consolidated Appropriation Act 2001 and amendment to Section 330C (c)(2)(c) Public Health Service Act through Senate Bill 2499 (passed the Senate 12/18/07) to extend funding through FY 2009, the Medicare Improvements for Patients and Providers Act of 2008 (P.L. 110-275) Title III Special Diabetes Program for Indians (SDPI) to extend funding through FY 2011, the H.R. 4994 Medicare and Medicaid Extenders Act of 2010 to extend SDPI funding through FY 2013,the American Taxpayer Relief Act of 2012 (P.L. 112-240) to extend funding through FY 2014, the Protecting Access to Medicare Act of 2014 (PL 113-93; H.R. 4302) to extend funding through FY 2015. The program authorization is set to expire after FY 2015.

FY 2016 Authorization..... Expires FY 2015

Allocation Method .....Grants, Interagency Agreements, and Contracts

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The Special Diabetes Program for Indians (SDPI) grant program provides funding for diabetes treatment and prevention through 404 Indian Health Service, Tribal and Urban (I/T/U) Indian health grant programs. Now in its 18th year, the SDPI operates with a budget of $150 million per year that is currently authorized through FY 2015. The IHS Office of Clinical and Preventive Services (OCPS) Division of Diabetes Treatment and Prevention (DDTP) provides leadership, programmatic, administrative, and technical oversight to the SDPI grant program.

The mission of the DDTP is to develop, document, and sustain public health efforts to prevent and control diabetes in American Indians and Alaska Natives (AI/ANs) by promoting collaborative strategies through its extensive diabetes network. The diabetes network consists of a national program office, Area Diabetes Consultants in each of the 12 IHS Areas, 19 Model Diabetes programs at 23 different IHS and Tribal sites, 364 SDPI Community-Directed grants and sub-grants, and 68 Diabetes Prevention (DP) and Healthy Heart (HH) Initiatives at I/T/U sites.

Target Population: American Indians and Alaska Natives

Diabetes and its complications are major contributors to death and disability in every Tribal community. AI/AN adults have the highest age-adjusted rate of diagnosed diabetes (15.9 percent) among all racial and ethnic groups in the United States, more than twice the rate of

the non-Hispanic white population (7.6 percent).[1] In some AI/AN communities, more than half of adults 45 to 74 years of age have diagnosed diabetes, with prevalence rates reaching as high as 60 percent.[2]

Allocation Method

In the Balanced Budget Act of 1997, Congress instructed the IHS to use SDPI funds to "establish grants for the prevention and treatment of diabetes" to address the growing problem of diabetes in AI/ANs. The entities eligible to receive these grants included I/T/Us. In accordance with legislative intent, the IHS distributes this funding to over 400 entities annually through a process that includes Tribal consultation, development of a formula for distribution of funds, and a formal grant application and administrative process.

Strategy

The SDPI brings Tribes together to work toward a common purpose and share information and lessons learned. The Tribal Leaders Diabetes Committee established in 1998, reviews information on the SDPI progress and provides recommendations on diabetes-related issues to the IHS Director. Through partnerships with federal agencies, private organizations and an extensive I/T/U network, DDTP undertook one of the most strategic diabetes treatment and prevention efforts ever attempted in AI/AN communities and demonstrated the ability to design, manage, and measure a complex, long-term project to address this chronic condition. Because of the significant costs associated with treating diabetes, Tribes and urban Indian organizations have used best and promising practices for their local SDPI funding to address the primary, secondary and tertiary prevention of diabetes and its complications.

This collaborative approach supports the strategic planning process necessary to identify the goals and objectives needed to achieve the intended SDPI outcomes. This process aligns with the IHS priority to renew and strengthen partnerships with Tribes, as well as supports the IHS priority to improve access to quality health care.

SDPI: Three Major Components

As directed by Congress and Tribal consultation, the SDPI consists of three major components: (1) Community-Directed Programs; (2) Diabetes and Cardiovascular Disease Prevention Demonstration Projects that have now transitioned to the Diabetes Prevention and Healthy Heart (DP/HH) Initiatives; and (3) Diabetes data and program delivery infrastructure.

1. <u>SDPI Community-Directed Program</u>

The SDPI Community-Directed Program provides over $116 million per year in grants and sub-grants for local diabetes treatment and prevention services at I/T/U health programs in 35 states. Each of the communities served by the SDPI Community-Directed Program is unique in that its diabetes treatment and prevention needs and priorities are defined locally. Based on

[1] Centers for Disease Control and Prevention (CDC). *National Diabetes Statistics Report: Estimates of Diabetes and Its Burden in the United States, 2014.* Atlanta, GA: U.S. Department of Health and Human Services; 2014. *Available at* http://www.cdc.gov/diabetes/pubs/statsreport14.htm.
[2] Lee ET, Howard BV, Savage PJ, et al. Diabetes and impaired glucose tolerance in three American Indian populations aged 45-74 years: the Strong Heart Study. *Diabetes Care*. 1995;18:599-610.

these local needs and priorities the SDPI Community-Directed programs implement proven interventions to address the diabetes epidemic, often where few resources existed before.

The Consolidated Appropriations Act of 2001 established statutory authority for SDPI to implement a best practices approach to diabetes treatment and prevention. The SDPI has incorporated these Indian Health Diabetes Best Practices into the Community-Directed Program grant application process used throughout AI/AN communities. Grant programs are required to document the use of at least one Diabetes Best Practice,[3] corresponding evaluation measures, and progress in achieving program objectives in order to enhance accountability. Grantees receive training on how to collect, evaluate, and improve their data collection and use it to improve their outcome results.

Impact of the Community-Directed Programs
SDPI funding has enabled staff and programs at the local and national levels to increase access to diabetes treatment and prevention services throughout the Indian health system. The following table demonstrates substantial increases in access to many activities and services:

Diabetes treatment and prevention services available to AI/AN individuals	Access in 1997	Access in 2013	Percentage increase
Diabetes clinics	31%	71%	+40%
Diabetes clinical teams	30%	96%	+66%
Diabetes patient registries	34%	98%	+64%
Nutrition services for adults	39%	93%	+54%
Access to registered dieticians	37%	79%	+42%
Culturally tailored diabetes education programs	36%	97%	+61%
Access to physical activity specialists	8%	80%	+72%
Adult weight management programs	19%	78%	+59%

Clinical Diabetes Outcomes During SDPI
At the same time that access to these diabetes services increased, key outcome measures for AI/ANs with diabetes showed improvement or maintenance at or near national targets. These results have been sustained throughout the inception of SDPI. Examples include:

- *Improving Blood Sugar Control*
  Blood sugar control among AI/ANs with diabetes served by the IHS has improved over time. The average blood sugar level (as measured by the A1C test) decreased from 9.0 percent in 1996 to 8.1 percent in 2014, nearing the A1C goal for most patients of less than 8 percent.
- *Improving Blood Lipid Levels*
  Average LDL cholesterol (i.e., "bad" cholesterol) declined from 118 mg/dL in 1998 to 92.1 mg/dL in 2014, surpassing the goal of less than 100 mg/dL.

2. SDPI Diabetes Prevention and Healthy Heart Demonstration Projects

In 2004, Congress established the SDPI Demonstration Projects to translate research findings on diabetes prevention and cardiovascular disease risk reduction in AI/AN community-based programs and health care settings. The SDPI Demonstration Projects consisted of the Diabetes Prevention (DP) and Healthy Heart (HH) Projects. Sixty-six Demonstration Project grants were

[3] *Available at* http://www.ihs.gov/MedicalPrograms/Diabetes/index.cfm?module=toolsBestPractices.

funded that served 110 tribal communities from FY 2004 through FY 2009. From FY 2010 through FY 2015, 68 grants were awarded as SDPI Diabetes Prevention and Healthy Heart Initiatives.

SDPI Diabetes Prevention Demonstration Project
The SDPI DP adapted the National Institutes of Health Diabetes Prevention Program (DPP) study's 16-session lifestyle intervention curriculum in a diverse set of AI/AN communities. The SDPI DP lifestyle intervention successfully reduced the risk factors for diabetes. The results demonstrated that the SDPI DP reduced rates of diabetes incidence in high risk AI/AN people compared with the NIH DPP control group.[4] Reductions in diabetes incidence have significant implications for preserving health and reducing health care costs.

SDPI Healthy Heart Demonstration Project
The SDPI HH Demonstration Project was created to demonstrate reduction of cardiovascular disease risk factors in adults with diabetes by implementing intensive, clinic-based case management interventions in AI/AN health programs using current standards of care. The SDPI HH Project achieved significant reductions in cardiovascular disease risk factors among AI/ANs with diabetes, including improvements in blood pressure and LDL cholesterol control.

Transition to SDPI DP/HH Initiatives
In September 2010, as a result of a new competitive grant application process, the IHS awarded 68 cooperative agreements to previous and new sites to continue to implement and disseminate the SDPI DP/HH Initiative activities.

SDPI DP/HH grantees must adhere to strict intervention protocols and data reporting requirements. SDPI DP/HH grantees are assessed as to their success in recruiting and retaining participants as well as the outcomes achieved. Grantees receive training on how to collect, evaluate, and improve their data collection and translate it to improved outcome results.

3. Diabetes Data and Program Delivery Infrastructure

The IHS has used administrative funding from the SDPI to strengthen the diabetes data infrastructure of the Indian health system by improving diabetes surveillance and evaluation capabilities. SDPI supports the development and implementation of the IHS Electronic Health Record, and the IHS Diabetes Management System in all 12 IHS Areas.

Facilities associated with SDPI programs participate in the annual IHS Diabetes Care and Outcomes Audit. The Diabetes Audit is the cornerstone of the IHS DDTP diabetes care surveillance system, tracking annual performance on diabetes care and health outcome measures. Data collection for the Diabetes Audit follows a standardized protocol to ensure statistical integrity and comparability of measures over time. The 2014 Diabetes Audit included a review of 115,724 patient charts at 331 I/T/U health facilities. The Diabetes Audit enables IHS and the SDPI programs to monitor and evaluate yearly performance at the local, regional, and national levels. DDTP provides diabetes training through multiple online and webinar formats. DDTP receives evaluations on all trainings provided to guide improvements for future sessions.

The Diabetes Audit and training evaluations are a method to track progress in meeting the defined goals and objectives of SDPI, as well as assisting in the identification and mitigation of risks and

[4] Jiang L, Manson SM, Beals J, et al. Translating the Diabetes Prevention Program into American Indian and Alaska Native communities. *Diabetes Care* 2013;36:2027-2034.

barriers to success of the Program. This aligns with the P3I integration framework, as well as the HHS Strategic Goal 2: Advancing Scientific Knowledge and Innovation.

Key Performance/Accomplishments

Annual SDPI assessments have shown significant improvements in diabetes clinical care and community services provided over time when compared to the baseline SDPI assessment in 1997 (see table above titled "Diabetes treatment and prevention services available to AI/AN individuals").

Ongoing efforts to improve blood glucose, blood pressure and cholesterol values will continue to reduce the risk for microvascular as well as macrovascular complications (see "Outcomes and Outputs" table below).

Reporting

In addition to internal monitoring of the SDPI Community-Directed Programs and the DP and HH Initiatives, the DDTP has completed four SDPI Reports to Congress to document the progress made since 1998. The SDPI Reports to Congress are as follows:

- January 2000 Interim Report to Congress on SDPI;
- December 2004 Interim Report to Congress on SDPI;
- 2007 SDPI Report to Congress: On the Path To A Healthier Future;
- 2011 SDPI Report to Congress: Making Progress Toward A Healthier Future; and
- A new SDPI Report to Congress is under Agency review with an anticipated release during FY 2015.

BUDGET REQUEST

The FY 2016 budget request includes a legislative proposal to extend the SDPI reauthorization for three years through FY 2018 at $150,000,000 annually. The SDPI Budget for FY 2004 through FY 2012 was $150,000,000 annually; however, the 2 percent mandatory sequestration in FY 2013 and FY 2014 reduced the SDPI budget to $147,000,000. SDPI administrative funds were decreased in those two years to avoid impact on grant amounts, however, reductions in these funds long-term would impair IHS' ability to support the SDPI grant program. As such, the FY 2016 President's budget proposes to maintain funding at an annual amount of $150,000,000 to ensure this successful program can continue serving the same population without reductions in service. The distribution of funding has remained the same since 2004 after Tribal consultation and is illustrated below:

Special Diabetes Program for Indians – Total Yearly Costs

CATEGORY	Percentage of the total	(Dollars in Millions)
Original Diabetes Grants – now called Community-Directed Diabetes Programs (364 Tribal and IHS grants and sub-grants in FY 2010)	69.9%	$104.8
Administration of Community-Directed SDPI grants (Includes administrative funds to IHS Areas, Tribal Leaders Diabetes Committee, Div. of Diabetes, Grants Operations, evaluation support contracts, etc.)	2.7%	4.1
Urban Indian Health Program Community-Directed diabetes programs (34 grants) ($7.4M allocated to 34 grants; remaining amount redistributed within existing grants)	5%	7.5
Diabetes Prevention & Healthy Heart Initiatives (68 grants)	15.5%	23.2
Administration of Demonstration Project Diabetes Grants (Includes administrative funds 1) to support the DP/HH Initiatives coordinating center; 2) to support dissemination activities; 3) to HQ; 4) to support contracts, etc.)	2.8%	4.1
Funds to strengthen the Data Infrastructure of IHS	3.4%	5.2
Native Diabetes Wellness Center (CDC)	0.7%	1.0
TOTAL:	**100%**	**$150.0**

The final agency decision on the distribution of FY 2016 SDPI funding will be based on consultation with Tribes and conferring with Urban Indian Organizations. SDPI activities will be continued or modified accordingly. In 2014, Tribes recommended that the $1 million in CDC funding be reallocated to SDPI Community-Directed grants.

The following table shows the accomplishments in terms of outputs and outcomes as well as the estimated change in performance. Modifications to program activities, including increased accountability and evaluation, are being implemented and will contribute to improved performance on outcome measures in subsequent years.

Outputs / Outcomes

Measure	Year and Most Recent/ Target for Recent Result/ (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
2: American Indian and Alaska Native patients with diagnosed diabetes achieve **Good Glycemic Control** (A1c less than 8.0) IHS-All[1]	FY 2014: 54% / 48.6% Target: 48.3% (Target Exceeded)	47.7%	49.5%	+1.8%
2: Tribally Operated Health Programs	FY 2014: 51.5% Target: 50.9% (Target Exceeded)	50.3%	52.5%	+2.2%
3: **Diabetes: Blood Pressure Control**: Proportion of patients with diagnosed diabetes that have achieved blood pressure control (<140/90). IHS-All[1]	FY 2014: 67% / 63.8% Target: 64.6% (Target Not Met)	63.8%	65.0%	+1.2%

Measure	Year and Most Recent/ Target for Recent Result/ (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
3: Tribally Operated Health Programs	FY 2014: 63.1% Target: 63.5% (Target Not Met)	62.7%	64.3%	+1.6%
4: **Diabetes: Dyslipidemia Assessment:** Proportion of patients with diagnosed diabetes assessed for Dyslipidemia (LDL cholesterol). IHS-All[1]	FY 2014: 80% / 73.4% Target: 73.9% (Target Not Met)	71.8%	74.8%	+3.0%
4: Tribally Operated Health Programs	FY 2014: 71.5% Target: 73.1% (Target Not Met)	70.9%	72.9%	+2.0%

[1]*First figure in results column is Diabetes audit data; second is from the Clinical Reporting System.*

SDPI has contributed substantially to improved clinical outcomes over the duration of the grant program. SDPI provides funds for diabetes clinical care programs across the country, each of which must select an evidenced-based Best Practice[5] on which to focus during the grant year. SDPI also provides funds at the national and Area levels to support and improve provision of care. This support includes clinical training, clinical tools, and performance data feedback to sites via the Diabetes Audit.

GRANTS AWARDS

The SDPI provides grants for diabetes treatment and prevention services to IHS, Tribal and Urban Indian health programs in 35 states. The Community-Directed grant programs provide local diabetes treatment and prevention services based on community needs. The DP/HH Initiative grant programs continue implementation of prevention activities and have begun the dissemination of best practices and lessons learned during the DP and HH Demonstration Projects.

Size of Awards

CFDA No. 93.443 / SDPI Community-Directed Grant Programs			
(whole dollars)	FY 2014 Enacted	FY 2015 Enacted	FY 2016 Request
Number of Awards	365 (includes sub-grants)	365 (includes sub-grants)	365* (includes sub-grants)
Average Award	$304,229	$304,229	$304,229
Range of Awards	$12,549 - $6,483,988	$12,549 - $6,483,988	$12,549 - $6,483,988
Total Awards	$111,347,776	$111,347,776	$111,347,776

*Exact number of grants awarded in FY 2016 may be different if a competitive application process is used.

[5] SDPI Best Practices: Adult Weight and Cardiovascular Risk Management and Diabetes Guidelines, Breastfeeding Support, Cardiovascular Health and Diabetes, Diabetes/Pre-Diabetes Case Management, Community Advocacy for Diabetes Prevention and Control, Community Diabetes Screening, Depression Care, Diabetes Prevention, Diabetes and Pregnancy, Diabetes Self-Management Education (DSME) and Support, Diabetes Eye Care, Foot Care, Nutrition for Diabetes Prevention and Care, Oral Health Care, Pharmaceutical Care, Physical Activity for Diabetes Prevention and Care, School Health: Promoting Healthy Eating and Physical Activity and Managing Diabetes in the School Setting, Screening for Chronic Kidney Disease, Systems of Care, and Youth and Type 2 Diabetes: Prevention and Treatment

CFDA No. 93.443 / SDPI Diabetes Prevention / Healthy Heart Initiative Grants			
(whole dollars)	FY 2014 Enacted	FY 2015 Enacted	FY 2016 Request
Number of Awards	68	68	68
Average Award	$324,300	$324,300	$324,300
Range of Awards	$137,500 – $397,000	$137,500 – $397,000	$137,500 - $397,000
Total Awards	$23,182,200	$23,182,200	$23,182,200

FY 2014 Mandatory State/Formula Grants

CFDA No. 93.442 / Special Diabetes Program for Indians Community-Directed Grant Programs by State and FY 2014 Annual Financial Assistance Awards						
State	State Name	Total # Grant Programs	FY 2014 Final	FY 2015 Enacted	FY 2016 Request*	Difference +/- 2014
AK	Alaska	25	$8,927,252	$8,927,252	$8,927,252	$0
AL	Alabama	1	207,422	207,422	207,422	0
AZ	Arizona	33	26,284,093	26,284,093	26,284,093	0
CA	California	42	8,714,164	8,714,164	8,714,164	0
CO	Colorado	3	728,212	728,212	728,212	0
CT	Connecticut	2	195,466	195,466	195,466	0
FL	Florida	2	526,853	526,853	526,853	0
IA	Iowa	1	254,197	254,197	254,197	0
ID	Idaho	4	760,150	760,150	760,150	0
IL	Illinois	1	226,282	226,282	226,282	0
KS	Kansas	6	366,961	366,961	366,961	0
LA	Louisiana	4	307,833	307,833	307,833	0
MA	Massachusetts	2	67,506	67,506	67,506	0
ME	Maine	5	460,160	460,160	460,160	0
MI	Michigan	13	2,128,707	2,128,707	2,128,707	0
MN	Minnesota	13	3,287,642	3,287,642	3,287,642	0
MS	Mississippi	1	1,029,119	1,029,119	1,029,119	0
MT	Montana	17	5,512,348	5,512,348	5,512,348	0
NE	Nebraska	5	1,590,573	1,590,573	1,590,573	0
NV	Nevada	14	2,941,217	2,941,217	2,941,217	0
NM	New Mexico	31	6,938,491	6,938,491	6,938,491	0
NY	New York	4	1,176,338	1,176,338	1,176,338	0
NC	North Carolina	1	1,184,081	1,184,081	1,184,081	0
ND	North Dakota	8	2,643,997	2,643,997	2,643,997	0
OK	Oklahoma	34	17,649,873	17,649,873	17,649,873	0
OR	Oregon	14	1,799,861	1,799,861	1,799,861	0
RI	Rhode Island	1	94,684	94,684	94,684	0
SC	South Carolina	1	136,424	136,424	136,424	0
SD	South Dakota	14	5,399,117	5,399,117	5,399,117	0
TN	Tennessee	2	79,915	79,915	79,915	0
TX	Texas	4	575,946	575,946	575,946	0

CFDA No. 93.442 / Special Diabetes Program for Indians Community-Directed Grant Programs by State and FY 2014 Annual Financial Assistance Awards						
State	State Name	Total # Grant Programs	FY 2014 Final	FY 2015 Enacted	FY 2016 Request*	Difference +/- 2014
UT	Utah	7	1,449,293	1,449,293	1,449,293	0
WA	Washington	34	3,892,836	3,892,836	3,892,836	0
WI	Wisconsin	13	3,062,885	3,062,885	3,062,885	0
WY	Wyoming	3	747,878	747,878	747,878	0
Funds Pending Distribution**			**235,530**	**235,530**	**235,530**	**0**
	TOTAL	**365**** * (IHS, Tribal & Urban grants and sub-grantees)	**$111,347,776**	**$111,347,776**	**$111,347,776**	**$0**
	Indian Tribes	**283 primary grants and sub-grants**	**$92,603,859**			
	Total States	**#35 states**	**$111,347,776**			

* Specific grant amounts subject to changes due to outcome of the FY 2016 application process.
**Funds pending distribution in FY 2014 due to late applications or review submissions.
***For FY 2014, 365 grants and sub-grants received financial assistance awards compared to 384 SDPI grants that ever received funding.

