DEPARTMENT OF HEALTH AND HUMAN SERVICES

Fiscal Year

2 0 1 5

Indian Health Service

Justification of Estimates for Appropriations Committees

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Indian Health Service
Rockville MD 20852

FEB 6 2014

I am pleased to present the Indian Health Service (IHS) FY 2015 Congressional Justification. This budget request provides support for the President's and 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 2015 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 Indians 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 2015 budget request represents our efforts to sustain the Agency's valuable programs and maintain improvements made in performance measures in recent years that are essential to meeting the health care needs 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 2015 Performance Budget Submission to Congress

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Approved:
/Yvette Roubideaux/
Date: 2/7/2014

INDIAN HEALTH SERVICE

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

DEPUTY DIRECTOR FOR MANAGEMENT OPERATIONS
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DEPUTY DIRECTOR FOR FIELD OPERATIONS
Randy Grinnell

SENIOR ADVISOR TO THE DIRECTOR
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(Positions are listed in order of succession to the IHS Director)
(GA)

OFFICE OF TRIBAL SELF-GOVERNANCE
DIRECTOR
Benjamin Smith
(GAA)

OFFICE OF DIRECT SERVICE AND CONTRACTING TRIBES
DIRECTOR
Chris Buchanan
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OFFICE OF URBAN INDIAN HEALTH PROGRAMS
DIRECTOR
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OFFICE OF PUBLIC HEALTH SUPPORT
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DIRECTOR
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OFFICE OF MANAGEMENT SERVICES
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Anna Whiting Sorrell
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DIRECTOR
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DIRECTOR
John Hubbard, Jr.
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DIRECTOR
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PHOENIX AREA OFFICE
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Dorothy Dupree
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DIRECTOR
Dean Seyler
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DIRECTOR
Priscilla Whitethorne
(Acting)
(GFN)

NOTE: THE STANDARD ADMINISTRATIVE CODE IS LOCATED IN THE LOWER LEFT HAND CORNER OF EACH BOX.

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 2.1 million American Indians and Alaska Natives through a network of over 632 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. The IHS has approximately 15,393 employees, including 2,543 nurses, 789 physicians, 337 engineers, 689 pharmacists, 288 dentists, and 124 sanitarians.

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. This budget request represents the President's annual report to Congress on IHS programs and its achievement of the goals of IHCIA as required in 25 USC Sec. 1671.

INDIAN HEALTH SERVICE
Performance Budget Overview

Overview of Budget Request

Tribal Consultation – Tribal consultation is fundamental to the Indian Health Service (IHS) budget process, and at its core are the priorities and recommendations developed by Tribes through an annual budget formulation process. Urban Indian Health Programs are involved and confer in the budget formulation process. This budget request incorporates Tribal priorities and recommendations to the greatest extent possible and reflects a Tribal recommendation to prioritize Indian health care by not applying any reductions to the budget line items. The priorities and increases in this budget request help continue efforts to improve the IHS.

Summary of Request – The FY 2015 President's Budget request for IHS is $4.634 billion in budget authority, an increase of $199.7 million over the FY 2014 Enacted level. The total program level is $5.989 billion, an increase of $28 million in collections. The request includes funds to support activities identified by the Tribes as budget priorities, as follows:

- Medical Inflation: +$63 million for addressing inflationary cost increases specific to providing health care, e.g., purchase of medical supplies and pharmaceuticals, for both direct services and the Purchased/Referred Care (formerly Contract Health Services) Program. Since providing medical care is IHS' primary activity, this is an essential component to maintaining current service levels from year to year.
- Pay Costs: +$2.6 million for pay cost increases at the IHS and Tribal service delivery level.
- Additional Staffing and Operating Costs for Newly-Constructed Healthcare Facilities: +$70.8 million for three newly-constructed health care facilities and one regional youth treatment center scheduled to open in FY 2015. One of these facilities is a Joint Venture project.
- New Tribes: +$8 million to partially fund five new federally recognized Tribes, whose members are now eligible for IHS services. This includes funds for Purchased/Referred Care.
- Purchased/Referred Care (PRC): +$18 million to expand access to care through the purchase of additional medical services that are not available in IHS and Tribal facilities. This amount includes $2.6 million for new tribes and is in addition to the $32.5 million increase for PRC medical inflation mentioned above, for a total of PRC increase of $50.5 million.
- Contract Support Costs (CSC): +$29.8 million to fund the estimated CSC need-continuing FY 2014 policy.
- Adjustments over FY 2014: +$10 million to restore Hospitals & Health Clinics, Indian Health Professions, Tribal Management Grants, and Self Governance to the FY 2013 funding level.