CFDA No. 93.442 / Special Diabetes Program for Indians Diabetes Prevention (DP) and Healthy Heart (HH) Initiative Grants by State and FY 2014 Annual Financial Assistance Awards						
	State	Total # DP and HH Initiatives	Total FY 2014 Final	FY 2015 Enacted	FY 2016 Request*	Difference +/- 2014
AK	Alaska	5	$1,694,200	$1,694,200	$1,694,200	$0
AZ	Arizona	6	2,163,900	2,163,900	2,163,900	0
CA	California	11	3,388,500	3,388,500	3,388,500	0
ID	Idaho	1	324,300	324,300	324,300	0
KS	Kansas	1	397,000	397,000	397,000	0
MI	Michigan	2	648,600	648,600	648,600	0
MN	Minnesota	4	1,297,200	1,297,200	1,297,200	0
MS	Mississippi	1	397,000	397,000	397,000	0
MT	Montana	2	648,600	648,600	648,600	0
NC	North Carolina	1	324,300	324,300	324,300	0
NE	Nebraska	2	648,600	648,600	648,600	0
NM	New Mexico	5	1,766,900	1,766,900	1,766,900	0
NY	New York	2	648,600	648,600	648,600	0
OK	Oklahoma	8	2,957,900	2,957,900	2,957,900	0
OR	Oregon	2	794,000	794,000	794,000	0
SD	South	8	2,667,100	2,667,100	2,667,100	0

CFDA No. 93.442 / Special Diabetes Program for Indians Diabetes Prevention (DP) and Healthy Heart (HH) Initiative Grants by State and FY 2014 Annual Financial Assistance Awards						
	State	Total # DP and HH Initiatives	Total FY 2014 Final	FY 2015 Enacted	FY 2016 Request*	Difference +/- 2014
	Dakota					
UT	Utah	1	397,000	397,000	397,000	0
WA	Washington	5	1,694,200	1,694,200	1,694,200	0
WI	Wisconsin	1	324,300	324,300	324,300	0
	Total	**68**	**$23,182,200**	**$23,182,200**	**$23,182,200**	**$0**
	Indian Tribes	**61 primary and sub-grant sites**				
	Total States	**#19 States**				

* Specific grant amounts subject to changes due to outcome of the FY 2016 application process.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Facilities: 75-0391-0-1-551
MAINTENANCE AND IMPROVEMENT

(Dollars in Thousands)

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$53,614	$53,614	$89,097	+$35,483
FTE	0	0	0	0

Authorizing Legislation .....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended 2010

FY 2016 Authorization.....Permanent

Allocation Method.....Direct Federal, P.L. 93-638 Self-Determination Contracts and Self-Governance Compacts

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

Maintenance and Improvement (M&I) funds are the primary source of funding to maintain, repair, and improve existing Indian Health Service (IHS and Tribal healthcare facilities, which are used to deliver and support health care services. M&I funding supports federal, government-owned buildings and tribally-owned space where health care services are provided pursuant to contracts or compacts executed under the provisions of the Indian Self-Determination and Education Assistance Act (P.L. 93-638). M&I funds are necessary to achieve and maintain accreditation, to meet building codes and standards, to maintain and repair the physical condition of health care facilities, to modernize existing health care facilities to meet changing health care delivery needs, and to implement mandated requirements (e.g., energy conservation, seismic, environmental, handicapped accessibility, security, etc.). Efficient and effective buildings and infrastructure are vital to delivering health care in direct support of the IHS mission and priorities.

Maintaining reliable and efficient buildings is an increasing challenge as existing health care facilities age and additional space is added into the real property inventory. The average age for IHS-owned healthcare facilities is 35 years, whereas the average age, including recapitalization of private-sector hospital plants, is 9 to 10 years.[1] Many IHS and Tribal health care facilities are operating at or beyond capacity, and their designs are not efficient in the context of modern health care delivery. In addition, as existing health care facilities continue to age, the operational and maintenance costs increase.

The physical condition of IHS-owned and many tribally-owned healthcare facilities is evaluated through routine observations by facilities personnel and by in depth condition surveys. These observations and surveys identify facility, fire-life-safety, and program deficiencies, and are used to develop IHS' estimate of Backlog of Essential Maintenance, Alteration, and Repair (BEMAR). The BEMAR is a measure of the condition of health care facilities in the Indian health system

[1] The 'average age of hospital plant' measures the average age of the facility including capital improvements, replacement of built-in equipment and modernization.

and establishes priorities for larger M&I projects. The BEMAR for all IHS and reporting Tribal health care facilities as of October 1, 2014 is $467 million.

M&I Funds Allocation Method

The IHS M&I funds are allocated in four categories: routine maintenance, M&I projects, environmental compliance, and demolition:

- *Routine Maintenance Funds* – These funds support activities that are generally classified as those needed for maintenance and minor repair to keep the health care facility in its current condition. Funding allocation is formula based. The Building Research Board of the National Academy of Sciences has determined that approximately two to four percent of current replacement value of supported buildings is required to maintain (i.e., 'sustain') facilities in their current condition.[2]

- *M&I Project Funds* – These funds are used for major projects to reduce the BEMAR and make improvements necessary to support health care delivery. Funding allocation is formula based.

- *Environmental Compliance Funds* – These funds are used to address findings and recommendations from environmental audits, to improve energy efficiency and water efficiency, to increase renewable energy usage, to reduce consumption of fossil-fuel generated electricity, and to implement other sustainability initiatives. These funds are available to Federal and Tribal health care facilities on a national basis.

- *Demolition Funds* – The IHS has a number of Federally-owned buildings that are vacant, excess, or obsolete. Demolition funds are used to dispose of these excess assets. These funds may be augmented with Environmental Compliance Funds as available for demolition and disposal to the extent that the proposed action reduces hazards, environmental concerns, or liability to IHS.

FUNDING HISTORY

Fiscal Year	Amount
2011 Omnibus	$53,807,000
2012 Enacted	$53,721,000
2013 Final	$50,919,000
2014 Final	$53,614,000
2015 Enacted	$53,614,000

BUDGET REQUEST

The FY 2016 budget request for the Maintenance and Improvement program of $89,097,000 is an increase of $35,483,000 above the FY 2015 Enacted Level.

FY 2015 Base Funding of $53,614,000 provides funding in the following allocation categories:

- Approximately $50.1 million for routine maintenance to sustain the condition of Federal and Tribal health care facilities buildings.

[2] *Committing to the Cost of Ownership - Maintenance and Repair of Public Buildings,* The National Academies Press (1990), *available at* http://www.nap.edu/catalog.

- $3 million for environmental compliance projects.
- $500,000 for demolition projects.

FY 2016 Funding Increases to Base Funding of $35,483,000 would provide funding for:

Population Growth +$483,000 – to fund the impact from the additional services need arising from the growing AI/AN population. The growth rate is projected to be 1.8 percent in FY 2016 based on State births and deaths data.

Program Increase +$35,000,000 - to fund the most critical needs on the maintenance backlog at existing Federal and Tribal health care facilities. Funds will be distributed using the M&I allocation methodology.

The population growth and program increases will be utilized to fund the following additional activities above the base funding allocations:

- Approximately $15.5 million for routine maintenance to sustain the condition of Federal and Tribal health care facilities.
- Approximately $20 million for Area and Tribal M&I projects to directly address deteriorating infrastructure and building systems, and improvements to the facilities to more effectively support the delivery of modern healthcare.

The funds will support non-personnel costs at these health care facilities including emergency repairs, preventive maintenance activities, maintenance supplies and materials, building service equipment replacement and Area-prioritized and local projects. This budget request funds routine maintenance and repair needs at approximately two percent of current replacement value and re-establishes M&I project funding for the major repair, restoration and modernization projects prioritized at the Area.

Increasing patient workload space requirements, changes in patient demographics and infrastructure improvements to support technological and health care delivery advancements pose challenges for IHS and Tribal health care administrators. This budget request will accomplish multiple benefits resulting from timely investments in health care facilities repair and improvement, such as effective mission attainment, compliance with regulations, improved health care facility condition, efficient operations and patient flow, enhanced recruitment of health care professionals, and implementation of stakeholder-driven initiatives.

With the largest portion of these funds allocated to routine maintenance, IHS and the Tribes will still need to prioritize the most critical projects to address the greatest facility and health delivery needs. However, local service units also have the option to use third party collections for maintaining health care services provided to patients and addressing identified accreditation deficiencies. There has been a significant growth in health care delivery space related to new federal construction, tribal joint venture construction, and expanded federal and tribal facilities, which has enhanced access to quality healthcare but has also increased the M&I needs over time. Federal and tribal health sites need to annually increase space (up to 3 percent) to meet the needs of the growing AI/AN population. The requested increase addresses this need.

Finally, IHS and Tribal healthcare administrators will work on making progress to achieve the goals of the Energy Policy Act of 2005, Executive Order 13423, “Strengthening Federal Environmental, Energy, and Transportation Management”, the Energy Independence and Security

Act of 2007, and Executive Order 13514, "Federal Leadership in Environmental, Energy and Economic Performance." The Office of Management and Budget (OMB) rates Agencies on their progress in achieving the sustainability/green targets established by these laws and Executive Orders and meeting the "Standard for Success", which will be challenging at this funding level.

OUTPUTS / OUTCOMES - The Outcomes for this program are measured through the BEMAR, i.e., progress in addressing maintenance needs and facility deficiencies.

GRANT AWARDS – This program has no grant awards.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Facilities: 75-0391-0-1-551

SANITATION FACILITIES CONSTRUCTION

(Dollars in Thousands)

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$79,423	$79,423	$115,138	+$35,715
FTE*	161	161	161	0

*FTE numbers reflect Federal staff only and do not include Tribal staff.

Authorizing Legislation .....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; 42 U.S.C. 2004a, Indian Sanitation Facilities Act; 25 U.S.C. 1632, Indian Health Care Improvement Act (IHCIA), as amended 2010

FY 2016 Authorization.....Permanent

Allocation Method ..... Needs-based priority system for construction project fund allocation and Implemented through P.L. 86-121 Memorandum of Agreements, P.L. 93-638 Self-Determination Construction Contracts and Self-Governance Construction Project Agreements

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

Sanitation Facilities Construction (SFC) is an integral component of IHS disease prevention activities. IHS has carried out the program since 1959 using funds appropriated for SFC to provide potable water and waste disposal facilities for American Indian and Alaska Native (AI/AN) people and communities. As a result, the rates for infant mortality, the mortality rate for gastroenteritis and other environmentally-related diseases have been reduced by about 80 percent since 1973. IHS physicians and health professionals credit many of these health status improvements to IHS provision of water supplies, sewage disposal facilities, development of solid waste sites, and provision of technical assistance to Indian water and sewer utility organizations. It is important to note that almost 13 percent, or almost 53,200, AI/AN homes are without access to safe water or adequate wastewater disposal facilities, and the individuals who live in those homes are still at a higher risk for gastrointestinal disease, respiratory disease and other chronic diseases. Many of these homes without service are very remote and may have limited access to health care which increases the importance of improving environmental conditions in the home as part of a comprehensive public health program.

The four types of sanitation facilities projects funded through IHS are: (1) projects to serve existing housing; (2) projects to serve new or like-new housing, such as Indian homes being constructed or rehabilitated by the BIA-Home Improvement Program, Tribes, individual homeowners, or other nonprofit organizations; (3) special projects (studies, training, or other needs related to sanitation facilities construction); and (4) emergency projects. Projects that serve new or like-new housing are funded based on a priority classification system. Projects that serve existing housing are annually prioritized as described below with tribal input, then funded in priority order.

SFC projects can be managed by IHS directly or they can be managed by Tribes that elect to use the Title I or Title V authorization under P.L. 93-638, the Indian Self-Determination and

Education Assistance Act. Sanitation facilities projects are carried out cooperatively with the Tribes who are to be served, and construction is performed by either the IHS or Tribes. Projects start with a Tribal Project Proposal and are funded and implemented through execution of an agreement between the Tribe and IHS. In these agreements the Tribes also agree to assume ownership responsibilities, including operation and maintenance. The overall SFC goals, eligibility criteria, project planning, and funding priorities remain the same, regardless of the delivery methods chosen by a Tribe. The majority of all sanitation facilities construction is performed by Indian Tribes and firms.

The Indian Health Care Improvement Act includes a requirement for the IHS to identify the universe of sanitation facilities needs for existing AI/AN homes by documenting deficiencies and then proposing projects to address those needs. These projects include providing new and existing homes with first time services such as water wells and onsite waste water systems or connecting homes to community water and waste water facilities. The universe of need also includes projects to upgrade existing water supply and waste disposal facilities and projects to improve sanitation facilities operation and maintenance capabilities in Indian country. At the end of FY 2014, the list of all projects to correct documented sanitation project deficiencies totaled approximately $3.39 billion with those projects considered feasible totaling almost $1.93 billion. Feasible projects must be economically feasible (when the cost per home is within an established allowable unit cost for a particular geography) and technically feasible (determined by operability and sustainability of the proposed system).

As of the end of FY 2014, there were about 217,000 or approximately 56 percent of AI/AN homes in need of some form of sanitation facilities improvements, including 6.1 percent or nearly 24,000 AI/AN homes without potable water. Maximum health benefits will be realized by addressing existing sanitation needs identified in the backlog, by providing sanitation facilities for new homes when they are constructed, and continuing technical assistance to support tribal operation and maintenance of these facilities. US (all races) population has sanitation facilities in approximately 99.36% of homes. In comparison, Indian Country has sanitation facilities in approximately 91.2% of AI/AN homes.

In FY 2014, IHS provided service to 16,998 AI/AN homes. Projects that provide sanitation facilities to homes are selected for funding in priority order each year from the Sanitation Deficiency System (SDS). The SDS is an inventory of the sanitation deficiencies of all federally recognized AI/AN communities, those sanitation deficiencies include needed water, sewer, and solid waste facilities for existing AI/AN homes. Project selection is driven by objective evaluation criteria that include health impact, existing deficiency level, adequacy of previous service, capital cost, local tribal priority, operations and maintenance capacity of receiving entity, availability of contributions from non-IHS sources, and other conditions that are locally determined. The SDS priority position of each unfunded project is reevaluated with the Tribes in each Area annually.

Beginning in FY 2015, the SFC worked to improve program transparency, accuracy and accountability by requiring Indian-occupied homes to be identified with geographic data to better track and report the SFC program progress and sanitation facility needs. Additionally, to ensure that appropriated funds are expediently and efficiently utilized to construct sanitation facilities serving Indian-occupied homes, the SFC program has increased focus on ‘ready to fund’ proposed projects with a well-defined scope, a detailed cost estimate, a completed preliminary design and that known potential risks to project construction, operation and maintenance have been considered and mitigated.

In FY 2016 the program will continue to examine and improve data quality of the reported home and community sanitation facility needs and will continue its focus on maintaining average project duration to less than 4 years in FY 2016.

FUNDING HISTORY

Fiscal Year	Amount
2011 Omnibus	$95,665,000
2012 Enacted	$79,582,000
2013 Enacted	$75,431,000
2014 Final	$79,423,000
2015 Enacted	$79,423,000

BUDGET REQUEST

The FY 2016 budget request for the Sanitation Facilities Construction program of $115,138,000 is an increase of $35,715,000 above the FY 2015 Enacted level.

FY 2015 Base Funding of $79,423,000 provides funding for sanitation facilities to approximately 16,000 Indian homes, and is allocated as follows:

- Approximately $47.423 million will be distributed to the Areas for prioritized projects to serve existing homes, based on a formula that considers, among other factors, the cost of facilities to serve existing homes that: (a) have not received sanitation facilities for the first time or (b) are served by substandard sanitation facilities (water and/or sewer). Another distribution formula element is a weight factor that favors Areas with larger numbers of AI/AN homes without water supply or sewer facilities, or without both.

  From this distribution up to $5 million will be used for projects to clean up and replace open dumps on Indian lands pursuant to the Indian Lands Open Dump Cleanup Act of 1994.

- Approximately $30 million will be used to serve new and like-new homes. Some of these funds may also be used for sanitation facilities for the individual homes of the disabled or sick with a physician referral indicating an immediate medical need for adequate sanitation facilities in their home. As needed, amounts to serve new and like-new homes will be established by Headquarters after reviewing Area proposals. Priority will be given to projects under the BIA Housing Improvement Program (HIP) to serve new and like-new homes with the exception of "Category A" BIA HIP homes.[1]

- Up to +$2 million will be reserved at IHS Headquarters.

  Of this amount, $1million will be used for special projects and for distribution to all Areas as needed to address water supply and waste disposal emergencies caused by natural disasters or other unanticipated situations that require immediate attention to minimize potential threats to public health. Emergency and special funds remaining at the end of the fiscal year may be distributed to the Areas to address the SDS priority list of needs. The remaining approximate $1 million is for funding special projects. Up to $500,000 will be used nationally to assess and enhance the ability of Tribes to establish effective and sustainable operation and

[1] "Category A" BIA HIP homes are considered existing homes and will be served with funds described in item 1.

maintenance organizations. An amount up to $500,000 will be used for improving data collection systems, providing technical assistance and training for users, supporting a national automated computer-aided drafting contract, and to fund a Tribal Water Center. Funding for the Tribal Water Center started in FY 2012 and will be funded at $250,000 annually for five years through FY 2016. The Tribal Water Center, in partnership with the Alaska Native Tribal Health Consortium, will develop a teaching system that can be used IHS-wide. The teaching system will include materials and techniques for homeowners and communities to improve usage and support of sanitation infrastructure in ways that promotes health.

The FY 2016 funding increase of $35,715,000 will provide sanitation facilities to approximately 7,700 Indian homes, and is comprised of:

Population Growth +$715,000 to fund the additional services impact arising from the growing AI/AN population. The growth rate is projected to be 1.8 percent in FY 2016 based on State births and deaths data.

Program Increase +$35,000,000

Of the combined increase above the base funding, up to $25 million will be distributed to the Areas for prioritized projects to serve existing homes, based on the formula mentioned above.

Approximately $10 million will be used to serve new and like-new homes as mentioned above.

The IHS appropriated funds for sanitation facilities construction are prohibited by law from being used to provide sanitation facilities for new homes funded with grants by the housing programs of the Department of Housing and Urban Development (HUD). These HUD housing grant programs for new homes should incorporate funding for the sanitation facilities necessary for those homes.

OUTPUT / OUTCOME

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
(35): Sanitation Improvement: Number of new or like-new and existing AI/AN homes provided with sanitation facilities.	FY 2014: 16,998 Target: 16,000 (Target Exceeded)	15,500	23,200	+7,700
SFC-E: Track average project duration from the Project Memorandum of Agreement (MOA) execution to construction completion. *(Efficiency)*	Calendar 2013: 3.69 years Target: 4.0 years (Target Exceeded)	4.0 years	3.5 years	-0.5 years
SFC-3: Percentage of AI/AN homes with sanitation facilities.	FY 2014: 91.2% Target: 89% (Target Exceeded)	91%	92%	+1%

GRANT AWARDS – This program has no grant awards.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Facilities – 75-0391-0-1-551
HEALTH CARE FACILITIES CONSTRUCTION

(Dollars in Thousands)

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$85,048	$85,048	$185,048	+$100,000
FTE	0	0	0	0

Authorizing Legislation .....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended 2010

FY 2016 Authorization.....Permanent

Allocation Method.....Direct Federal, P.L. 93-638 Self-Determination Construction Contracts and Self-Governance Construction Project Agreements

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The Indian Health Service (IHS) Health Care Facilities Construction (HCFC) funds support construction of functional, modern IHS and Tribal operated health care facilities, and staff quarters where no suitable housing alternative is available. The IHS is authorized to construct health care facilities and staff quarters, support Tribal construction of facilities under the Joint Venture Construction Program (JVCP), provide construction funding for Tribal small ambulatory care facilities projects, and provide funding to construct new and replacement dental units. The health care facilities constructed through the HCFC program ensure access to quality, culturally sensitive health care for American Indians and Alaska Natives (AI/AN).

The HCFC program is funded based on an IHS-wide list of priorities for construction projects. During FY 1990, in consultation with the Tribes, the IHS revised its Health Facilities Construction Priority System (HFCPS) methodology. The HFCPS ranks proposals using factors reflecting the total amount of space needed, age and condition of the existing health care facility, if any, degree of isolation of the population to be served in the proposed health care facility, and availability of alternate health care resources. The health care facilities projects remaining on the HFCPS list, including those partially funded, total approximately $2.0 billion as of April 2014. The reauthorization of the Indian Health Care Improvement Act in the Affordable Care Act in 2010 included a provision that 'any project established under the construction priority system in effect on the date of enactment of the … Act of 2009 shall not be affected by any change in the construction priority system taking place after that date…'

FUNDING HISTORY

Fiscal Year	Amount
2011 Omnibus	$39,156,000
2012 Enacted	$85,048,000
2013 Enacted,	$77,238,000
2014 Final	$85,048,000
2015 Enacted	$85,048,000

BUDGET REQUEST

The FY 2016 budget request for the Health Care Facilities Construction program of $185,048,000 is an increase of $100,000,000 above the FY 2015 Enacted level. The following facilities will be constructed depending on the availability of funding and construction schedules.

FY 2015 Base Funding of $85,048,000 provides funding for the following projects:

- Gila River Southeast Health Center, Chandler, AZ to complete construction
- Salt River Northeast Health Center, Scottsdale, AZ to design and begin site development
- Rapid City Health Center, Rapid City, SD to design and begin site development

The FY 2016 funding increase of $100,000,000 provides funding for the following additional activities and projects:

- Begin facility construction of the Salt River Northeast Health Center in Scottsdale, AZ
- Begin facility construction of the Rapid City Health Center in Rapid City, SD
- Design and construct the infrastructure for the Dilkon Alternative Rural Health Center in Dilkon, AZ

In summary, the funds will be allocated to the facilities as described below:

Gila River Southeast Health Center, Chandler, AZ $63,684,000
These funds will be used to complete construction of the Gila River Southeast Health Center which received design funding in 2005 and initial construction funds in 2009 and 2015. The proposed new Southeast Health Center will consist of 139,522 gross square feet (GSF) outpatient health center and serve a projected user population of 15,220 generating 58,600 primary care provider visits and 117,000 outpatient visits annually. It will be a modern, technologically advanced health care facility with enough space and staff to provide an expanded level of health care services specifically designed to meet the health care needs of the Gila River Health Care Corporation (GRHCC) and the southeast portion of the Phoenix Service Unit. This facility will improve access to medical care as well as improve the collaboration and partnership between the GRHCC and the IHS Phoenix Service Unit. The new health care facility will provide an expanded outpatient department, community health department, and a full array of ancillary and support services.

Salt River Northeast Health Center, Scottsdale, AZ $50,000,000
These funds will be used to design the health care facility and begin construction of the Salt River Northeast Health Center. The proposed new Northeast Health Center will consist of 148,252 GSF outpatient health center and serve a projected user population of 15,313 generating 51,275 primary care provider visits and 124,837 outpatient visits annually. It will be a modern, technologically advanced health care facility with enough space and staff to provide an expanded level of health care services specifically designed to meet the health care needs of the northeast portion of the Phoenix Service Unit. This facility will improve access to medical care as well as improve the collaboration and partnership between the Salt River Pima-Maricopa Indian Community and the IHS Phoenix Service Unit. The new health care facility will provide an expanded outpatient department, community health department, and a full array of ancillary and support services. Additional funding in subsequent years will be required to complete construction of this project.

Rapid City Health Center, Rapid City, SD $50,864,000

These funds will be used to design and begin construction of the health care facility to replace the Sioux San Hospital with a new 137,391 GSF ambulatory care center and modernize 3025 GSF of existing space to today's medical standard. This project includes funding for refurbishing historic buildings and mitigation of historic buildings that will be demolished. The proposed new ambulatory health care center will serve a projected user population of 13,657 generating 52,195 primary care provider visits and 104,233 outpatient visits annually. It will be a modern, technologically advanced, facility with enough space and staff to provide an expanded level of health care services specifically designed to meet the health care needs of the Rapid City Service Unit. This facility will improve access to medical care as well as improve the collaboration and partnership between the Great Plains Tribes and the IHS. The new health care facility will provide an expanded outpatient department, community health department, and a full array of ancillary and support services. Additional funding in subsequent years will be required to complete construction of this project.

New Dilkon Alternative Rural Health Center, Dilkon, AZ $20,500,000

These funds will be used for facility design and to construct infrastructure to prepare for a health care facility with 8 short stay beds and 109 staff quarters located in Dilkon, Arizona. The proposed new facility will consist of 129,232 GSF outpatient health center and serve a projected user population of 15,314 generating 61,633 primary care provider visits and 123,080 outpatient visits annually. The new facility will provide an expanded outpatient department, community health department, and a full array of ancillary and support services. Additional funding in subsequent years will be required to complete construction of this project.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
36 Health Care Facilities Construction: Number of health care facilities construction projects completed.	FY 2014: 0 Target: 1 (Target Not Met)	3**	2***	+1
HCFC-E Health Care Facilities Construction: Energy consumption in Leadership in Energy and Environmental Design (LEED) certified IHS health care facilities compared to the industry energy consumption standard for comparable facilities.	FY 2014: 0 Target: N/A	3	2	+1

*[1]The facilities scheduled to be constructed in FY 2016 include the Gila River Southeast Health Center, Salt River Northeast Health Center, Rapid City Health Center, and Dilkon Alternative Rural Health Center, depending on the availability of funding and construction schedules.

** The health care facilities scheduled to be completed in FY 2015 are Kayenta, Arizona San Carlos, Arizona, and Southern California YRTC.

*** The health care facilities scheduled to be completed in FY 2016 are Winterhaven, CA (Fort Yuma) and Northern California YRTC.

GRANT AWARDS -- Program has no grant awards.

AREA ALLOCATIONS – Program does not allocate funds by Area.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Facilities: 75-0391-0-1-551

FACILITIES AND ENVIRONMENTAL HEALTH SUPPORT

(Dollars in Thousands)

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$211,051	$219,612	$226,870	+$7,258
FTE*	1,007	1,058	1,063	+5

*FTE numbers reflect Federal staff only and do not include Tribal staff.

(Dollars in Thousands)

Detail Breakout of FEHS Activity	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$211,051	$219,612	$226,870	+$7,258
Facilities Support	*$124,096*	*$130,941*	*$135,448*	*+$4,507*
Environmental Health Support	*$70,902*	*$72,551*	*$74,791*	*+$2,240*
Office of Environmental Health and Engineering Support	*$16,053*	*$16,120*	*$16,631*	*+$511*
FTE	1,007	1,058	1,063	+5
Facilities Support	*384*	*423*	*427*	*+4*
Environmental Health Support	*555*	*567*	*568*	*+1*
Office of Environmental Health and Engineering Support	*68*	*68*	*68*	*0*

Authorizing Legislation .....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended 2010

FY 2016 Authorization.....Permanent

Allocation Method.....Direct Federal, P.L. 93-638 Self-Determination Contracts, Self-Governance Compacts and competitive cooperative agreements

SUMMARY OF PROGRAMS

Facilities and Environmental Health Support (FEHS) programs provide and support an extensive array of real property, health care facilities and staff quarters construction, maintenance and operation services, as well as community and institutional environmental health, injury prevention, and sanitation facilities construction services. The programs both directly and indirectly support all of the Indian Health Service (IHS) facilities performance measures and improved access to quality health services. The programs and staff at the IHS Headquarters, Area Office, and Service Unit levels work collaboratively with Tribes and other agencies to promote and provide access to improvements in public health through surveillance, education, intervention activities, construction of sanitation facilities and health care facilities.

The FEHS activity has three sub-activities to align program and functions and is summarized below:

1. Facilities Support (FS) provides funding for staff and management activities to support operation and maintenance of real property and building systems; medical equipment technical support; and planning/design of new and replacement facilities projects.

2. Environmental Health Support (EHS) provides funding for staff and management activities in support of sanitation facilities construction, and environmental health services activities.
3. Office of Environmental Health and Engineering Support provides funding for Headquarters management activities and for real property asset management across the IHS facilities and environmental health programs, including technical services and support for capital investments, construction contracting and management of new and replacement facilities, budget formulation, long range planning, national policy development and implementation and liaison with HHS, Congress, Tribes, and other Federal agencies.

In addition to staffing costs, funding under this activity is used for utilities, certain non-medical supplies and personal property, and biomedical equipment repair.

FUNDING HISTORY

Fiscal Year	Amount
2011 Omnibus	$192,701,000
2012 Enacted	$199,413,000
2013 Enacted	$193,578,000
2014 Final	$211,051,000
2015 Enacted	$219,612,000

BUDGET REQUEST

The FY 2016 budget request for the Facilities and Environmental Health Support program of $226,870,000 is an increase of $7,258,000 above the FY 2015 Enacted level.

FY 2015 Base Funding of $219,612,000 provides funding for the Facilities Support, Environmental Health Support, and the Office of Environmental Health Support. All are described in greater detail below.

The FY 2016 funding increase of $7,258,000 would provide funding for:

- Pay Costs +$1,757,000 – to cover pay raises for Federal and Tribal employees.

- Inflation +$1,931,000 – to cover inflationary costs associated with the FEHS program activities.

- Population Growth +$1,986,000 – to fund the additional services need arising from the growing AI/AN population. The growth rate is projected to be 1.8 percent in FY 2016 based on State births and deaths data.

- Staffing/Operating Cost Requirements for Newly Constructed Facilities +$1,584,000 – Facility and Environmental Health Support funds are requested for 2 new and expanded healthcare facilities and 1 youth treatment facility that are planned to complete construction and/or fully open in FY 2016. One of the 3 facilities is a Joint Venture Construction Program (JVCP) project where the Tribe is fulfilling its responsibility under the JVCP agreements to fund the construction and equipment for the health care facility and IHS is fulfilling its responsibility to request staffing and operating funds from Congress. Funding these facilities allows IHS to expand provision of health care capacity to address critical health care needs.

Staffing and Operating Costs for New/Replacement Facility – FY2016	Amount	Tribal Pos./FTE
Southern California Youth Treatment Center, Hemet, CA	$311,000	3
Choctaw Alternative Rural Healthcare Center (JV), Choctaw, MS	$930,000	4
Ft. Yuma Health Center, Winterhaven, CA	$343,000	2
Grand Total:	**$1,584,000**	**9**

FACILITIES SUPPORT – Program Description and Accomplishments

Facilities Support (FS) provides funding for Area and Service Unit staff for facilities-related management activities, operation and maintenance of real property and building systems, medical equipment technical support, and planning and construction management support for new and replacement health facilities projects. The sub-activity directly supports the Agency's priorities including: (1) renewing and strengthening our partnership with Tribes; (2) improving the quality of and access to care; and (3) making all our work accountable, transparent, fair and inclusive.

The IHS owns approximately 10,465,000 square feet of facilities (totaling 2,150 buildings) and 1,834 acres of federal and trust land. The nature of space varies from sophisticated medical centers to residential units and utility plants. Facilities range in age from less than one year to more than 160 years, with an average age greater than 35 years. A professional and fully-staffed workforce is essential to ensure effective and efficient operations. Typical staff functions funded may include:

- Facilities engineers and maintenance staff responsible for ensuring that building systems are operated properly, facilities and grounds are maintained adequately, utilities are managed appropriately, environmental compliance requirements are met, and buildings are safe;
- Specialized clinical engineers and technicians who maintain and service medical equipment;
- Realty staff that manages the real property requirements and quarters; and
- Facilities planning and construction-monitoring that assist in the planning and construction of projects.

In addition, FS provides funding for related Area and Service Unit operating costs, such as utilities, building operation supplies, facilities-related personal property, and biomedical equipment repair and maintenance.

During the period FY 2003 through FY 2014, total utility costs have increased 11.6 percent from $15.5 million to $17.3 million and total utility costs per Gross Square Feet (GSF) increased 53 percent from $2.32/GSF to $3.55/GSF. IHS has made conscious efforts to help stem the growth in utility costs to ensure limited appropriations are sufficient to fund these needs. For example, IHS reduced the energy related utility consumption for IHS managed facilities from 199,649 British Thermal Units per Square Foot (BTU/SF) in 2003 to 187,153 BTU/SF in 2014, which is a 6.2 percent reduction. Additionally, IHS continues to aggressively investigate options to reduce energy costs and work towards achievement of the goals of the Energy Policy Act of 2005, Executive Order 13423, "Strengthening Federal Environmental, Energy, and Transportation Management", the Energy Independence and Security Act of 2007, and Executive Order 13514, "Federal Leadership in Environmental, Energy and Economic Performance."

ENVIRONMENTAL HEALTH SUPPORT – Program Description and Accomplishments

The Environmental Health Support Account (EHS) provides funding for IHS Area, District, and Service Unit management activities and environmental health staff which include engineers, environmental health officers, environmental health technicians, engineering aides, injury

prevention specialists, and institutional environmental health officers. AI/ANs face hazards in their environments that affect their health status, including communities in remote and isolated locations, severe climatic conditions, limited availability of safe housing, lack of safe water supply, and lack of public health and safety legislation.

Two programs are funded by EHS:

- **Sanitation Facilities Construction Program (SFC) –** Under this program, staff manage and provide professional engineering services to construct over 400 sanitation projects annually at a total cost of over $190 million. The program manages annual project funding that includes contributions from Tribes, states, and other federal agencies. Services funded include management of staff; pre-planning, consultation with Tribes, coordination with other federal, state, and local governmental entities, identifying supplemental funding outside of IHS, developing local policies and guidelines with Tribal consultation, developing agreements with Tribes and others for each project, providing project design, project construction, assuring environmental and historical preservation procedures are followed, and assisting Tribes where the Tribes provide construction management.

  Consistent with the 1994 Congressional set aside for "…tribal training on the operation and maintenance of sanitation facilities," $1 million of these support funds are used for technical assistance, training, and guidance to Indian families and communities regarding the operation and maintenance of essential water supply and sewage disposal facilities.

  In accordance with the Indian Health Care Improvement Act, the staff annually updates its inventory of sanitation facilities deficiencies for existing Indian occupied homes.[1] This is accomplished through extensive consultation with Tribes. The SFC staff also develops and updates an inventory of all open dump sites on Indian lands as required under the Indian Lands Open Dump Cleanup Act.[2] Both of these inventories are widely used by other governmental agencies in their evaluation and funding of sanitation projects.

- **Environmental Health Services Program (EHS)** – This program includes the specialty areas of injury prevention and institutional environmental health. The EHS program identifies environmental hazards and risk factors in tribal communities and proposes control measures to prevent adverse health effects. These measures include monitoring and investigating disease and injury in Tribal communities, identifying environmental hazards in community facilities such as food service establishments, Head Start centers, community water supply systems, and health care facilities, and providing training, technical assistance, and project funding, including competitive cooperative agreements, to develop the capacity of Tribal communities to address their environmental health issues.

  The IHS **Injury Prevention Program** has been instrumental in reducing the injury mortality rate of AI/ANs by 58 percent since it moved from an "education only" focus to a public health approach in the 1970's. The Injury Prevention Program has developed effective strategies and initiatives to reduce the devastating burden of injuries experienced by AI/ANs.

  The IHS **Institutional Environmental Health Program (IEH)** identifies environmental hazards and risk factors in the built environment and proposes control measures to prevent adverse health effects in health care and other community facilities and to support health care accreditation. Maintaining accreditation ensures that IHS continues to have access to third-

[1] Title III, Section 302(g) 1 and 2 of P.L. 94-437.
[2] P.L. 103-399.

party funding. The IHS IEH Program developed and maintains an incident reporting system (WebCident) to prepare required Occupational Safety and Health Administration logs, identify and document hazardous conditions, and develop targeted prevention strategies.

Tribal Health Programs: Area, District, and Service Unit environmental health personnel work with Tribes/Tribal organizations to encourage maximum participation in planning health services delivery programs. They provide training and technical assistance to the Tribal officials who carry out administrative/management responsibilities associated with operation of federally supported programs.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2015 Budget	FY 2016 Target	FY 2016 Target+/- FY 2015 Budget
Environmental Surveillance: Identification and control of environmental health risk factors (Output)	CY 2014: Areas reported final food risk factor deficiency percentages that were used to develop one national food risk factor deficiency percent of 5.9%. This is an increase of 1.3 percentage points from the 2011 baseline measure. Target: Areas will report final food risk factor deficiency measures which will be compared to the 2011 baseline (4.6%) measure with a target of reducing the national deficiency percentage by 2 percentage points. (Target Not Met)	Expand the implementation of the effective strategies identified in the targeted food service operations toward additional food service operations to reduce food risk factors.	Areas will identify targeted Head Start and Day Care establishments from which a national baseline measure of foodborne illness risk factors will be calculated.	N/A

GRANT AWARDS

In 2014, the Injury Prevention Program awarded $2.28 million in cooperative agreements to continue funding 33 Tribal Injury Prevention Programs that were initially funded in 2010. Seven Tribal programs that were previously awarded $70,000 to implement proven or promising motor vehicle or elder fall injury interventions completed their funding cycles in 2013. In 2015, all cooperative agreements will come to an end and a new cycle will be competitively awarded.

	FY 2014 Final	**FY 2015 Enacted**	**FY 2016 President's Budget**
Number of Awards	Part Ia 16 Part Ib 17 Part II 0	TBD	TBD
Average Award	Part Ia $65,000 Part Ib $80,000 Part II 0	TBD	TBD
Range of Awards	Part Ia $65,000 Part Ib $80,000 Part II 0	TBD	TBD

OFFICE OF ENVIRONMENTAL HEALTH AND ENGINEERING SUPPORT – Program Description and Accomplishments:

The IHS Office of Environmental Health and Engineering Support activity (OEHE) provides funds for management activities, personnel, contracts, contractors, and operating costs for the OEHE Headquarters. Personnel have management responsibility for IHS facilities and environmental health programs, provide direct technical services and support to Area personnel, and perform critical management functions. Management activities include national policy development and implementation, budget formulation, project review and approval, congressional report preparation, quality assurance (e.g., internal control reviews, Federal Managers Financial Integrity Act activities and other oversight), technical assistance (e.g., consultation and training), long range planning, meetings (with HHS, Tribes, and other federal agencies), and recruitment and retention. Typical direct support functions performed by OEHE personnel who serve as project officers and contracting officer representatives for health care facilities construction projects are: reviewing and/or writing technical justification documents, participating in design reviews and site surveys, conducting onsite inspections, and monitoring project funding status. In addition, these positions support real property asset management requirements as required by Executive Order 13327, Real Property Asset Management, and HHS Program Management objectives. These actions are to ensure management accountability and the efficient and economic use of federal real property.