Healthcare Facilities Construction $85 million will fund construction to complete Kayenta Health Center, Fort Yuma Health Center and the Northern California Youth Regional Treatment Center, as well as continue construction of Gila River Southeast Health Center.

Opportunity, Growth, and Security Initiative - In addition to the base Budget request, the Budget proposes the Opportunity, Growth, and Security Initiative, government-wide initiative to support both domestic and security expenditures that reflect the President's priorities to grow the economy and create opportunities. Resources for the initiative would be offset with a balanced package of spending reductions and the closing of tax loopholes. Multiple, specific HHS programs would benefit from the initiative.

The Initiative includes an additional $200 million for projects on the IHS Health Care Facilities Construction priority list. This funding would build upon the FY 2015 request of $85 million for Health Care Facilities Construction projects.

The average age of IHS facilities is over 25 years, well above the industry standard for comparable private sector facilities of 9 to 10 years. Currently IHS needs to spend additional funds to ensure facilities are safe for occupancy. This investment would decrease IHS's construction and maintenance backlogs and help ensure American Indians and Alaska Natives are receiving high-quality, state-of-the-art health care services. IHS would be able to build two to three additional health care facilities with this additional funding.

Legislative Proposals

- Provide Indian Health Service Health Professions Scholarship Program and Health Professions Loan Repayment Program with a Tax Exemption: This proposal would decrease the tax burden for struggling students and give IHS the ability to fund an estimate of 105 new loan repayment awards (at average 2-year award of $52,000) to attract more potential participants as a recruitment and retention tool. IHS, as a rural healthcare provider, has difficulty recruiting healthcare professionals. There are over 1,550 vacancies for healthcare professionals (physicians, dentists, nurses, pharmacists, physician assistants, nurse practitioners) across the IHS health system.

- Special Diabetes Program for Indians (SPDI) Reauthorization: $150 million to reauthorize the successful prevention and treatment program. The FY 2015 request includes a proposal for a three-year reauthorization to continue to address the ongoing epidemic of diabetes complications and reverse the increasing incidence of diabetes through primary prevention in AI/AN communities.

- Medicare-Like Rates for Nonhospital and Physician/Non-physician Services to permit IHS, Tribes, tribal Organizations, or IHS-funded programs operated by Urban Indian organization to pay Medicare rates for outpatient services funded through Purchased/Referred Care (PRC) program. Since 2007, IHS's PRC program has had the authority to pay "Medicare-like" rates for referred in-patient services furnished by Medicare-participating hospitals. This proposal expands these rates 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 Medicare-Like Rate cap is a budget-neutral mechanism that will allow IHS and Tribal facilities to save millions of dollars and increase the care they are able to provide through the PRC program.

Overview of Performance

Priority Setting –To help the IHS undertake its mission and strategic goals, four priorities were established to guide the Agency's work and to address input from key stakeholders on areas of greatest interest for improvement. The IHS 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. IHS uses the four Agency priorities as a strategic framework for progress on agency reforms.

The IHS has managed agency performance since 2005 through an Agency performance plan, updated annually, that cascades performance goals and objectives and performance-related metrics agency wide. In 2010, IHS strengthened its performance management process to enhance

employee focus on Agency priorities with specific measures that were cascaded from senior executive performance plans to managers to supervisors and into employee plans. This enhanced plan ensures that performance of all employees relates their job duties to progress on Agency priorities. Along with the four priorities, a fifth critical program objective on improving customer service was added to the Agency performance plan in FY 2011. The four priorities will remain the same through FY 2015.

Progress Reviews – Measuring progress, communicating progress and problems, and being open about the challenges to advancement are important to performance management. The IHS uses an internally-developed technological performance management tool, the Executive Performance Management System (EPMS), to review Agency-wide progress in meeting the performance measures on each critical element and sub-elements within the Agency performance plan. The EPMS is a secure electronic reporting and tracking tool that includes capability for monitoring progress and for producing narrative, dashboard, and rollup reports. The system provides an input field for senior executives to enter quarterly progress narratives for documenting achievements and/or describing how challenges were addressed in meeting performance elements and sub-elements. In addition, the EPMS provides senior executives a status menu to designate progress on meeting the performance measures, which produces a dashboard report.