OEHE funds personnel and activities to develop, maintain, and utilize data systems to distribute resources to Area offices for facilities and environmental health activities. Also, technical guidance, information, and training are provided throughout the IHS system in support of the Facilities Appropriation. Some of the activities and accomplishments include review and approval of program justification documents and program of requirements, announcement and review of Joint Venture and Small Ambulatory projects; and awarding and monitoring contracts for all aspects of the Facilities Appropriation. OEHE coordinates construction, environmental health, and real property activities through the 12 Area Offices to ensure program consistency, to ensure the most effective use of resources across IHS, and to support field programs through budget preparation and required reporting, thus ensuring the most effective, accountable use of resources to improve access to quality healthcare services.

The OEHE facilities programs integrate strategic planning, performance, and program integrity into the office's daily business practices. One example is the Sanitation Facilities Construction Strategic planning efforts which have been recognized by OMB. Implementation of the SFC strategic plan has improved project management, reduced project durations and transformed the data system used by IHS and federal partners to manage sanitation programs in Indian country. Another example is the Environmental Health program strategic visioning and the Ten Essential Environmental Health Services as a framework. Implementation of both of these initiatives is ongoing.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Facilities: 75-0391-0-1-551
EQUIPMENT

(Dollars in Thousands)

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$22,537	$22,537	$23,572	+$1,035
FTE	0	0	0	0

Authorizing Legislation .....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended 2010

FY 2016 Authorization.....Permanent

Allocation Method.....Direct Federal, P.L. 93-638 Self Determination contracts and Self-Governance compacts for replacement medical equipment is formula based; Equipment funds for Tribally-constructed health care facilities are competitively allocated; TRANSAM/ambulance purchase programs are federally managed.

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

Equipment funds are used for maintenance, upgrades, replacement, and the purchase of new medical equipment systems at Indian Health Service (IHS) and Tribal health care facilities. It directly supports the Agency's priorities by: (1) renewing and strengthening our partnership with Tribes and (2) improving the quality of and access to care.

Accurate clinical diagnosis and effective therapeutic procedures depend in large part on health care providers using modern and effective medical equipment/systems to assure the best possible health outcomes. The IHS and tribal health programs manage approximately 90,000 biomedical devices consisting of laboratory, medical imaging, patient monitoring, pharmacy, and other biomedical, diagnostic, and patient equipment valued at approximately $500 million. With today's medical devices/systems having an average life expectancy of approximately six years and rapid technological advancements, medical equipment replacement is a continual process making it necessary to replace worn out equipment or provide equipment with newer technology to enhance the speed and accuracy of diagnosis and treatment.

Equipment Funds Allocation Method

The IHS Equipment funds are allocated in three categories: Tribally-constructed health care facilities, TRANSAM and ambulance programs, and new and replacement equipment:

- Tribally-Constructed Health/Care Facilities – The IHS provides medical equipment funds to support the initial purchase of equipment for tribally-constructed health care facilities. $5 million is set aside annually for competitive awards to Tribes and Tribal organizations that construct new or expand health care facilities space using non-IHS funding sources. As a result, approximately 500,000 patients will be treated with newly purchased medical equipment.

- TRANSAM and Ambulance Programs – Equipment funds are also used to acquire new and like-new excess medical equipment from the Department of Defense (DoD) or other sources through the TRANSAM (i.e., Transfer of DoD Excess Medical and Other Supplies to Native Americans) Program and to procure ambulances for IHS and Tribal emergency medical services programs. Currently IHS budgets $500,000 for Ambulances and $500,000 for TRANSAM annually from the Equipment budget.[1] Under the TRANSAM Program, excess equipment and supplies, at an annual estimated value of $5 million, are acquired for distribution to federal and Tribal sites.

- New and Replacement Equipment – The balance of the equipment funds, approximately $18.4 million, are allocated to IHS and Tribal health care facilities to maintain existing and purchase new medical equipment, including the replacement of existing equipment used in diagnosing and treatment of illnesses. The funding allocation is formula based.

FUNDING HISTORY

Fiscal Year	Amount
2011 Omnibus	$22,618,000
2012 Enacted	$22,582,000
2013 Enacted	$21,404,000
2014 Final	$22,537,000
2015 Enacted	$22,537,000

BUDGET REQUEST

The FY 2016 budget request for the Equipment program of $23,572,000 is an increase of $1,035,000 above the FY 2015 Enacted level.

FY 2015 Base Funding of $22,537,000 provides funding to provide for new and routine replacement medical equipment.

- The FY 2016 funding increase of $1,035,000 would provide funding for:

- Inflation +$825,000 – to cover inflationary cost of equipment.

- Population Growth +$210,000 – to fund the impact of additional equipment need arising from the growing AI/AN population. The growth rate is projected to be 1.8 percent in FY 2016 based on State births and deaths data.

The Total Equipment program funding of $23,572,000 will be used as follows:

- Approximately $18.072 million for new and routine replacement medical equipment to over 1,500 federally and Tribally-operated health care facilities.
- Approximately $5 million for new medical equipment in Tribally-constructed health care facilities.
- Approximately $500,000 for the TRANSAM and $500,000 for ambulance programs.

IHS and Tribal health care administrators and clinical engineers take into account the medical equipment life cycle, acquisition costs, maintenance requirements, intensity of use, and new technologies to prioritize the procurement of new and replacement medical equipment. Emerging

[1] The IHS Facilities appropriation limits total expenditures up to $500,000 for equipment purchased through the TRANSAM Program and up to $2.7 million for purchasing ambulances.

medical equipment technologies, telemedicine, and Electronic Health Records have a profound impact on the quality of health care. Modern medical equipment enhances the ability to effectively and efficiently diagnose and treat patients. Equipment funds are used to address the most pressing medical equipment needs while incorporating new medical equipment advances.

OUTPUTS / OUTCOMES - This program measures outcomes through its inventory of medical equipment.

GRANT AWARDS – This program has no grant awards.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Facilities: 75-0391-0-1-551
PERSONNEL QUARTERS/QUARTERS RETURN FUNDS

(Dollars in Thousands)

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$8,000	$8,000	$8,500	+$500
FTE*	29	29	29	0

Quarters funds are not BA but are rents collected for quarters which are returned to the service unit for maintenance and operation costs. They fall under the Program Level Authority.
*FTE numbers reflect Federal staff only and do not include Tribal staff.

Authorizing Legislation .....Public Law 98-473, Sec. 320, as amended

FY 2016 Authorization.....Permanent

Allocation Method.....Federal Direct

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

When available housing is limited in the area of Indian Health Service (IHS) health care facilities, staff quarters are provided to assist with recruitment and retention of health care providers. The operation, maintenance, and improvement costs of the staff quarters are funded with Quarters Return (QR) funds, i.e., the rent collected from tenants residing in the quarters. The use of the funds includes maintenance personnel services, security guard services, repairs to housing units and associated grounds, purchase of materials, supplies, and household appliances/equipment (e.g., stoves, water heaters, furnaces, etc.). In certain situations, Maintenance and Improvement Program funds may be used, in conjunction with QR funds, to ensure adequate quarters' maintenance. For example, this may be necessary in locations with few quarters where QR funds are not enough to pay for all required maintenance costs.

FUNDING HISTORY

Fiscal Year	Amount
2011 Omnibus	$6,288,000
2012 Enacted	$7,500,000
2013 Enacted	$8,000,000
2014 Final	$8,000,000
2015 Enacted	$8,000,000

BUDGET REQUEST

The FY 2016 Quarters budget for rent collections of $8,500,000 is an increase of $500,000 above the FY 2015 Enacted level for anticipated rental collections. Rental rates are established in accordance with OMB Circular A-45 and adjusted annually based on the national Consumer Price Index.

FY 2016 Quarters Budget for Anticipated Rent Collections of $8,500,000 provides funding for the following:

The operation, management, and general maintenance of quarters, including maintenance personnel services, repairs to housing units and associated grounds, purchase of materials, supplies, and household appliances/equipment (e.g., stoves, water heaters, furnaces, etc.).

OUTPUTS / OUTCOMES - This program measures outcomes through the inventory of staff quarters.

GRANT AWARDS – This program has no grant awards.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Drug Control Budget
FY 2016

RESOURCE SUMMARY			
	Budget Authority (in Millions)		
	FY 2014 Final	FY 2015 Enacted	FY 2016 Request
Drug Resources by Function			
Prevention	17.905	18.179	31.337
Treatment	89.833	93.167	92.532
Total Drug Resources by Function	**$107.738**	**$111.346**	**$123.869**
Drug Resources by Decision Unit			
Alcohol and Substance Abuse	103.246	106.854	119.377
Urban Indian Health Program	4.492	4.492	4.492
Total Drug Resources by Decision Unit	**$107.738**	**$111.346**	**$123.869**
Drug Resources Personnel Summary			
Total FTEs (direct only)	171	171	171
Drug Resources as a Percent of Budget			
Agency Budget	$ 5,649.292	$ 5,906.445	$6,392.367

MISSION

The Indian Health Service (IHS), an agency within the Department of Health and Human Services, is responsible for providing Federal health services to American Indians and Alaska Natives (AI/AN). IHS supports substance abuse treatment and prevention services as part of this mission.

METHODOLOGY

The IHS includes the appropriation for Alcohol and Substance Abuse (excluding the amount designated as Adult Alcohol Treatment) and the portion of Urban Indian Health Program (UIHP) funds from the National Institute on Alcohol Abuse and Alcoholism programs transferred to the IHS under the UIHP budget. For FY 2014 and FY 2015, the total drug resources include funds for staffing and operating both the Southern and Northern California Youth Regional Treatment Centers, respectively.

BUDGET SUMMARY

In FY 2016, IHS requests $123.9 million for its drug control activities, an increase of $12 million above the FY 2015 Enacted level. The FY 2015 enacted includes an increase for staffing and operation costs for the Northern California Youth Regional Treatment Center.

Alcohol and Substance Abuse
FY 2016 Request: $119.3 million

The FY 2016 budget request is necessary to maintain the program's progress in addressing the alcohol and substance abuse needs by improving access to behavioral health services through tele-behavioral health efforts and providing a comprehensive array of preventive, educational, and treatment services.

FY 2016 Overall Funding Changes (+$12 million), including:

- +$25 million, for the Tribal Behavioral Health Initiative for Native Youth (TBHINY) initiative funding as part of the Alcohol and Substance Abuse budget. This funding will allow IHS to increase the number of Methamphetamine and Suicide Prevention grant projects in the Indian health system. These grants will create a larger network of behavioral health providers focused on child, adolescent, and family behavioral health and drug prevention services. While the grants will provide drug-related services, the programs will also reflect the integration of mental health and wellness services for youth.
- -$17 million, which was used in FY 2015 for YRTC construction. There are no corresponding projects in FY 2016 because all statutorily authorized YRTCs will have been completed by FY 2016.
- +$4 million, for increases dedicated to staffing, inflation, and pay increases for drug prevention programs.

Urban Indian Health Program – Alcohol and Substance Abuse Title V Grants
FY 2016 Request: $4.5 million
(Flat with FY 2015)

The FY 2016 request includes funding for the Urban Indian Health Program which will be used to continue serving urban AI/ANs impacted by alcohol and substance abuse through the Title V grant program, Alcohol and Substance Abuse Prevention and Treatment. Substance abuse prevention, treatment, and education programs address alcohol/drugs, suicide, self-esteem, injury control, domestic violence, and sexual abuse. All Urban Indian Health Programs have active partnerships with their local Veterans Health Administration programs and several have identified joint alcohol and substance abuse initiatives.

ONDCP FUNDING PRIORITIES

In FY 2016, the IHS budget request for its drug control activities supports the Office of National Drug Control Policy's (ONDCP) funding priorities as well as the 2014 National Drug Control Strategy. The Strategy emphasizes the partnership between federal agencies, state, local, Tribal, and international counterparts and addresses public health and public safety challenges. IHS is also working with federal partners to implement the ONDCP's Prescription Drug Abuse Prevention Plan, "Epidemic: Responding to America's Prescription Drug Abuse Crisis."

The Prescription Drug Abuse Prevention Plan expands upon the Administration's National Drug Control Strategy which offers a valuable opportunity for IHS to advance its mission by strengthening existing programs to control and reduce substance abuse and eliminate its deleterious effects on the health and safety of AI/AN patients and communities.

In FY 2016, IHS will continue to serve AI/ANs impacted by substance abuse and dependence through its Youth Regional Treatment Centers (YRTCs) and other IHS, Tribal, and Urban Indian operated substance abuse treatment and prevention programs. In addition to those direct services, the IHS Methamphetamine and Suicide Prevention Initiative (MSPI) is a nationally-coordinated demonstration pilot program, focusing on providing targeted methamphetamine and suicide prevention and intervention resources to communities in Indian Country with the greatest need for these programs. There is mutual development and implementation of the MSPI project with Tribes, Tribal programs, and other Federal agencies which now provides support to 130 IHS, Tribal, and Urban Indian health programs nationally. The strategic goal is to support Tribal programs in their continued substance abuse prevention, treatment, and infrastructure development. These efforts represent an innovative partnership with IHS to deliver services by and for the communities themselves, with a national support network for ongoing program development and evaluation.

TBHINY – MSPI Expansion- Over 40 percent of AI/AN people are under the age of 24 and face negative health, education, and economic disparities in Indian Country in comparison to the general population.[1] These negative disparities are a high priority for Tribal leaders to address within their communities. In response, IHS and SAMHSA are collaborating on the TBHI to improve behavioral health outcomes for AI/AN communities as part of the government-wide Generation Indigenous initiative, created to remove the barriers to success for Native youth.

Specifically, the TBHINY responds to requests from Tribal leaders to: (1) improve access to behavioral health prevention efforts and treatment services for AI/AN youth; (2) address issues that lead to increased rates of suicide and substance abuse and opportunities to promote mental health; (3) increase the number of behavioral health staff positions focused on child, adolescent, and family services; and (4) increase funding for the IHS MSPI and SAMHSA Tribal Behavioral Health Grant (TBHG) program. These efforts will complement the successful MSPI program.

Through the original program in 2009, IHS funded 130 IHS, Tribal, and Urban Indian health programs to participate in a six year pilot demonstration project. This MSPI pilot demonstration phase promoted the use and development of evidence-based and practice-based models that represented culturally-appropriate prevention and treatment approaches to methamphetamine abuse and suicide prevention. Over 85 percent of these MSPI projects focused on positive development activities, prevention, behavioral health treatment, and wraparound aftercare services for AI/AN youth. Those projects provided over 500,000 evidence-based and practice-based youth encounters in the first five years of implementation. This early success of the MSPI revealed strength-based interventions, such as the protective role of culture, social connectedness, and cultural activities as being central to AI/AN wellness, especially for prevention of suicide and substance abuse efforts.

To further promote the successes of the MSPI, the TBHINY presents an opportunity to fund additional MSPI projects to focus on broader behavioral health prevention efforts in their communities. The expansion of MSPI will offer Tribes the flexibility to address

[1] Center for Native American Youth. Why We Exist. *Available at*: http://cnay.org/WhyWeAreHere.html.

methamphetamine abuse, suicide prevention, strength-based interventions for AI/AN youth, increase the behavioral health workforce, or a combination of those services.

The TBHINY MSPI Expansion funds will be used as follows:

- Fund 200 IHS, Tribal, and Urban Indian health care programs. IHS will administer a new competition for a 5-year funding cycle and selection of awardees will be based on the priority areas to increase behavioral health staff and AI/AN youth-focused programming through local IHS, Tribal, and Urban Indian health care facilities, school-based settings, or other youth-based programs.
- National management, information technology systems for data collection and reporting, training and technical assistance, including continuing education, and national evaluation.

The expected annual accomplishments are increased access to behavioral health services for AI/AN youth and a strengthened behavioral health workforce. The planned performance measures to assess progress are:

- Number of BH providers recruited and hired under the projects;
- Number of professional staff trained to deliver prevention, intervention, and treatment services to AI/AN youth;
- Number of youth screened for substance abuse, depression, and/or suicide risk; and
- Number of youth receiving behavioral health services.

Substance abuse and dependence in all of its forms continue to rank high on the concern list of the Tribal partners. IHS believes that a shift in emphasis to earlier intervention is required to be successful in reducing the consequences of substance abuse and dependence. IHS proposes focusing on intervention earlier with younger high risk and hazardous users and preventing further progression by recognizing and responding to the sequel of the abuse. IHS promotes expanded health care services, such as mental and behavioral health treatment and prevention, by providing training on substance use disorders to IHS, Tribal, and Urban Indian health programs at annual conferences, meetings, and webinars. Continuing Medical Education (CMEs) and Continuing Education Credits (CEUs) are offered in these training opportunities provided to primary care providers with a special focus on emergency clinics and on women and families.

IHS continues to support the integration of substance abuse treatment into primary care and emergency services through its activities to implement ONDCP's National Drug Control Strategy. Integrating treatment into healthcare offers opportunities for healthcare providers to identify patients with substance use disorders, provide them with medical advice, help them understand the health risks and consequences, and refer patients with more severe substance use-related problems to treatment.[2] One integration activity is Screening, Brief Intervention, Referral to Treatment (SBIRT) which is an early intervention and treatment service for people with substance use disorders and those at risk of developing these disorders. IHS is broadly promoting SBIRT as an integral part of a sustainable primary care-based behavioral health program through reimbursement from the Center for Medicare and Medicaid. Another activity is Medication Assisted Treatment (MAT) for opioid addiction which is an approach that uses Food and Drug Administration approved pharmacological treatments, often in combination with psychosocial treatments, for patients with opioid use disorders.[3] IHS will also continue to provide the

[2] U.S. Office of National Drug Control Policy. Integrating Treatment into Healthcare. *Available at* http://www.whitehouse.gov/ondcp/integrating-treatment-and-healthcare.
[3] U.S. Office of National Drug Control Policy. Medication Assisted Treatment for Opioid Addiction. Available at http://www.whitehouse.gov/sites/default/files/ondcp/recovery/medication_assisted_treatment_9-21-20121.pdf

necessary training through its Tele-Behavioral Health Center of Excellence (TBHCE) for IHS, tribal, and urban Indian healthcare providers who prescribe MAT. To provide clinical support for providers, the TBHCE recently launched weekly Pain and Addiction consultations. Healthcare providers may receive a no-cost consultation from an expert panel on the most challenging pain and addiction cases.

IHS convened a multi-disciplinary workgroup to focus on Prescription Drug Abuse in Indian Country. The workgroup utilized the published ONDCP epidemic framework to address four main focus areas, including participation with existing state prescription drug monitoring programs (PDMP) programs. IHS has worked with ONDCP, the Bureau of Justice Assistance, and numerous state PDMPs to participate in development of best practice recommendations and begin to report controlled substance dispensing data to state PDMPs. To date, IHS has developed software compatible with five American Society for Automation in Pharmacy formats; deployed reporting capacity in 21 IHS states; and assisted tribal programs with PDMP program deployment. Future development work includes enhanced prescriber utilization of PDMP data through integration with existing interconnects.

FY 2016 Changes (no change): IHS will continue to serve AI/ANs impacted by substance abuse and dependence through its YRTCs and other IHS, Tribal, and Urban Indian operated substance abuse treatment and prevention programs.

Information regarding the performance of the drug control efforts of IHS is based on agency GPRA/GPRAMA documents and other information that measures the agency's contribution to the *Strategy*. The IHS monitors two program measures on the number of substance use disorder (SUD) encounters provided in emergency departments and primary care clinics. The FY 2014 target for emergency department SUD encounters was exceeded. However, the FY 2014 target for primary care clinics SUD encounters was missed by 1.5 percent. The decrease in primary care clinics SUD encounters is related to staff turnover, workforce development and training needs of new staff, and patients accessing services in other clinical settings.

In FY 2016, IHS will include overall SUD encounters provided in all clinical settings across the health system to aid in promoting integrated SUD services. Tracking overall clinical SUD encounters will allow IHS to report on the effectiveness of IHS programs that focus on drug abuse. In FY 2014, IHS clinics provided 490,994 SUD encounters.

In addition, the IHS is currently in the process of developing a measure for prescription drug abuse for rollout in FY 2017.

The table and accompanying text below represent highlights of IHS's achievements during FY 2014, the latest year for which data are available. The selected performance measures reported in the table provide targets and results from both Tribally-Operated Health Programs and Federally-Administered Health Programs.

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Indian Health Service		
Selected Measures of Performance	**FY 2014 Target**	**FY 2014 Achieved**
» Alcohol-use screening among appropriate female patients	65.9%	66.0%
» Accreditation rate for Youth Regional Treatment Centers in operation 18 months or more	100%	90%
» Report on number of emergency department patients who receive SUD intervention	41,761	42,415
» Report on number of SUD services in primary care clinics	115,187	113,562

Office of Urban Indian Health Programs

AI/AN people who live in urban centers present a unique morbidity and mortality profile. Urban AI/AN populations suffer disproportionately higher mortality from certain causes in sharp contrast to mainstream society. These unique challenges require a targeted response. Existing Urban Indian Organizations (UIO) see their efforts in health education, health promotion, and disease prevention as essential to impacting the behavioral contributors to poor health[4]:

- Alcohol-induced death rates are 2.8 times greater for urban AI/AN people than urban all races.
- Chronic liver disease death rates are 2.1 times greater for urban AI/AN people than urban all races.
- Tuberculosis death rates are 2 times greater for urban AI/AN people than urban all races.
- Accidents and external causes of death rates are 1.4 times greater for urban AI/AN people than urban all races.

Alcohol and drug-related deaths continue to plague urban AI/AN. Alcohol-induced mortality rates for urban AI/AN are markedly higher than for urban all races. All regions,[5] with the exception of eastern seaboard cities in the Nashville Area, show dramatically higher rates for urban AI/AN than for urban all races who live in the same communities: the Billings Area is 4 times greater, the Phoenix Area is 6 times greater, the Tucson Area is 6.7 times greater, and the Aberdeen Area has a 13.4 times greater alcohol-induced rate of mortality[6].

Urban AI/AN populations are more likely to engage in health risk behaviors. Urban AI/AN are more likely to report heavy or binge drinking than all-race populations and urban AI/AN are 1.7 times more likely to smoke cigarettes. Urban AI/AN more often view themselves in poor or only fair health status, with 22.6 percent reporting fair/poor health as compared to 14.7 percent of all races reporting as fair/poor.

UIO' emphasis on behavioral health, health education, health promotion and disease prevention, within a culturally appropriate framework, leads to positive outcomes for AI/AN. AI/AN in need of substance abuse treatment commonly exhibit co-occurring disorders. UIO and former National Institute on Alcohol Abuse and Alcoholism (NIAAA) programs have recognized the need for more mental health and substance abuse counselors to adequately address the needs presented by AI/AN with co-occurring disorders. AI/AN need gender- and age-appropriate substance abuse treatment. Stakeholders reported the need for more age- and gender-appropriate resources for substance abuse treatment. While male AI/AN can encounter wait times for treatment admission

[4] Indian Health Service, Office of Urban Indian Health Programs, *Urban Needs Assessment Report – Draft*, 2014.
[5] Ibid.
[6] Ibid.

up to 6 months, treatment options for youths, women, and women with children can be greater than 6 months. Some of the best AI/AN treatment programs for youths, women, and women with children are administered by UIO and urban NIAAA programs. Affecting lifestyle changes among AI/AN families requires a culturally sensitive approach. The existing UIO have operated culturally appropriate initiatives to reduce health risk factors. UIO' continued efforts to target behavioral or lifestyle changes offer the best hope for impacting the major health challenges of the urban AI/AN population.

UIO and former NIAAA programs are resources to both tribal and urban communities. Several UIO and former NIAAA programs that offer inpatient substance abuse treatment have become reliable referral sites for tribes, including programs in San Francisco, Portland, Lincoln, Seattle, Stockton, Duluth/Sawyer, Shell Lake, and Phoenix. Former NIAAA programs commonly provide substance abuse treatment services to reservation-based AI/AN from both local and distant tribal communities.

Heavy drinking during pregnancy can cause significant birth defects, including Fetal Alcohol Syndrome (FAS). FAS is the leading and most preventable cause of intellectual disability. The rates of FAS are higher among AI/ANs than the general population. Screening with intervention has been shown to be effective in reducing alcohol misuse in pregnancy and to reduce the incidence of FAS. In FY 2014, IHS exceeded its alcohol screening measure target.

The accreditation measure for YRTCs reflects an evaluation of the quality of care associated with accreditation status by either the Joint Commission on Accreditation of Healthcare Organizations, the Commission on Accreditation of Rehabilitation Facilities (CARF), state certification, or regional Tribal health authority certification. The 100 percent accreditation performance measure was not met in FY 2014 as a result of the ongoing difficulties experienced by one Tribally-Operated YRTC. However, the YRTC made significant progress toward achieving accreditation in calendar year 2014 by completing a CARF site visit on November 17-18, 2014, which resulted in accreditation in December 2014. The goal for FY 2015 is again to remain at 100 percent accreditation.

The IHS provides several training opportunities annually on alcohol and substance abuse issues for its providers. In 2014, the TBHCE, in partnership with the University of New Mexico, provided webinar training for 8,632 participants on current and pressing behavioral health issues through a series of webinars, including a concentrated focus on substance use disorders through a weekly Pain and Addiction Series and Addiction Mini-Series. Topics included: Introduction to Addiction; Opioid Dependence; Chronic Pain and Depression; Anxiety and Chronic Pain; Fibromyalgia; Chronic Pain and Neurology; Epidemiology of Chronic Pain; Non-Opioid Pain Medication; Screening for Misuse, Diversion, and Addiction; Buprenorphine; Medication Management; Screening for Opiate Addictions; Methadone - An Introduction; Substance Abuse I & II; Naloxone and MAT for Opioid Dependence.

The TBHCE evaluates models of care delivery, access to care, and sustainability. A toolkit is available for sites to prepare the infrastructure for tele-behavioral health services. Intra-Agency agreements continue between the TBHCE and IHS Billings, Great Plains, Nashville, Navajo, Phoenix, and Tucson Areas. In FY 2014, over 8,200 patient encounters were provided nationally via tele-behavioral health.

FY 2016 BUDGET SUBMISSION
INDIAN HEALTH SERVICE
OBJECT CLASSIFICATION
(Dollars in Thousands)

Object Class	FY 2014 Final	FY 2015 Enacted	FY 2016 Pres. Budget	FY 16 +/- FY 2015
DIRECT OBLIGATIONS				
Personnel Compensation:				
Full-Time Permanent(11.0)……	427,486	438,811	444,897	6,086
Other than Full-Time Permanent(11.3)……	19,501	20,113	20,472	359
Other Personnel Comp.(11.5)……	56,272	57,603	58,390	787
Military Personnel Comp (11.7)……	93,573	96,291	97,615	1,324
Special Personal Services Payments (11.8)……	273	275	276	1
Subtotal, Personnel Compensation..…	597,105	613,093	621,650	8,557
Civilian Personnel Benefits(12.1)……	153,071	157,061	159,235	2,174
Military Personnel Benefits (12.2)	39,136	40,235	40,791	556
Benefits to Former Personnel(13.0)……	1,830	1,850	1,854	4
Subtotal, Pay Costs……	**791,142**	**812,239**	**823,530**	**11,291**
Travel(21.0)……	41,867	42,055	44,078	2,023
Transportation of Things(22.0)……	9,152	9,303	9,714	411
Rental Payments to GSA(23.1)……	14,475	14,694	15,301	607
Rental Payments to Others(23.2)……	1,760	1,787	1,869	82
Communications, Utilities and				
Miscellaneous Charges(23.3……	25,737	26,530	27,680	1,150
Printing and Reproduction(24.0)……	203	200	206	6
Other Contractual Services:				
Advisory and Assistance Services(25.1)……	6,179	6,206	6,529	323
Other Services(25.2)……	161,487	165,083	226,630	61,547
Purchases from Govt. Accts.(25.3)……	53,371	54,474	57,318	2,844
Operation and Maintenance of Facilities(25.4)….	10,370	10,400	28,311	17,911
Research and Development Contracts(25.5)…….	11	12	12	0
Medical Care(25.6)……	326,672	328,123	344,400	16,277
Operation and Maintenance of Equipment(25.7).	15,175	15,623	33,947	18,324
Subsistence and Support of Persons(25.8)……	3,917	3,937	3,954	17
Subtotal, Other Contractual Current.....…	**577,182**	**583,858**	**701,101**	**117,243**
Supplies and Materials(26.0)……	99,968	104,249	111,288	7,039
Equipment (31.0)……	18,804	19,235	20,133	898
Land & Structures (32.0)……	88,631	87,571	187,466	99,895
Investments & Loans (33.0)……	0	0	0	0
Grants, Subsidies, & Contributions (41.0)……	2,764,566	2,939,652	3,159,589	219,937
Insurance Claims & Indemnities (42.0)……	997	977	998	21
Interest & Dividends (43.0)……	31	31	32	1
Subtotal Non-Pay Costs.....…	**3,643,373**	**3,830,142**	**4,279,455**	**449,313**
Total, Direct Obligations……	**4,434,515**	**4,642,381**	**5,102,985**	**460,604**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
Salaries and Expenses
(Budget Authority - Dollars in Thousands)

Object Class	FY 2014 Final	FY 2015 Enacted	FY 2016 Pres. Budget	Increase or Decrease
Personnel Compensation:				
Full-Time Permanent (11.0)	427,486	438,811	444,897	6,086
Other than Full-Time Permanent (11.3)	19,501	20,113	20,472	359
Other Personnel Comp. (11.5)	56,272	57,603	58,390	787
Military Personnel Comp. (11.7)	93,573	96,291	97,615	1,324
Special Personnel Services Payments (11.8)	273	275	276	1
Subtotal, Personnel Compensation	597,105	613,093	621,650	8,557
Civilian Personnel Benefits (12.1)	153,071	157,061	159,235	2,174
Millitary Personnel Benefits (12.2)	39,136	40,235	40,791	556
Benefits to Former Personnel (13.0)	1,830	1,850	1,854	4
Total, Pay Costs	**791,142**	**812,239**	**823,530**	**11,291**
Travel (21.0)	6,482	6,636	6,882	246
Transportation of Things (22.0)	9,152	9,303	9,714	411
Rental Payments to Others (23.2)	1,760	1,787	15,301	13,514
Communications, Utilities & Misc. Charges (23.3)	25,737	26,530	27,680	1,150
Printing and Reproduction (24.0)	203	200	206	6
Other Contractual Services:				
Advisory and Assistance Services (25.1)	6,179	6,206	6,259	53
Other Services (25.2)	161,487	165,083	226,630	61,547
Purchases from Govt. Accts. (25.3)	53,371	54,474	57,318	2,844
Operation and Maintenance of Facilities (25.4)	10,370	10,400	28,311	17,911
Operation and Maintenance of Equipment (25.7)	15,175	15,623	33,947	18,324
Subsistance and Support of Persons (25.8)	3,917	3,937	3,954	17
Subtotal, Other Contractual	250,499	255,723	356,419	100,696
Supplies and Materials (26.0)	99,968	104,249	111,288	7,039
Total, Non-Pay Costs	**393,801**	**404,428**	**527,490**	**123,062**
Total Salaries & Expenses	1,184,943	1,216,667	1,351,020	134,353
Direct FTE	8,943	9,502	9,559	57

INDIAN HEALTH SERVICE
Detail of Full-Time Equivalents (FTE)

	FY 2014 Final	FY 2015 Enacted	FY 2016 Pres. Budget
Headquarters			
Sub-Total, Headquarters	434	464	464
Area Offices			
Alaska Area Office	453	453	453
Albuquerque Area Office	1,013	1,013	1,013
Bemidji Area Office	551	551	551
Billings Area Office	963	998	998
California Area Office	94	94	151
Great Plains Area Office	2,191	2,191	2,191
Nashville Area Office	197	197	197
Navajo Area Office	4,050	4,544	4,544
Oklahoma City Area Office	1,653	1,653	1,653
Phoenix Area Office	2,626	2,626	2,626
Portland Area Office	522	522	522
Tucson Area Office	474	474	474
Sub-Total, Area Offices	14,787	15,316	15,373
Trust Funds (Gift)	23	23	23
TOTAL FTES	15,244	15,803	15,860

Average GS Grade

2012.....	8.1
2013.....	8.1
2014.....	8.1

INDIAN HEALTH SERVICE

DETAIL OF PERMANENT POSITIONS

(Dollars in Thousands)

	FY 2014 Final	FY 2015 Enacted	FY 2016 Pres. Budget
Total - ES's	17	21	22
Total - ES Salaries	$2,844	$3,294	$3,444
GS/GM-15	420	439	441
GS/GM-14	421	440	442
GS/GM-13	427	447	449
GS-12	1,001	1,048	1,052
GS-11	1,303	1,364	1,370
GS-10	572	599	602
GS-9	1,344	1,407	1,413
GS-8	338	354	355
GS-7	1,161	1,216	1,221
GS-6	1,364	1,428	1,434
GS-5	2,191	2,294	2,304
GS-4	1,092	1,143	1,148
GS-3	186	195	196
GS-2	32	33	33
Subtotal	11,850	12,405	12,461
Total - GS Salaries	$609,698	$652,289	$670,019
Director Grade CO-06	429	429	429
Senior Grade CO-05	605	605	605
Full Grade CO-04	641	641	641
Senior Assistant Grade CO-03	351	351	351
Assistant Grade CO-02	46	46	46
Junior Grade CO-01	8	8	8
Subtotal	2,081	2,081	2,081
Total - CO Salaries	$132,709	$136,526	$138,406
Ungraded	1,273	1,273	1,273
Total - Ungraded Salaries	$45,891	$49,097	$50,432
Trust Funds (Gift)	23	23	23
Average ES level	ES-02	ES-02	ES-02
Average ES salary	$174	$174	$174
Average GS grade	8.1	8.1	8.1
Average GS salary	$51	$53	$54

INDIAN HEALTH SERVICE
Programs Proposed for Elimination

The Indian Health Service FY 2016 budget request does not include any programs for proposed elimination.

Physicians' Comparability Allowance (PCA)

Indian Health Service

Table 1

		PY 2014 (Actual)	CY 2015 (Estimates)	BY 2016* (Estimates)
1) Number of Physicians Receiving PCAs		10	8	6
2) Number of Physicians with One-Year PCA Agreements		0	0	0
3) Number of Physicians with Multi-Year PCA Agreements		10	8	5
4) Average Annual PCA Physician Pay (without PCA payment)		$152,245	152,972	142,681
5) Average Annual PCA Payment		$22,400	$20,500	$27,000
6) Number of Physicians Receiving PCAs by Category (non-add)	Category I Clinical Position	9	7	5
	Category II Research Position			
	Category III Occupational Health			
	Category IV-A Disability Evaluation			
	Category IV-B Health and Medical Admin.	1	1	1

*FY 2016 data will be approved during the FY 2017 Budget cycle.

7) If applicable, list and explain the necessity of any additional physician categories designated by your agency (for categories other than I through IV-B). Provide the number of PCA agreements per additional category for the PY, CY and BY.

Not applicable.

8) Provide the maximum annual PCA amount paid to each category of physician in your agency and explain the reasoning for these amounts by category.

Maximum annual PCA for Category I (Clinical Position) - $30,000. Factors used were board certification, multi-year agreements, shortage specialty, location (remote), and duties.

Maximum annual PCA for Category IV-B (Health and Medical Administration) - $18,000. Factors used were board certification, multi-year agreement, categorical allowance.

9) Explain the recruitment and retention problem(s) for each category of physician in your agency (this should demonstrate that a current need continues to persist).

(*Please include any staffing data to support your explanation, such as number and duration of unfilled positions and number of accessions and separations per fiscal year.)*

Overall, Physician vacancy rates continue in the 20% range due to a shortage of physicians, particularly in primary care specialties. IHS has moved to using Title 38 Physician and Dentist Pay instead of PCA as the only option to compete successfully with private sector salaries. Many of our previous PCA recipients have been converted to Title 38.

10) Explain the degree to which recruitment and retention problems were alleviated in your agency through the use of PCAs in the prior fiscal year.

(*Please include any staffing data to support your explanation, such as number and duration of unfilled positions and number of accessions and separations per fiscal year.)*

IHS is using Title 38 Physician and Dentist Pay authority more than PCA authority at this point in time. In general, PCA does not provide the pay flexibility needed to recruit and retain Physicians.

11) Provide any additional information that may be useful in planning PCA staffing levels and amounts in your agency.

Over the next two years IHS PCA levels will probably drop from 10 recipients to 6. This is based on knowledge of the physicians' contract dates and their locations. If the recipients predicted do change to T38 PDP then only 6 will be left.

INDIAN HEALTH SERVICE
Summary of Reimbursements, Assessments, and Purchases
FY 2016 Estimates

CJ FY 2016

		FY 2013 Actual	FY 2014 Actual	FY 2015 Estimate	FY 2016 Estimate
Type of Funding	**Reimbursement for Services Purchased within HHS**				
SSF	Service & Supply Fund	24,166,950	23,812,836	23,850,178	24,000,000
SSF	HHS Consolidated Acquisition System (HCAS) Operations and Maintenance	2,711,448	2,711,000	2,710,000	2,838,000
SSF	Unified Financial Management System (UFMS) Operations and Maintenance	6,013,562	5,687,000	5,663,000	5,778,000
SSF	UFMS (Governance)	1,105,000	1,106,000	1,106,000	1,129,000
SSF	UFMS (CFRS, FBIS)		1,733,000	1,732,000	1,769,000
	Subtotal SSF	33,996,960	35,049,836	35,061,178	35,514,000
OS TAP	Audit Resolution	33,543	75,000	73,000	383,000
OS TAP	Web Communications	2,339,000	2,339,000	2,312,000	2,312,000
OS TAP	DATA ACT	0	0	416,662	416,662
OS TAP	Strategic Sourcing Program (SSP)	81,000	69,000	91,000	243,022
OS TAP	Web Crawler	6,000	6,000	9,000	9,000
OS TAP	Telecommunications Management/WITS	222,121	155,000	321,000	321,000
OS TAP	Telecommunications Services	132,231	43,000	91,000	91,000
OS TAP	Small Business Center	179,000	179,000	22,000	1,390,000
OS TAP	Tracking Accountability Government Grants System (TAGGS)	256,000	251,000	261,000	452,000
OS TAP	Departmental Contract Information System (DCIS)	458,000	458,000	474,000	507,000
OS TAP	Acquisition Integration Modernization (AIM)	227,000	278,000	227,000	252,000
OS TAP	Commissioned Corps Force Management (CCFM)	7,499,965	7,849,000	7,723,000	7,859,000
OS TAP	Human Resource Services	1,816,143	2,662,000	2,584,000	2,584,000
OS TAP	OGC Claims	350,000	315,000	322,000	325,000
	Subtotal Non-PSC	13,600,002	14,679,000	14,926,662	17,144,684
JFA	Office of General Counsel	1,338,648	1,236,668	1,458,332	1,500,000
JFA	OGC Departmental Ethics Program	320,000	320,000	340,000	360,000
JFA	OGC Ethics Program - 2-OMS-13-0007	201,560	207,624	201,560	203,560
JFA	Legislatively Mandated Initiatives and Emerging Technologies (formerly part of HHS Enterprise) (LMIE)	624,164	535,136	562,866	600,000
JFA	Regional Health Administrators	308,010	308,010	308,010	310,010
JFA	National Institute of Health - Health Services Research Library	940,921	608,609	608,609	608,609
JFA	Office of Global Health Affairs	13,404	13,404	13,404	13,404
JFA	CFO Financial Statement Audit	537,700	583,000	600,500	650,500
JFA	Media Monitoring and Analysis	65,125	71,946	74,823	80,000
	Subtotal JFA Assessments	4,349,532	3,884,397	4,168,104	4,326,083
	Government-wide Administrative Functions				
JFA	Federal Employment Services (USAJOBS)	74,513	71,450	74,513	77,513
JFA	President's Council on Study of Bioethics	22,800	22,800	22,800	25,800
	Subtotal, GAF	97,313	94,250	97,313	103,313
	Grand Total	52,043,807	53,707,483	54,253,257	57,088,080

House Report 113-551

Preventive Dental Care for Children - The Committee received testimony this year about an initiative to increase preventive dental care for children by bringing dentists and hygienists into elementary schools. The Committee recommendation includes $500,000 to begin the initiative and directs the Service to work with the Bureau of Indian Education (BIE) and to consult with Tribes about piloting the initiative in the BIE school system (p. 85).