Internal Agency Review – Agency leadership periodically reviews progress in meeting the Agency performance plan measures and holds regular discussions with senior executives. Accountability for each performance plan element is clearly communicated at the start of the performance cycle and progress reviews are conducted at least biannually. Discussions about progress on the Agency priorities are part of regular leadership meetings, such as the Headquarters monthly general staff meetings, the bi-monthly teleconference with IHS executives, Area Directors' meetings, and weekly senior staff meetings. Cascading performance plan elements linked directly to Agency priorities to employees holds them accountable for performing their work duties, holds supervisors accountable for the quality of the work, and holds managers and executives responsible for performance results and for taking corrective actions. The connection between performance measures and employee accountability contributes to the 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. In addition, the IHS Director provides monthly reports to the HHS Secretary, which includes progress on the Agency priorities.

IHS Priorities and the HHS Strategic Plan – Each agency priority and broad program performance objective aligns to and directly contributes to the Department's goals and priorities established in the HHS Strategic Plan for Fiscal Years 2010-2015 and the Secretary's top priorities and approved budget. Specifically, all four Agency priorities align to the HHS Strategic Plan Goal 1, Strengthen Health Care, and to several of the Goal's objectives. The IHS quality and access to care priority area also aligns to Goal 5, Strengthen the Nation's Health and Human Service Infrastructure and Workforce. The transparency and accountability priority area also aligns to Goal 4, Increase Efficiency, Transparency, and Accountability of HHS programs. When the new HHS Strategic Plan for Fiscal Years 2014-2018 is published in March 2014, the Goal references above will be updated. Therefore, the IHS shares in the Secretary's future-oriented priority setting, definition of success, and action planning through its Agency priorities and the Agency program performance plan. The IHS has two performance measures, tribal consultation and depression screening, in the HHS Strategic Plan. Both were selected because tribal consultation and mental health issues are top Tribal priorities.

FY 2014 HHS Priority Goals – The FY 2014 HHS Priority Goals link to goals and objectives in the HHS Strategic Plan and IHS participates in regular HHS reviews of progress on these goals. Reviews include quarterly reporting and face-to-face quarterly review meetings to provide an opportunity for Goal Owners and Goal Partners and Contributors and HHS leaders to discuss performance around the HHS Priority Goals.

The IHS partners with six other HHS Operating Divisions and the Office of the Assistant Secretary for Health on the HHS's Combustible Tobacco Use Goal: *By December 31, 2015, reduce annual adult' combustible tobacco consumption in the U.S. from 1,174 cigarettes equivalents per capita, which will represent a 12 percent decrease from the 2012 baseline.*

Tobacco Cessation is an IHS-wide budget performance measure. The IHS collects data through the IHS Clinical Reporting System (CRS) on this budget measure and others and holds regular teleconferences with the 12 IHS Area Government Performance and Results Act (GPRA) coordinators to discuss the status of this measure and to share best practices and ways to address challenges in achieving targets. The FY 2015 target is that 45.2 percent of smokers either quit smoking or will be offered tobacco cessation intervention strategies.

The IHS is also a contributor to another HHS Priority Goal: Health Information Technology (IT): *Improve healthcare through meaningful use (MU) of health IT*. Key Outcome Indicators for this Goal relate to incentive payments from the Centers for Medicare and Medicaid Services (CMS). Internally, IHS contributes to Electronic Health Record (EHR) certification and MU by maintaining certification and by working toward development for 2014 certification. The IHS is tracking the status of MU payments to eligible professionals in Indian Country. As of July 2013, 1819 eligible professionals from IHS, Tribal, and Urban Indian health programs have registered with CMS, and 931 eligible professionals have received CMS EHR Incentive payments. IHS facilities have received $11.8 million in incentive payments for these providers, and Tribal/Urban programs have received $19 million. Also as of July 2013, 26 IHS hospitals have received a total of $35 million from the Medicare and Medicaid incentive programs, and an additional 14 Tribal hospitals that use the IHS Resource and Patient Management System have received $17.8 million. The IHS Senior Staff meets face-to-face with the IHS Chief Information Officer monthly to review IHS' progress, and IHS Area Directors report monthly to the IHS senior staff on incentive payments received in the Areas.