Action taken or to be taken

Indian Health Service (IHS) will do their best to work with the Bureau of Indian Education (BIE) and to consult with Tribes about piloting the initiative in the BIE school system to the extent the limited funds would permit. In 2011 and 2012, the IHS conducted the largest-ever oral health surveillance of 6-9 year-old children to determine the disease burden of this population, and in conducting the screening surveys; the IHS utilized Bureau of Indian Education-operated (BIE) elementary schools. IHS programs throughout the country engage in delivering preventive services such as dental screenings, dental sealants, and fluoride applications to school-age children in both dental clinics and in BIE-operated schools, and the success of these services are measured through three Government Performance and Results Act (GPRA) indicators annually – access to care, dental sealants in 2-15 year-olds, and the number of 1-15 year-olds receiving fluoride applications.

Pilot Program on Credentialing Process - Several national health organizations recognize that the Service needs additional health care providers and that the Service has established volunteer programs to deliver needed medical, dental and mental health care. Many more volunteers could be recruited if the credentialing process were simplified and centralized similar to the processes used by the Departments of Defense and Veterans Affairs. Such a system would assure Tribes that the volunteers are in compliance with State licensure and accreditation laws. Because IHS faces a health care provider shortage of 1,500 professionals, the Committee directs the Service to expeditiously convene a meeting of interested Tribes and health care organizations to design a pilot program to address credentialing problems and report the results to the Committee within 180 days of the enactment of this Act (p. 85-86).

Action taken or to be taken

Following a detailed analysis of centralized credentialing for the IHS in 2007, the Agency determined that implementing an IHS-wide centralized credentialing program was possible, but costly. Due to constraints in program dollars and human resources, as well as the lack of identified advantages, doing so would not demonstrate appropriate stewardship of Agency funds.

A system-wide, centralized credentialing program and database would have some advantages for health care practitioners seeking both short- and long-term employment with the IHS, mainly for those few individuals who transfer frequently and/or work at multiple locations as they do in the Department of Defense. The benefit of a centralized credentials database to medical staff appears small compared to the cost to establish and maintain it. IHS has begun discussion of this issue with its Hospital Consortium that is focused on making accreditation-related training and systems

more consistent. Making credentialing processes and policies more consistent is the current goal, and we will address the option of a centralized credentialing program again to assess for any change in demand signal or operational requirements.

A centralized credentialing system would not benefit efforts to recruit additional volunteers due to the lack of clear legislation providing Federal Tort Claims Act liability coverage for volunteers.

Electronic Dental Record (EDR) - The Committee directs the Service to work towards completion of electronic dental records (EDR) at the remaining 80 of 230 Federal and tribal dental sites. The Committee recognizes that EDR will significantly improve the gathering of data to analyze the early childhood caries program and therefore result in cost savings (p. 86).

Action taken or to be taken

The Indian Health Service (IHS) continues to make significant strides in the implementation of electronic dental records (EDR) at IHS/Tribal/Urban sites running the Resource and Patient Management System (RPMS). A new 5-year contract was awarded to Science Applications International Corporation on May 20, 2013 to continue the deployment of the IHS Dentrix Enterprise. An IHS EDR Project update is provided below:

- 230 RPMS EDR implementations planned (Original implementation schedule)
- 170 RPMS EDR Fully implemented (as of January 6, 2015)
- 60 RPMS sites remain to be implemented (as of January 6, 2015)
- Remaining 60 RPMS sites plan to be implemented as available funds allow
  - Available funds will determine how many sites are implemented during the current contract which expires May 19, 2018
  - 7 RPMS sites are in process of EDR implementation (as of January 6, 2015)
- After 7 RPMS sites currently in progress complete EDR implementation, 77 percent (177 of 230 sites) of original implementation schedule will be fully implemented

Payment Rates for Non-hospital Services - The Committee recognizes that the Service and Tribes are forced to prioritize care by Levels I–V and to ration funding in this program because the needs outweigh available funds. (a) The Committee encourages the Service and Tribes to measure the impacts of funding increases on the ability to provide care at each level. Currently the program's only measurable goal stated in the fiscal year 2015 budget request is, ''Average Days between Service End and Purchase Order Issued,'' which is by itself an insufficient program goal. (b) The Committee urges the Service, Tribes, and the congressional authorizing committees to make reasonable and expeditious progress to address the concerns and recommendations made by the Government Accountability Office (GAO), most notably with regard to unfair allocations, third-party overbilling, and under-enrollment in other qualifying Federal programs. (c) The Committee urges the Service to work aggressively with the relevant congressional authorizing committees to enact authorization for the Service to cap payment rates for non-hospital services, as recommended by the Government Accountability Office (GAO–13–272). Failure to do so costs the program an estimated $30 million annually that could be used to purchase more services (p. 86). Emphasis added.

Action taken or to be taken

(a) The Committee encourages the Service and Tribes to measure the impacts of funding increases on the ability to provide care at each level. Currently the program's only

measurable goal stated in the fiscal year 2015 budget request is, ''Average Days between Service End and Purchase Order Issued,'' which is by itself an insufficient program goal.

IHS is adopting the 2014 GAO report recommendation to ensure that IHS and Tribes have meaningful information on the timeliness with which it issues purchase orders authorizing payment under the PRC program and improve the timeliness of payments to providers. The IHS PRC program is developing a measure to track PRC authorized referrals and patient self-referrals and establish a separate target timeframe for authorization and payment for these referrals. The PRC program is retiring the current measure "average days between service end and purchase order issued." The two new proposed measures better assess the timeliness of provider payments ensuring continued access to care and program quality in monitoring timely payment to external providers and reinforces partnerships.

The IHS' Workgroup on Improving Purchased/Referred Care (Workgroup) is reviewing ways to better identify unmet need, measure the impact of funding levels and obtain more complete reporting from federal and tribal facilities.

(b) The Committee urges the Service, Tribes, and the congressional authorizing committees to make reasonable and expeditious progress to address the concerns and recommendations made by the Government Accountability Office (GAO), most notably with regard to unfair allocations, third-party overbilling, and under-enrollment in other qualifying Federal programs.

The Workgroup has reviewed the allocation formula for PRC and recommended the allocation formula remain the same until the impact of the Affordable Care Act is realized on the PRC program. IHS concurred with the GAO on adjusting the access to care component of the PRC allocation formula. The Workgroup is reviewing this piece of the formula and will make recommendations for Tribal consultation on the allocation formula.

The IHS and tribes are working closely with CMS and States to fully implement Affordable Care Act and increase overall enrollment in alternate resources. Areas have developed and implemented business plans to increase enrollment and maximize revenue through third party collections. The IHS and Tribes have conducted a number of training sessions and outreach and education activities throughout Indian country that focused on increasing access to care and third party enrollment. One example is that all of the IHS Federal sites and many of the tribal sites are now billing the VA and over $11 million was collected from the VA in FY 2014. Increasing access to care for AIAN people by improving and expanding our health care delivery system is a priority for the IHS and Tribes.

(c) The Committee urges the Service to work aggressively with the relevant congressional authorizing committees to enact authorization for the Service to cap payment rates for non-hospital services, as recommended by the Government Accountability Office.

On December 5, 2014, the IHS issued a proposed rulemaking for the payment rates for non-hospital services in the Federal Register. The IHS is seeking comments on how to establish reimbursement that is consistent across Federal health care programs, aligns payment with inpatient services, and enables IHS to expand beneficiary access to medical care. In addition, the IHS is seeking comment on whether it should be allowed to negotiate a rate higher than the MLR in instances where MLR could cause access issues.

The comment period ends on January 20, 2015, all comments will be reviewed and a final notice will be published in the Federal Register; responses to the comments will be included. Once finalized, training will be conducted for Federal and tribal PRC programs and Urban Indian health programs. Additionally IHS will work in partnership with Tribes and external providers to provide notification and education on implementation of the final MLR.

Eligibility - The Committee recognizes the Federal government's trust responsibility for providing healthcare for American Indians and Alaska Natives. The Committee is aware that the definition of who is an ''Indian'' is inconsistent across various Federal health programs, which has led to confusion, increased paperwork and even differing determinations of health benefits within Indian families themselves. The Committee therefore directs the Department of Health and Human Services, the Indian Health Service, and the Department of the Treasury to work together to establish a consistent definition of an ''Indian'' for purposes of providing health benefits (p. 86).

Action taken or to be taken

Under the ACA, only members of federally recognized tribes and shareholders in Alaska Native regional or village corporations who purchase coverage through a state or federal Marketplaces are eligible to receive special protections and some exemptions from cost sharing. This definition of Indian is narrower than the definition used by IHS, Medicaid and CHIP, leaving out a significant population of American Indians and Alaska Natives that the ACA was intended to benefit and protect. HHS has determined it does not have the administrative authority to align the inconsistent definitions under the ACA and that a legislative fix is necessary. The definition of Indian used by IHS, Medicaid, and CHIP is found in 42 C.F.R. 447.50 (b) and includes individuals who: (1) are members of a federally recognized Indian tribe who reside in an urban center and meet one of four criteria, (2) are considered by the Secretary of the Interior to be an Indian for any purpose, or (3) are considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for IHS services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.

Recruitment and Retention of Health Care Professionals - Recruitment and retention of health care professionals is a serious problem in the IHS system which the loan repayment program helps to alleviate. In fiscal year 2013, IHS turned away over 500 applicants for loan repayment due to limited funds. While the recommended increases for fiscal year 2015 will help reduce vacancies, the Committee notes with concern that unfair Federal tax liabilities consume 25 percent of the funds. The Committee encourages efforts to extend fair tax treatment of Federal scholarship and loan repayment programs to IHS-funded programs so that appropriated funds can help more applicants and further reduce vacancies. To that end, the Committee notes that IHS collected $85.3 million from private insurers in fiscal year 2013, which suggests that increased costs to the government to hire more IHS professionals by fairly adjusting the tax code are at least partially offset by private collections as a result of services provided by those newly-hired professionals. The Committee encourages IHS to re-submit its legislative proposal with the fiscal year 2016 budget and to include defensible estimates of offsets via third party collections (p. 87).

Action taken or to be taken

The IHS continues to believe that providing tax treatment, similar to the treatment provided to recipients of National Health Service Corps (NHSC) and Armed Forces Health Professions scholarships, to allow scholarship funds for qualified tuition and related expenses received under the Indian Health Services Health Professions Scholarships to be excluded from gross income

under Section 117(c)(2) of the Internal Revenue Code (IRC) and to allow participants in the IHS Loan Repayment Program to exclude from gross income student loan amounts that are forgiven by the IHS Loan Repayment program under Section 108(f)(4) of the IRC would greatly benefit Indian health programs.

IHS understands the Committee's concern that part of the current tax costs for the IHS Scholarship and Loan Repayment Program expense could possibly be offset by third party collections generated by the providers fulfilling their service obligation as participants in these programs. In researching this possibility, several issues were identified. First, third party billing is done at the point of service, at the local facility. Third party collections are used at the local facility to pay the salary of the provider and to pay hospital/clinic costs not covered through appropriations. Third party collections vary widely by provider discipline and facility location. In the latest IHS study (from 2011) looking at physician salaries vs average net revenue generated by provider, it was estimated that a facility collected approximately twice the physician's salary in third party collections. The funds were collected by and used at the local site to offset the difference between appropriated funding and actual cost of running the health care facility. Any additional collections were used to provide additional health care services to patients. Furthermore, third-party collections are essential for most facilities to remain accredited and ensure these facilities are providing high quality healthcare across Indian Country. Diverting funds from these purposes would strain both the IHS and tribal health care systems.

Joint Explanatory Statement; Omnibus P.L. 113-235

Preventive Dental Care for Children - The Service is encouraged to coordinate with the Bureau of Indian Education to establish a pilot program integrating preventative dental care at schools within the Bureau system (p. 46).

Action taken or to be taken

Indian Health Service (IHS) will do their best to work with the Bureau of Indian Education (BIE) and to consult with Tribes about piloting the initiative in the BIE school system to the extent the limited funds would permit. In 2011 and 2012, the IHS conducted the largest-ever oral health surveillance of 6-9 year-old children to determine the disease burden of this population, and in conducting the screening surveys; the IHS utilized Bureau of Indian Education-operated (BIE) elementary schools. IHS programs throughout the country engage in delivering preventive services such as dental screenings, dental sealants, and fluoride applications to school-age children in both dental clinics and in BIE-operated schools, and the success of these services are measured through three Government Performance and Results Act indicators annually – access to care, dental sealants in 2-15 year-olds, and the number of 1-15 year-olds receiving fluoride applications.

Health Care Provider Shortage - The Service is encouraged to work with Tribes and health care organizations to find creative ways to address the Service's health care provider shortage, including improvements to the credentialing process (p. 46).

Action taken or to be taken

The IHS continues to work with our Tribal and Urban Indian program partners to address recruitment and retention issues associated with the health care provider shortage. In November 2014, IHS centralized recruitment and retention activities with the creation of the Office of

Human Resources. By moving all activities associated with recruitment and retention of federal employees, including IHS Area Human Resource offices, under one organizational lead, IHS anticipates improved coordination of recruitment and retention activities for health and non-health professionals throughout our system. The IHS uses a number of incentives to assist in the recruitment and retention of health professionals including loan repayment, scholarships and extern programs.

Many health professionals leave school or post graduate training with substantial educational loan debt. Having the IHS Loan Repayment Program (LRP) allows IHS to attract individuals interested in working in Indian communities, but who would be unable to do so if there were not a way to pay off their educational loans. In fiscal year (FY) 2014, the IHS LRP was able to fund 710 health care professionals. In FY 2014, the IHS Scholarship Program was able to fund 260 health professions students. The IHS Extern Program is designed to give IHS scholars and other health professions students the opportunity to gain clinical experience with IHS and Tribal health professionals in their chosen discipline. The program also allows students the opportunity to work at sites they may want to apply to for employment after they complete their health professions training. This program is open to scholars and non-scholars. Students are employed up to 120 days annually, with most students working during the summer months. In FY 2014, the Extern Program funded a total of 111 extern students. Hundreds of additional students rotate through Indian health facilities on academic rotations throughout the school year.

The IHS and Health Resources and Services Administration (HRSA) have worked together to make the National Health Service Corps (NHSC) more accessible to fill health professional vacancies. Starting in 2010, the IHS and HRSA have collaborated to expand the number of IHS and Tribal facilities designated as NHSC-approved sites. This allows these facilities to recruit and retain primary care providers by using NHSC scholarship and loan repayment incentives. As of November 2014, a total of 641 IHS, Tribal Clinics, and Urban Indian Health Clinics have been approved as eligible sites for NHSC scholars and LRP applicants. That compares to 494approved sites as of 2011, and 60 at the end of 2010. There are currently 161 open positions at IHS and Tribal sites listed on the NHSC Job Center Website. As of November 2014, a total of 376 NHSC scholars and NHSC loan repayment recipients providing health care services to Indian communities.

IHS facilities have existing authorities for other incentives to assist in the recruitment and retention of health professionals. These include Title 5 and Title 38 Special Salary Rates, Title 38 Physician and Dentist Pay, the 3Rs (recruitment, retention and relocation bonuses), and use of service credit to increase annual leave. Title 38 Special Salary Rates have allowed IHS facilities to offer pay that is closer to what health care providers would receive in the private sector.

IHS has also worked to encourage Tribal leaders and the local community to participate in recruitment efforts. Encouraging the Tribe to participate when a prospective provider visits for an interview can often provide a venue for the Tribe to introduce the local culture and activities while providing a welcoming environment for the prospective provider. The IHS provides assistance to local Chief Executive Officers, Clinical Directors, Tribal Leaders and prospective new hires through the development of recruitment and retention materials. The newly developed Applicant Support Program Guide provides guidance to IHS and Tribal hiring officials on building relationships with prospective hires as they go through the hiring process. Additional materials focus on preparing a community liaison to work with prospective employees and new hires, materials to help new hires and their families' transition to a new culture and rural community, and a guide for sites to develop an onboarding process for new hires that will promote retention of these health care professionals.

A system-wide, centralized credentialing program and database could have some advantages for health care practitioners seeking both short- and long-term employment with the IHS, mainly for those few individuals who transfer frequently and/or work at multiple locations as they do in the Department of Defense. The benefit of a centralized credentials database to medical staff appears small compared to the cost to establish and maintain it. IHS has begun discussion of this issue with its Hospital Consortium that is focused on making accreditation-related training and systems more consistent. Making credentialing processes and policies more consistent is the current goal, and we will address the option of a centralized credentialing program again to assess for any change in demand signal or operational requirements.

Department of Health & Human Services
Indian Health Service
Number of Service Units and Facilities
Operated by IHS and Tribes, October 1, 2014

Type of Facility	TOTAL	IHS Total	TRIBAL Total	Title I [a]	Title V [b]	Other [c]
Service Units	**170**	64	106			
Hospitals	**46**	28	18	2	16	
Ambulatory	**606**	**90**	516	163	340	13
Health Centers	344	62	282	111	166	5
School Health Centers	7	3	4	2	2	0
Health Stations	105	25	80	41	37	2
Alaska Village Clinics	150	0	150	9	135	6

[a] Operated under P.L. 93-638, Self Determination Contracts

[b] Operated under P.L. 106-260, Tribal Self-Governance Amendment of 2000

[c] Operated by a local government, not a tribe, for some Alaska Native villages through a standard procurement contract or also to denote certain Navajo Area contractors

Indian Health Service
Summary of Inpatient Admissions and Outpatient Visits
Federal and Tribal
FY 2013 (1) Data

Direct Care Admissions

	IHS	Tribal	TOTAL
TOTAL	**20,469**	**24,208**	**44,677**
Alaska	*	12,154	12,154
Albuquerque	1,197	*	1,197
Bemidji	419	*	419
Billings	873	*	873
California	*	*	
Great Plains	3,706	*	3,706
Nashville	*	920	920
Navajo	8,346	5,225	13,571
Oklahoma	1,325	5,885	7,210
Phoenix	4,193	24	4,217
Portland	*	*	
Tucson	410	*	410

* No direct inpatient facilities in FY 2013
(1) FY 2014 Inpatient Memorandum is produced following the inpatient data review and is expected in Spring 2015.

Direct Care Outpatient Visits (2)

	IHS	Tribal	TOTAL
TOTAL	**5,260,870**	**7,825,417**	**13,180,745**
Alaska	**	1,611,624	1,611,624
Albuquerque	491,802	109,303	601,105
Bemidji	238,712	649,119	887,831
Billings	485,552	126,379	611,931
California	**	588,428	588,428
Great Plains	1,066,552	120,980	1,187,532
Nashville	15,647	498,136	513,783
Navajo	1,057,335	677,675	1,735,010
Oklahoma	607,796	2,353,377	2,961,173
Phoenix	823,510	506,671	1,330,181
Portland	303,371	584,768	888,139
Tucson	170,593	93,415	264,008

** No IHS facilities in FY 2013
(2) FY 2014 Outpatient Memorandum is produced following the outpatient data review and might not be finalized until as late as Summer 2015.

INDIAN HEALTH SERVICE
Immunization Expenditures

	FY 2012 Enacted	FY 2013 Estimate	FY 2014 Estimate	FY 2015 Estimate	FY 2016 Estimate	Increase or Decrease
Infants, <2 yrs	$12,903,354	$13,329,165	$21,922,093	$18,793,408	$30,855,296	+ $12,061,888
Adolescents, 13-17 yrs			$12,412,350	$11,704,995	$11,551,407	- $153,588
HPV vaccine, Female 19-26 yrs	$9,088,511	$9,388,432	$6,001,292	$7,389,130	$2,654,568	- $4,734,562
HPV Vaccine, Males 19-21 yrs			$5,889,641	$6,799,171	$3,136,902	- $3,662,269
Tdap, 19+ yrs			$6,508,229	$6,977,397	$1,399,293	- $5,578,104
Hepatitis B for diabetics, 19-64 yrs			$5,752,971	$4,595,452	$4,870,146	+ $274,694
Influenza, 19yrs+		$3,210,800	$25,969,076	$29,225,712	$29,542,047	+ $316,335
Zoster vaccine, 60yrs			$494,463	$36,189	$558,050	+ $521,861
Pneumococcal (PPSV23), 65yrs+	$1,786,625		$392,934	$432,156	$179,359	- $252,797
Pneumococcal (PCV13), 65yrs+					$4,410,552	+ $4,410,552
Monitoring	$106,914	$110,442	$114,528	$118,078	$122,565	+ $4,487
TOTAL	$23,885,404	$26,038,839	$85,457,577	$86,071,688	$89,280,185	+ $3,208,497

1. The immunization estimates do not include the Hepatitis B and Haemophilus Immunization program; estimates for these immunizations are included under the Immunization Alaska budget.

The Indian Health Service (IHS) patient care data system does not calculate itemized costs for the treatment of various conditions. Because the cost of vaccines for infants and adolescents < 18 years of age is covered by the Vaccines for Children (VFC) program, only the costs for vaccine administration, which are not covered by the VFC program, are included for this age group. Vaccine administration fees were based on an average of the CMS Maximum Regional Charges for vaccine administration, multiplied by the number of doses of vaccine routinely recommended for each age group (25 doses for children < 2 yrs; 5 doses of vaccine for adolescents).

In order to incorporate the vaccine provisions included under the Affordable Care Act and Healthcare Reform, all routinely recommended adult vaccines were added to the IHS Core Formulary in September of 2011. Costs for the purchase and administration of these vaccines are included in the 2016 estimated costs. In prior years, costs were only included for adults 65+ yrs and for influenza vaccine. In August 2014, the Advisory Committee on Immunization Practices (ACIP) for the first time recommended routine use of 13-valent pneumococcal conjugate vaccine (PCV13) among adults aged ≥65 years; the projected costs for incorporating this additional vaccine are included in the FY 2016 expenditures. The assumptions for all calculations are included in the table below.

Costs for monitoring of immunization coverage were also included, and represent 3.8 percent increase over the FY 2014 estimate.

- FY 2012 Estimated Costs = FY 2011 cost times 3.3 percent
- FY 2013 Estimated Costs = FY 2012 cost times 3.1 percent
- FY 2014 Estimated Costs = FY 2013 cost times 3.7 percent

- FY 2015 Estimated Costs = FY 2014 cost times 3.1 percent
- FY 2016 Estimated Costs = FY 2015 cost times 3.8 percent

For 2016, $89,157,620 is estimated for vaccine costs, and $122,565 for immunization monitoring costs, for a total of $89,280,185 estimated for all immunization expenditures. This represents a $3,208,497 increase over FY 2015 due to increases and redistribution in population age categories and the addition of the newly recommended pneumococcal (PCV13) vaccine.

Calculations for the costs included as part of the 2016 estimated immunization costs were based on the assumptions outlined in the table below:

	Estimated User Pop (FY 2013)	Coverage Goal†	Current Coverage	No. to be vaccinated	Vaccine costs (per dose)	Admin fee (per dose)**	No. of doses per patient	Total Immun expenditures per patient	Total
Infants, <2 yrs	70,997	80%	NA	56,798	$0.00	$21.73	25	$543.25	$30,855,296
Adolescents, 13-17 years	132,897	80%	NA	106,318	$0.00	$21.73	5	$108.65	$11,551,407
HPV Females, 19-26	120,722	60%	53%	8,451	$82.98	$21.73	3	$314.13	$2,654,568
HPV Males, 19-21 yrs	39,944	60%	35%	9,986	$82.98	$21.73	3	$314.13	$3,136,902
Tdap, 19+ yrs	1,068,815	80%	77%	32,064	$21.91	$21.73	1	$43.64	$1,399,293
Hepatitis B for diabetics, 19-64 yrs	93,330	60%	21%	36,399	$22.87	$21.73	3	$133.80	$4,870,146
Influenza, 19+ yrs	1,068,815	80%	NA	855,052	$12.82	$21.73	1	$34.55	$29,542,047
Zoster, 60 yrs	13,913	30%	NA	4,174	$111.97	$21.73	1	$133.70	$558,050
Pneumococcal (PPSV23) 65yrs+	130,509	90%	87%	3,915	$24.08	$21.73	1	$45.81	$179,359
Pneumococcal (PCV13) 65yrs+	130,509	30%	NA	39,153	$90.92	$21.73	1	$112.65	$4,410,552
Vaccine Costs									$89,157,620
Monitoring									$122,565
Total Vaccine Costs									$89,280,185

*Coverage estimates based on most current coverage levels reported by IHS.
HPV estimate is 1 dose coverage. http://www.ihs.gov/epi/index.cfm?module=epi_vaccine_reports
** Based on an average of the 2012 state CMS Maximum Regional Charges for Vaccine administration.
http://www.cdc.gov/vaccines/programs/vfc/index.html
† Based on Healthy People 2020 where applicable

Overall, the estimated costs for these immunizations are affected by:

1. Individuals outside these target groups are regular recipients of immunizations (e.g., immunization for health care workers and those at specific risk for other vaccine-preventable diseases), however, there is not a methodology to estimate the size of these groups.
2. The CMS vaccine administration fee was used to estimate these indirect costs, which is necessary because there is not a methodology to estimate indirect costs or administrative overhead associated with the administration of immunizations, or operation of the immunization program.

FY 2014 Crosswalk
Budget Authority
Final Distribution
(Dollars in Thousands)

Sub Activity	Federal Health Administration								Tribal Health Administration								FY 2014 Final
	Clinical Services	Urban Health	Preventive Health	Indian Health Professions	Federal Administration	Self-Governance	Facilities	TOTAL Federal Health Admini-stration	Clinical Services	Preventive Health	Urban Health	Management Training	Self-Governance	Contract Support	Facilities	TOTAL Tribal Health Admini-stration	
SERVICES																	
Hospitals & Health Clinics	710,975	0	0	0	0	0	0	710,975	1,062,956	0	0	0	0	0	0	1,062,956	1,773,931
Dental Health	57,326	0	0	0	0	0	0	57,326	107,934	0	0	0	0	0	0	107,934	165,260
Mental Health	23,170	0	0	0	0	0	0	23,170	54,810	0	0	0	0	0	0	54,810	77,980
Alcohol & Substance Abuse	36,339	0	0	0	0	0	0	36,339	150,039	0	0	0	0	0	0	150,039	186,378
Purchased/Referred Care	310,313	0	0	0	0	0	0	310,313	568,262	0	0	0	0	0	0	568,262	878,575
Subtotal (CS)	1,138,123	0	0	0	0	0	0	1,138,123	1,944,001	0	0	0	0	0	0	1,944,001	3,082,124
Public Health Nursing	0	0	21,516	0	0	0	0	21,516	0	49,313	0	0	0	0	0	49,313	70,829
Health Education	0	0	3,299	0	0	0	0	3,299	0	13,627	0	0	0	0	0	13,627	16,926
Community Health Repr.	0	0	4,117	0	0	0	0	4,117	0	53,778	0	0	0	0	0	53,778	57,895
Immunization AK	0	0	0	0	0	0	0	0	0	1,826	0	0	0	0	0	1,826	1,826
Subtotal (PH)	0	0	28,932	0	0	0	0	28,932	0	118,544	0	0	0	0	0	118,544	147,476
Urban Health Project	0	15,911	0	0	0	0	0	15,911	0	0	24,818	0	0	0	0	24,818	40,729
Indian Health Professions	0	0	0	28,466	0	0	0	28,466	0	0	0	0	0	0	0	0	28,466
Tribal Management	0	0	0	143	0	0	0	143	0	0	0	1,299	0	0	0	1,299	1,442
Direct Operations	0	0	0	0	46,971	0	0	46,971	0	0	0	18,923	0	0	0	18,923	65,894
Self-Governance	0	0	0	0	0	2,654	0	2,654	0	0	0	0	1,573	0	0	1,573	4,227
Contract Support Costs	0	0	0	0	0	0	0	0	0	0	0	0	0	612,484	0	612,484	612,484
Subtotal (OS)	0	15,911	0	28,609	46,971	2,654	0	94,145	0	0	24,818	20,222	1,573	612,484	0	659,097	753,242
Total, Services	1,138,123	15,911	28,932	28,609	46,971	2,654	0	1,261,200	1,944,001	118,544	24,818	20,222	1,573	612,484	0	2,721,642	3,982,842
FACILITIES																	
Maintenance & Improvement	0	0	0	0	0	0	23,702	23,702	0	0	0	0	0	0	29,912	29,912	53,614
Sanitation Facilities Constr.	0	0	0	0	0	0	27,798	27,798	0	0	0	0	0	0	51,625	51,625	79,423
Health Care Facs. Constr.	0	0	0	0	0	0	72,548	72,548	0	0	0	0	0	0	12,500	12,500	85,048
Facs. & Env. Health Sup	0	0	0	0	0	0	96,323	96,323	0	0	0	0	0	0	114,728	114,728	211,051
Equipment	0	0	0	0	0	0	7,712	7,712	0	0	0	0	0	0	14,825	14,825	22,537
Total, Facilities	0	0	0	0	0	0	228,083	228,083	0	0	0	0	0	0	223,590	223,590	451,673
TOTAL, IHS	1,138,123	15,911	28,932	28,609	46,971	2,654	228,083	1,489,282	1,944,001	118,544	24,818	20,222	1,573	612,484	223,590	2,945,233	4,434,515
% Federal Health Admin.								33.6%									
% Tribal and Urban Health Admin.																	66.4%

FY 2015 Crosswalk
Budget Authority
Estimated Distribution
(Dollars in Thousands)

Sub Activity	Federal Health Administration: Clinical Services	Urban Health	Preventive Health	Indian Health Professions	Federal Administration	Self-Governance	Facilities	TOTAL Federal Health Admini-stration	Tribal Health Administration: Clinical Services	Preventive Health	Urban Health	Management Training	Self-Governance	Contract Support	Facilities	TOTAL Tribal Health Admini-stration	FY 2015 Enacted
SERVICES																	
Hospitals & Health Clinics	725,644	0	0	0	0	0	0	725,644	1,111,145	0	0	0	0	0	0	1,111,145	1,836,789
Dental Health	57,356	0	0	0	0	0	0	57,356	116,626	0	0	0	0	0	0	116,626	173,982
Mental Health	23,170	0	0	0	0	0	0	23,170	57,975	0	0	0	0	0	0	57,975	81,145
Alcohol & Substance Abuse	36,339	0	0	0	0	0	0	36,339	154,642	0	0	0	0	0	0	154,642	190,981
Purchased/Referred Care	324,120	0	0	0	0	0	0	324,120	590,019	0	0	0	0	0	0	590,019	914,139
Subtotal (CS)	1,166,629	0	0	0	0	0	0	1,166,629	2,030,407	0	0	0	0	0	0	2,030,407	3,197,036
Public Health Nursing	0	0	21,596	0	0	0	0	21,596	0	54,044	0	0	0	0	0	54,044	75,640
Health Education	0	0	3,374	0	0	0	0	3,374	0	14,652	0	0	0	0	0	14,652	18,026
Community Health Repr.	0	0	4,567	0	0	0	0	4,567	0	53,902	0	0	0	0	0	53,902	58,469
Immunization AK	0	0	0	0	0	0	0	0	0	1,826	0	0	0	0	0	1,826	1,826
Subtotal (PH)	0	0	29,537	0	0	0	0	29,537	0	124,424	0	0	0	0	0	124,424	153,961
Urban Health Project	0	16,877	0	0	0	0	0	16,877	0	0	26,727	0	0	0	0	26,727	43,604
Indian Health Professions	0	0	0	48,342	0	0	0	48,342	0	0	0	0	0	0	0	0	48,342
Tribal Management	0	0	0	143	0	0	0	143	0	0	0	2,299	0	0	0	2,299	2,442
Direct Operations	0	0	0	0	48,971	0	0	48,971	0	0	0	19,094	0	0	0	19,094	68,065
Self-Governance	0	0	0	0	0	3,154	0	3,154	0	0	0	0	2,573	0	0	2,573	5,727
Contract Support Costs	0	0	0	0	0	0	0	0	0	0	0	0	0	662,970	0	662,970	662,970
Subtotal (OS)	0	16,877	0	48,485	48,971	3,154	0	117,487	0	0	26,727	21,393	2,573	662,970	0	713,663	831,150
Total, Services	1,166,629	16,877	29,537	48,485	48,971	3,154	0	1,313,653	2,030,407	124,424	26,727	21,393	2,573	662,970	0	2,868,494	4,182,147
FACILITIES																	
Maintenance & Improvement	0	0	0	0	0	0	23,702	23,702	0	0	0	0	0	0	29,912	29,912	53,614
Sanitation Facilities Constr.	0	0	0	0	0	0	27,798	27,798	0	0	0	0	0	0	51,625	51,625	79,423
Health Care Facs. Constr.	0	0	0	0	0	0	82,322	82,322	0	0	0	0	0	0	2,726	2,726	85,048
Facs. & Env. Health Sup	0	0	0	0	0	0	96,323	96,323	0	0	0	0	0	0	123,289	123,289	219,612
Equipment	0	0	0	0	0	0	7,712	7,712	0	0	0	0	0	0	14,825	14,825	22,537
Total, Facilities	0	0	0	0	0	0	237,857	237,857	0	0	0	0	0	0	222,377	222,377	460,234
TOTAL, IHS	1,166,629	16,877	29,537	48,485	48,971	3,154	237,857	1,551,509	2,030,407	124,424	26,727	21,393	2,573	662,970	222,377	3,090,872	4,642,381
% Federal Health Admin.								33.4%									
% Tribal and Urban Health Admin.																	66.6%

FY 2016 Crosswalk
Budget Authority
Estimated Distribution
(Dollars in Thousands)

Sub Activity	Federal Health Administration: Clinical Services	Urban Health	Preventive Health	Indian Health Professions	Federal Administration	Self-Governance	Facilities	TOTAL Federal Health Admini-stration	Tribal Health Administration: Clinical Services	Preventive Health	Urban Health	Management Training	Self-Governance	Contract Support	Facilities	TOTAL Tribal Health Admini-stration	FY 2016 PB
SERVICES																	
Hospitals & Health Clinics	749,612	0	0	0	0	0	0	749,612	1,186,711	0	0	0	0	0	0	1,186,711	1,936,323
Dental Health	58,872	0	0	0	0	0	0	58,872	122,587	0	0	0	0	0	0	122,587	181,459
Mental Health	23,780	0	0	0	0	0	0	23,780	60,705	0	0	0	0	0	0	60,705	84,485
Alcohol & Substance Abuse	40,796	0	0	0	0	0	0	40,796	186,266	0	0	0	0	0	0	186,266	227,062
Purchased/Referred Care	349,551	0	0	0	0	0	0	349,551	634,924	0	0	0	0	0	0	634,924	984,475
Subtotal (CS)	1,222,611	0	0	0	0	0	0	1,222,611	2,191,193	0	0	0	0	0	0	2,191,193	3,413,804
Public Health Nursing	0	0	22,587	0	0	0	0	22,587	0	56,989	0	0	0	0	0	56,989	79,576
Health Education	0	0	3,526	0	0	0	0	3,526	0	15,610	0	0	0	0	0	15,610	19,136
Community Health Repr.	0	0	4,614	0	0	0	0	4,614	0	57,749	0	0	0	0	0	57,749	62,363
Immunization AK	0	0	0	0	0	0	0	0	0	1,950	0	0	0	0	0	1,950	1,950
Subtotal (PH)	0	0	30,726	0	0	0	0	30,726	0	132,299	0	0	0	0	0	132,299	163,025
Urban Health Project	0	16,877	0	0	0	0	0	16,877	0	0	26,727	0	0	0	0	26,727	43,604
Indian Health Professions	0	0	0	48,342	0	0	0	48,342	0	0	0	0	0	0	0	0	48,342
Tribal Management	0	0	0	143	0	0	0	143	0	0	0	2,299	0	0	0	2,299	2,442
Direct Operations	0	0	0	0	49,183	0	0	49,183	0	0	0	19,155	0	0	0	19,155	68,338
Self-Governance	0	0	0	0	0	3,162	0	3,162	0	0	0	0	2,573	0	0	2,573	5,735
Contract Support Costs	0	0	0	0	0	0	0	0	0	0	0	0	0	717,970	0	717,970	717,970
Subtotal (OS)	0	16,877	0	48,485	49,183	3,162	0	117,707	0	0	26,727	21,454	2,573	717,970	0	768,724	886,431
Total, Services	1,222,611	16,877	30,726	48,485	49,183	3,162	0	1,371,043	2,191,193	132,299	26,727	21,454	2,573	717,970	0	3,092,217	4,463,260
FACILITIES																	
Maintenance & Improvement	0	0	0	0	0	0	38,296	38,296	0	0	0	0	0	0	50,801	50,801	89,097
Sanitation Facilities Constr.	0	0	0	0	0	0	40,298	40,298	0	0	0	0	0	0	74,840	74,840	115,138
Health Care Facs. Constr.	0	0	0	0	0	0	121,364	121,364	0	0	0	0	0	0	63,684	63,684	185,048
Facs. & Env. Health Sup	0	0	0	0	0	0	98,569	98,569	0	0	0	0	0	0	128,301	128,301	226,870
Equipment	0	0	0	0	0	0	7,994	7,994	0	0	0	0	0	0	15,578	15,578	23,572
Total, Facilities	0	0	0	0	0	0	306,521	306,521	0	0	0	0	0	0	333,203	333,203	639,725
TOTAL, IHS	1,222,611	16,877	30,726	48,485	49,183	3,162	306,521	1,677,565	2,191,193	132,299	26,727	21,454	2,573	717,970	333,203	3,425,420	5,102,985
% Federal Health Admin.								32.9%									
% Tribal and Urban Health Admin.																	67.1%

FISCAL YEAR 2015 LEGISLATIVE PROPOSAL
Indian Health Service

Special Diabetes Program for Indians Three Year Reauthorization

Proposal: Three year reauthorization for the Special Diabetes Program for Indians (SDPI) at $150 million per year.

Current Law: The Public Health Service Act (42 U.S.C. 254c-3) as amended by the Balanced Budget Act of 1997 (P.L. 105-33, Section 4922) established the Special Diabetes Program for Indians (SDPI) to address the need for diabetes prevention and treatment for American Indian and Alaska Native (AI/AN) populations. The SDPI is codified in the Public Health Service Act at 42 U.S.C. § 254c-3 and is reauthorized under the American Taxpayer Relief Act of 2012, P.L. 112-240, Section 625(b), at $150 million through September 30, 2015. The successful program has been reauthorized every year since 1997.

Rationale: Reauthorization of the SDPI beyond FY 2015 will be required to continue progress in the prevention and treatment of diabetes in AI/AN communities. Three year reauthorization allows the programs more continuity and the ability to plan more long term interventions and activities.

The SDPI has provided the funding which has enabled AI/AN programs to implement and sustain quality diabetes treatment and prevention services. As the four SDPI Reports to Congress in FY 2000, 2004, 2007, and 2011 have demonstrated, substantial improvements in clinical measures and outcomes have been associated with the diabetes prevention and treatment activities implemented with SDPI funding. A 2014 Report to Congress, which documents continued improvements, has been drafted and is undergoing review.
Recent data show that the rate of increase in diabetes prevalence is slowing in AI/AN adults, rising only from 15.2 percent to 15.9 percent from 2006 to 2012, with almost no increase in prevalence in youth. Another positive trend is that rates of obesity in AI/AN children and youth aged 2-19 years remained nearly constant during the same time period. Key clinical outcome measures have continued to improve overall at IHS, Tribal and urban facilities since the inception of the SDPI:

- Improved blood sugar control: Average blood sugar (as measured by the A1C test) in AI/AN patients with diabetes decreased from 9.0 percent in 1996 to 8.1 percent in 2014, nearing the A1C goal for most patients of less than 7 percent.
- Improved blood lipid levels: Average LDL cholesterol in AI/AN patients with diabetes decreased 22 percent from 118 mg/dL in 1998 to 92 mg/dL in 2014, well below the target of 100 mg/dL.
- Reduced kidney failure: From 2000 to 2011, the rate of new cases of kidney failure due to diabetes leading to dialysis declined 43 percent in AI/AN people. This is a much larger decline than in any other racial group in the U.S.