IHS Performance Goals - The IHS has three internal key performance goals that link to the goals and objectives in the HHS Strategic Plan. Leadership focus on the three performance goals produced notable accomplishments in FY 2013. The first performance goal is linked to the first IHS priority: To renew and strengthen the Agency's partnership with Tribes. The IHS has an annual performance goal to implement three Tribal recommendations to improve the Tribal consultation process. As of September 30, 2013, the IHS has implemented a total of fifteen recommendations from tribes to improve the tribal consultation process. Among these accomplishments IHS counts the annual Tribal Consultation Summits, first introduced in July 2011, where Tribes learned about current Agency consultation activities in a "one stop shop" event. The IHS has been consulting with Tribes on numerous issues, including improving the Purchased/Referred Care (formerly Contract Health Services) Program. For example, Tribal consultation on this issue has resulted in the accomplishment of significant work through a Tribal workgroup on improving the Purchased/Referred Care Program that resulted in recommendations and sharing of best practices that will improve management of IHS operated Purchased/Referred Care programs and third-party collections. In general, consultations result in better decisions for the future of IHS and help to improve patient care.

A second performance goal is related to recruitment and retention of health care providers. The IHS and the Health Resources and Services Administration (HRSA) worked collaboratively to pre-approve all Indian health system sites for participation in the National Health Service Corp (NHSC), a result that far exceeded the original 10 percent increase target for FY 2011. Site eligibility places Indian health program facilities on the lists of pre-qualified facilities for NHSC placements sent to NHSC loan repayment and scholarship recipients. In FY 2013, Indian health programs had 600 active sites (IHS federal, tribally-operated sites, and urban Indian health clinics plus dual-funded tribal health clinics), and the NHSC programs (Loan Replacement and Scholarships) had placed over 300 clinicians/ providers. Progress is tracked on a monthly basis.

Another performance goal was to improve hiring times. The IHS has made available Agency-wide, standardized position descriptions in commonly recruited job series and the IHS has improved the effectiveness of the on-line application process. The FY 2013 performance goal for IHS executives across the IHS is to have an IHS average overall hiring time of fewer than 80 days.

HHS GPRAMA Performance Plan Measures – The IHS has six performance measures approved by HHS for inclusion within the HHS Performance Plan for FY 2015. The representative set of measures and their FY 2015 targets are:

a. 100 percent of hospitals and outpatient clinics operated by the IHS maintain accreditation.
b. 47.7 percent of American Indian and Alaska Native patients with diagnosed diabetes achieve good glycemic control.
c. 64.3 percent of adults 18 and older are screened for depression in IHS-funded clinical facilities per year.
d. To implement at least three recommendations from tribes annually to improve the tribal consultation process.
e. 46.1 percent of American Indian and Alaska Native patients, 22 years and older, with Coronary Heart Disease are assessed for five cardiovascular disease risk factors.
f. 73.9 percent of 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.

These measures are included in the set of measures within the HHS Performance Plan to meet the formal reporting requirements for the GPRA Modernization Act of 2010 (GPRAMA). All of the measures align to the HHS Strategic Plan for Fiscal Years 2014-2018.

Agency Performance Accomplishments and Challenges – In 2013, IHS met all of its clinical GPRA measures for the second time in the history of the Agency. This success in clinical performance measurement relates to the IHS' Agency-wide, coordinated focus on performance improvement that links specific Agency priorities to a performance plan containing specific measures that guide action and reform, from leadership in IHS headquarters and Area Offices to local Service Unit employees. Other reforms, including the IHS Improving Patient Care Initiative that is implementing the patient centered medical home model, indicate a transition in IHS to more continuous quality improvement and a greater focus on evaluation and improvement focused on measurable results. These preventive health approaches demonstrate the IHS' commitment to targeting measures via performance management.

The IHS performance improvement requires a concerted effort by all members of the Indian health system. This includes all clinic-, hospital- and community-based programs, as well as federal, tribal, and urban programs, working together to improve agency performance on the comprehensive set of existing performance measures. The IHS will continue to encourage and

evaluate culture-based prevention and interventions/modalities addressing the persistent health disparities facing the American Indian and Alaska Native population.