The SDPI Community-directed Grant Programs have implemented diabetes prevention and treatment activities that are culturally appropriate and community-driven, and centered on evidence based practices. These programs will continue to implement specific prevention and treatment strategies and best practices for AI/AN adults, children and youth.

The Diabetes Prevention (DP) and Healthy Heart (HH) Demonstration Projects were implemented to translate the findings of research on diabetes and cardiovascular disease prevention into real world communities. These programs completed their demonstration projects and the evaluation showed significant reductions in risk factors for developing diabetes and also for cardiovascular disease in patients with diabetes. The DP and HH Initiatives are continuing to implement these prevention services and are developing tools to share best practices with other SDPI programs through FY 2015. In FY 2016 IHS will continue to implement and disseminate the DP and HH Initiative activities into AI/AN communities and health care programs.

IHS proposes to continue to support data infrastructure improvements, focusing on the Diabetes Care and Outcomes Audit, estimates of diabetes prevalence, the National Data Warehouse, and updates to the Diabetes Management System and iCare programs.

Given the complexity of the grant programs, IHS will provide administrative support to ensure their appropriate implementation and evaluation.

Reauthorization is highly supported by the Tribes. In 2014, Tribes submitted testimony to the House Subcommittee on Interior, Environment and Related Agencies and the Senate Committee on Indian Affairs indicating SDPI progress and the need for continued support. Distribution of the FY 2016 SDPI funding will be based on tribal consultation and final agency decision; the activities will be modified appropriately.

Budget Impact: (Costs)

SDPI Funding 3 year Total			
FY 2015	FY 2016	FY 2017	3-Year Total
$150 M	$150 M	$150 M	$450 M

Effective Date: Upon enactment; beginning FY 2016.

FISCAL YEAR 2015 LEGISLATIVE PROPOSAL
Indian Health Service

Provide Indian Health Service Health Professions Scholarship Program and Health Professions Loan Repayment Program with a Tax Exemption

Proposal: IHS is seeking tax treatment, similar to the treatment provided to recipients of National Health Service Corps (NHSC) and Armed Forces Health Professions scholarships, to allow scholarship funds for qualified tuition and related expenses received under the Indian Health Services Health Professions Scholarships to be excluded from gross income under Section 117(c)(2) of the Internal Revenue Code (IRC) and to allow participants in the IHS Loan Repayment Program to exclude from gross income student loan amounts that are forgiven by the IHS Loan Repayment program under Section 108(f)(4) of the IRC. In addition, IHS is seeking exemption from any Federal Employment Tax (FICA), making the IHS programs comparable to the current NHSC status.

Current Law: Generally, benefits awarded in the form of scholarship awards and loan repayments are regarded as federal taxable income by the IRS under Title 25 of the Internal Revenue Code. However, three federal laws currently provide for the non-taxability of federal scholarship awards and loan repayment programs:

- Section 413 of P.L. 107-16, the Economic Growth and Tax Relief Reconciliation Act of 2001 provides that tuition, fee, and other related cost payments by the National Health Service Corps and F. Edward Hebert Armed Forces Health Professions Scholarships and Financial Assistance Program scholarships are not taxable. This tax exemption was made permanent by Congress in December 2012 but did not include IHS scholarships.

- 26 USC 108(f)(4) provides that funds received through the National Health Service Corps Loan Repayment Program authorized under 338B(g) of the Public Health Service Act or a state loan repayment program described in section 338I of the Public Health Service Act are permanently not subject to federal income tax.

- 26 USC 3401(a)(19) excludes NHSC loan repayment from federal employment tax.

As IHS programs are not included in the exceptions, IHS health professions scholarships and loan repayment awards are taxed under the IRC.

Rationale**:** The IHS, as a rural healthcare provider, has difficulty recruiting healthcare professionals. There are over 1,550 vacancies for healthcare professionals including: physicians, dentists, nurses, pharmacists, physician assistants, and nurse practitioners. The IHS Health Professions Scholarship Program and the Loan Repayment Program play a significant role in the recruitment and retention of the healthcare professionals needed to fill these vacancies.

The IHS Health Professions Scholarship and IHS Loan Forgiveness Program are very similar to other programs that receive preferred tax treatment, and should therefore receive similar tax treatment. Currently, benefits awarded through IHS in the form of loan repayment and scholarships are regarded as federal taxable income to the recipient; however, the same benefits offered under the NHSC are not taxable. This disparate tax treatment of IHS-funded scholarship and loan repayment awards increases the overall tax bracket for the participants and creates a

financial disincentive for those otherwise willing to serve American Indian and Alaska Native patients by working in Indian health facilities.

The ability to exempt scholarship and loan repayment funds from gross income would make this recruitment and retention tool more attractive to potential participants. Thus, the IHS would be better able to increase the number of healthcare providers entering and remaining within the IHS to provide primary healthcare and specialty services.

Budget Impact: To Department of Treasury

Federal Tax Revenue Foregone:

Loan Repayment	$5,711,893
Scholarship	$3,793,319
Total	$9,505,212

Budget impact is the amount of tax revenue withheld from IHS Health Professions Scholarship and Loan Repayment and forwarded to the Internal Revenue Service. This also includes the tax liability owed by the scholarships recipients.

Effective Date: Upon enactment.

Medicare-like Rate (MLR) Payment for Non-ITU Physician and Other Health Care Professional Services Associated with Either Outpatient or Inpatient Care Provided at Non-ITU Facilities

Current Legislation

MLR for Nonhospital Services would permit IHS, Tribes, tribal Organizations, or IHS-funded programs operated by Urban Indian organization to pay Medicare rates for outpatient services funded through the Purchased/Referred Care (PRC) program. Since 2007, IHS's PRC program has had the authority to pay MLR for PRC authorized in-patient services furnished by Medicare-participating hospitals, and require those hospitals to accept that rate as a condition of participation in Medicare. This legislative proposal would expand these rates, and the condition that Medicare participating providers must accept the rate, to outpatient services, which will reduce the amount of funds IHS and tribal providers would pay for PRC outpatient services. As noted in the GAO's April 2013 report, expanding the MLR cap is a budget-neutral mechanism that will allow IHS and Tribal facilities to save millions of dollars and use those savings to increase the care that IHS provides through the PRC program.

Proposed MLR Regulation Expansion

On December 5, 2014, IHS published a notice of proposed rulemaking which would amend PRC regulations to apply Medicare payment methodologies to all physician and other health care professional services and non-hospital-based services that are authorized by IHS or Tribal PRC programs or purchased by urban Indian organizations. Unlike the legislative proposal, the regulation cannot require that providers participating in Medicare accept the MLR rate from IHS. The IHS sought comments on this proposed rule on how to establish reimbursement that is consistent across federal health care programs, aligns payment with inpatient services, and enables IHS to expand beneficiary access to medical care. IHS also sought comment on whether it should be allowed to negotiate a rate higher than the Medicare methodology. Comments were due by February 4, 2015 and IHS will review them to determine if any revisions are needed for a potential final rule.

Indian Health Service
Indian Self Determination

Indian Health Service Philosophy -- The Indian Health Service (IHS) implements the Indian Self-Determination and Education Assistance Act (ISDEAA), Public Law (Pub. L. No.) 93-638, as amended, which recognizes the unique legal and political relationship between the United States and American Indian and Alaska Native peoples. Accordingly, the IHS supports Tribal sovereignty: (1) by assisting Tribes in exercising their right to administer the IHS health programs, or portions thereof, and (2) by continuing to directly provide services to Tribes that choose the IHS as their health care provider. A Tribal decision to enter or not enter into ISDEAA agreements are equal expressions of self-determination.

Title I Contracts and Title V Self-Governance Compacts – Titles I and V of the ISDEAA provide Tribes the option to exercise the right to self-determination by assuming control and management of programs previously administered by the federal government. Since 1975, the IHS has entered into agreements with Tribes and Tribal organizations to plan, conduct, and administer programs authorized under Section 102 of the Act. Today, over $2.5 billion of the Agency's appropriation is transferred to Tribes and Tribal Organizations through Title I contracts and Title V compacts. There are 227 Title I contracts and annual funding agreements. Under Title V, IHS is party to 84 compacts and 109 funding agreements; through which $1.8 billion or 40% of the IHS budget is transferred to Tribes and Tribal organizations. Sixty percent of federally-recognized Tribes participate in Title V.

IHS and Tribally-Operated Service Unit and Medical Facilities – In recent years, the amount of funding administered under ISDEAA contracts and compacts has nearly doubled, with a corresponding increase in services provided and managed by Tribal programs. Tribes have traditionally assumed operation of community services and have expanded into providing medical care. For example, Tribes operate nearly all of the Community Health Representative Program and community-based alcohol programs. In addition, the number of tribally-operated hospitals has increased to over 36 percent of the hospitals funded by the IHS. With the increase of ambulatory medical facilities, Tribes continue to expand their provision of health care.

Compacts by State	IHS Services	IHS Facilities	Contract Support Costs Direct	Contract Support Costs Indirect	Total
Alabama	**3,982**	**188**	**139**	**680**	**4,989**
Poarch Band of Creek Indians	3,982	188	139	680	4,989
Alaska	**503,277**	**40,773**	**48,905**	**148,334**	**741,289**
Alaska Native Tribal Health Consortium	108,710	19,142	10,650	18,739	157,241
Aleutian Pribilof Islands Association, Inc.	3,274	764	369	1,486	5,893
Arctic Slope Native Association	22,467	1,963	3,016	7,443	34,889
Bristol Bay Area Health Corporation	21,699	836	2,165	8,612	33,312
Chickaloon Native Village	56	1	14	11	82
Chugachmiut	3,591	21	205	1,726	5,543
Copper River Native Association	5,376	336	444	1,236	7,392
Council of Athabascan Tribal Governments	1,752	97	91	924	2,864
Eastern Aleutian Tribes, Inc.	3,042	25	163	1,626	4,856
Kenaitze Indian Tribe	8,346	1,034	693	2,903	12,976
Ketchikan Indian Community	5,600	113	847	4,028	10,588
Knik Traditional Council	71	1	9	14	95
Kodiak Area Native Association	7,252	85	417	2,243	9,997
Maniilaq Association	26,976	830	2,588	14,180	44,574
Metlakatla Indian Community	6,039	921	436	1,330	8,726
Mount Sanford Tribal Consortium	773	1	75	210	1,059
Native Village of Eklutna	176	1	6	21	204
Native Village of Eyak	760	19	81	227	1,087
Norton Sound Health Corporation	42,094	3,553	3,979	7,273	56,899
Seldovia Village Tribe	1,771	31	80	794	2,676
Southcentral Foundation	88,800	3,780	8,832	28,682	130,094
SouthEast Alaska Regional Health Corporation	39,045	1,435	3,273	14,298	58,051
Tanana Chiefs Conference	60,194	3,800	5,159	13,072	82,225
Yakutat Tlingit Tribe	303	2	29	92	426
Yukon-Kuskokwim Health Corporation	45,110	1,982	5,284	17,164	69,540
Arizona	**100,416**	**9,656**	**4,372**	**29,494**	**143,938**
Gila River Indian Community	36,275	4,916	1,622	9,791	52,604
Tuba City Health Regional Care Corporation	41,167	3,520	2,001	13,909	60,597
Winslow Indian Health Care Center, Inc.	22,974	1,220	749	5,794	30,737
California	**67,141**	**2,243**	**2,551**	**25,565**	**97,500**
Chapa-De Indian Health Program, Inc.	6,877	8	164	3,598	10,647
Consolidated Tribal Health Project, Inc.	4,003	209	86	1,617	5,915
Feather River Tribal Health, Inc.	6,091	227	150	1,117	7,585
Hoopa Valley Tribe	5,226	201	241	2,293	7,961
Indian Health Council, Inc.	8,393	363	254	3,261	12,271
Karuk Tribe of California	3,018	175	87	1,205	4,485
Northern Valley Indian Health, Inc.	4,188	208	103	1,110	5,609
Redding Rancheria	6,584	208	526	3,235	10,553
Riverside-San Bernardino County Indian Health, Inc.	21,092	446	795	7,386	29,719
Susanville Indian Rancheria	1,669	198	145	743	2,755
Connecticut	**2,417**	**30**	**-**	**535**	**2,982**
Mohegan Tribe of Indians of Connecticut	2,417	30	0	535	2,982
Florida	**7,553**	**460**	**891**	**1,546**	**10,450**
Seminole Tribe of Florida	7,553	460	891	1,546	10,450
Kansas	**2,409**	**100**	**6**	**231**	**2,746**
Prairie Band of Potawatomi Nation	2,409	100	6	231	2,746
Idaho	**15,969**	**916**	**1,762**	**5,674**	**24,321**
Coeur D'Alene Tribe	6,444	272	1,300	3,243	11,259
Kootenai Tribe of Idaho	809	33	70	209	1,121
Nez Perce Tribe	8,716	611	392	2,222	11,941
Louisana	**1,179**	**112**	**114**	**151**	**1,556**
Chitimacha Tribe of Louisana	1,179	112	114	151	1,556
Maine	**3,233**	**197**	**156**	**868**	**4,454**
Penobscot Indian Nation	3,233	197	156	868	4,454
Massachusetts	**703**	**47**	**201**	**282**	**1,233**
Wampanoag Tribe of Gay Head	703	47	201	282	1,233
Michigan	**25,524**	**1,145**	**1,976**	**3,308**	**31,953**
Grand Traverse Band of Ottawa and Chippewa Indians	2,862	165	285	559	3,871
Keweenaw Bay Indian Community	3,409	317	746	888	5,360
Little River Band of Ottawa Indians	2,050	66	230	478	2,824
Sault Ste. Marie Tribe of Chippewa Indians	17,203	597	715	1,383	19,898
Minnesota	**20,506**	**1,167**	**2,603**	**2,429**	**26,705**
Bois Forte Band of Chippewa Indians	2,710	214	369	845	4,138
Fond du Lac Band of Lake Superior Chippewa	11,745	535	1,122	776	14,178
Mille Lacs Band of Ojibwe	4,331	361	1,096	491	6,279
Shakopee Mdewakanton Sioux Community	1,720	57	16	317	2,110

Compacts by State	IHS Services	IHS Facilities	Contract Support Costs Direct	Contract Support Costs Indirect	Total
Mississippi	**17,686**	**944**	**1,143**	**2,064**	**21,837**
Mississippi Band of Choctaw Indians	17,686	944	1,143	2,064	21,837
Montana	**20,449**	**1,398**	**1,687**	**4,405**	**27,939**
Chippewa Cree Tribe of the Rocky Boy's Reservation	10,237	692	997	2,397	14,323
Confederated Salish and Kootenai Tribes of Flathead	10,212	706	690	2,008	13,616
Nevada	**25,435**	**1,139**	**1,446**	**5,439**	**33,459**
Duck Valley Shoshone-Paiute Tribe	6,662	464	638	1,821	9,585
Duckwater Shoshone Tribe	1,181	33	184	667	2,065
Ely Shoshone Tribe	1,272	51	52	286	1,661
Las Vegas Paiute Tribe	3,307	61	110	393	3,871
Reno-Sparks Indian Colony	6,042	218	149	1,372	7,781
Washoe Tribe of Nevada and California	5,027	149	217	568	5,961
Yerington Paiute Tribe of Nevada	1,944	163	96	332	2,535
New Mexico	**15,720**	**608**	**1,113**	**1,714**	**19,155**
Pueblo of Jemez	9,517	161	889	1,328	11,895
Pueblo of Sandia	2,019	103	30	227	2,379
Taos Pueblo	4,184	344	194	159	4,881
New York	**7,936**	**430**	**295**	**1,198**	**9,859**
St. Regis Mohawk Tribe	7,936	430	295	1,198	9,859
North Carolina	**20,499**	**1,366**	**918**	**4,478**	**27,261**
Eastern Band of Cherokee Indians	20,499	1,366	918	4,478	27,261
Oklahoma	**361,573**	**35,123**	**28,261**	**63,525**	**488,482**
Absentee Shawnee Tribe of Oklahoma	17,644	1,180	1,780	4,183	24,787
Cherokee Nation	121,429	9,477	6,909	15,192	153,007
Chickasaw Nation	81,633	12,764	9,339	17,735	121,471
Choctaw Nation of Oklahoma	57,920	7,942	5,870	13,986	85,718
Citizen Potawatomi Nation	13,424	1,473	1,665	3,544	20,106
Kaw Nation	1,374	95	194	648	2,311
Kickapoo Tribe of Oklahoma	7,445	100	268	1,454	9,267
Modoc Tribe of Oklahoma	48	70	5	14	137
Muscogee (Creek) Nation	40,669	1,774	1,762	4,350	48,555
Northeastern Tribal Health System	7,154	55	141	902	8,252
Ponca Tribe of Oklahoma	3,654	54	139	372	4,219
Sac and Fox Nation	7,283	68	153	766	8,270
Wyandotte Nation	1,896	71	36	379	2,382
Oregon	**24,378**	**1,174**	**2,394**	**8,228**	**36,174**
Confederated Tribes of Coos, Lower Umpqua and Siuslaw Indians of Oregon	1,770	60	275	515	2,620
Confederated Tribes of Grand Ronde	6,430	275	509	2,433	9,647
Confederated Tribes of Siletz Indians of Oregon	7,540	301	702	2,193	10,736
Confederated Tribes of the Umatilla Reservation	6,603	447	690	2,102	9,842
Coquille Indian Tribe	2,035	91	218	985	3,329
Utah	**7,374**	**107**	**1,699**	**3,104**	**12,284**
Utah Navajo Health System, Inc.	7,374	107	1,699	3,104	12,284
Washington	**53,854**	**3,549**	**2,634**	**14,262**	**74,299**
Cowlitz Indian Tribe	3,105	132	22	679	3,938
Jamestown S'Klallam Indian Tribe	1,261	57	86	324	1,728
Kalispel Tribe of Indians	1,057	154	20	83	1,314
Lower Elwha Klallam Tribe	1,840	145	102	414	2,501
Lummi Indian Nation	7,849	645	253	2,173	10,920
Makah Indian Tribe	3,856	413	286	880	5,435
Muckleshoot Indian Tribe	7,064	263	197	0	7,524
Nisqually Indian Tribe	2,265	98	108	802	3,273
Port Gamble S'Klallam Tribe	2,550	136	134	1,341	4,161
Quinault Indian Nation	5,472	470	216	1,518	7,676
Shoalwater Bay Indian Tribe	1,766	55	276	802	2,899
Skokomish Indian Tribe	2,022	90	110	540	2,762
Squaxin Island Indian Tribe	2,687	193	194	1,357	4,431
Suquamish Tribe	1,643	71	145	672	2,531
Swinomish Indian Tribal Community	2,201	140	174	602	3,117
Tulalip Tribes of Washington	7,216	487	311	2,075	10,089
Wisconsin	**24,527**	**1,102**	**1,440**	**1,939**	**29,008**
Forest County Potawatomi Community	2,541	112	695	410	3,758
Oneida Tribe of Indians of Wisconsin	18,698	756	295	936	20,685
Stockbridge-Munsee Community	3,288	234	450	593	4,565
Grand Total	**1,333,740**	**103,974**	**106,706**	**329,453**	**1,873,873**

Area	Program Tribal Shares	Area Tribal Shares	Headquarters Tribal Shares	Contract Support Costs (Direct)	Contract Support Costs (Indirect)	Total
Alaska	519,949	13,736	10,365	48,905	148,334	**741,289**
Albuquerque	13,396	2,219	713	1,113	1,714	**19,155**
Bemidji	68,841	3,121	2,009	6,019	7,676	**87,666**
Billings	18,967	1,916	964	1,687	4,405	**27,939**
California	63,243	3,665	2,476	2,551	25,565	**97,500**
Nashville	61,376	5,483	2,103	3,857	11,802	**84,621**
Navajo	70,525	3,222	2,615	4,449	22,807	**103,618**
Oklahoma	377,986	10,803	10,416	28,267	63,756	**491,228**
Phoenix	64,072	1,764	1,929	3,068	15,230	**86,063**
Portland	90,542	5,998	3,300	6,790	28,164	**134,794**
Total, IHS	**1,348,897**	**51,927**	**36,890**	**106,706**	**329,453**	**1,873,873**