Despite complex, ongoing challenges, the Agency has made significant progress on some important indicators of health and clinical care. Early identification of diabetes and improved diabetes management has helped prevent or delay the need for renal dialysis and transplant. Nephropathy (kidney disease) assessment is an essential diabetes management component. The agency has been measuring nephropathy assessment rates since it began reporting GPRA rates in FY 2002. Nephropathy assessments increased a relative 36.4 percent between FY 2008 and FY 2013. Such efforts support the President's stated goals of investing in prevention, wellness, and improving the quality of care. In FY 2014 the nephropathy performance measure logic will be reprogrammed to conform to revised clinical standards of care for nephropathy screening. Since the Indian Health Service provides clinical services at the individual patient level, it is important that clinical performance measures are also updated to reflect new standards of care.

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 thirteenth year of reporting electronic performance results for GPRA/GPRAMA clinical measures from our Clinical Reporting System (CRS) software module, within the IHS Resource and Patient Management System (RPMS). 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.

As reported in the FY 2014 Congressional Justification, the IHS successfully completed a pilot demonstration of the ability to produce aggregated, clinical performance measures from the National Data Warehouse (NDW). The Office of Information Technology will complete the programming of the remaining clinical GPRA/GPRAMA measures and expand the architecture of the National Patient Information Reporting System (NPIRS), a data mart within the NDW, so that the clinical data elements needed to calculate measure results will be available. This new national performance data mart will produce results based on the User Population that reflect the IHS funding methodology. 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 twelve Area 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.

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. The HHS Measurement Policy Council has been meeting since 2012 to align core performance measures around specific domains. For instance, the National Quality Strategy (NQS) developed the Million Hearts Initiative to represent the NQS's 4th priority: "Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease." The blood pressure control performance measure for the "B" of Million Hearts ABCs has been programmed into CRS and added to the IHS clinical GPRA measure set for 2014. 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 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 developing a new, more efficient way to program performance measures in a centralized location for national performance reporting. The Agency is working as part of the MPC team to determine core measures for various health and medical conditions; when newly developed measures support the needs of our AI/AN population, IHS will use those measures for reporting in our annual budget.

All Purpose Table
Indian Health Service
(Dollars in Thousands)

Feb 7, 2014

Program	FY 2013 Enacted	FY 2014 Enacted	FY 2015 Presidents Budget	FY 2015 +/- FY 2014 Enacted
SERVICES				
Hospitals & Health Clinics	1,749,072	1,790,904	1,862,501	71,597
Dental Services	156,653	165,290	175,654	10,364
Mental Health	74,131	77,980	82,025	4,045
Alcohol & Substance Abuse	185,154	186,378	193,824	7,446
Purchased/Referred Care	801,258	878,575	929,041	50,466
Total, Clinical Services	2,966,268	3,099,127	3,243,045	143,918
Public Health Nursing	66,282	70,909	76,353	5,444
Health Education	16,552	17,001	18,263	1,262
Community Health Representatives	58,304	58,345	59,386	1,041
Immunization AK	1,826	1,826	1,855	29
Total, Preventive Health	142,963	148,081	155,857	7,776
Urban Health	40,729	40,729	41,375	646
Indian Health Professions	38,467	33,466	38,466	5,000
Tribal Management Grants	2,442	1,442	2,442	1,000
Direct Operations	67,894	67,894	68,065	171
Self-Governance	5,727	4,727	5,727	1,000
Contract Support Costs	447,788	587,376	617,205	29,829
Total, Other Services	603,047	735,634	773,280	37,646
TOTAL, SERVICES	3,712,278	3,982,842	4,172,182	189,340
FACILITIES				
Maintenance & Improvement	50,919	53,614	53,614	0
Sanitation Facilities Construction	75,431	79,423	79,423	0
Health Care Facilities Construction	77,238	85,048	85,048	0
Facilities & Environmental Health Support	193,578	211,051	220,585	9,534
Equipment	21,404	22,537	23,325	788
TOTAL, FACILITIES	418,570	451,673	461,995	10,322
TOTAL, BUDGET AUTHORITY	**4,130,847**	**4,434,515**	**4,634,177**	199,662
COLLECTIONS / MANDATORY				
Medicare	215,647	217,348	217,348	0
Medicaid	719,792	828,310	850,310	22,000
Subtotal, M / M	*935,439*	*1,045,658*	*1,067,658*	*22,000*
Private Insurance	85,303	90,303	90,303	0
VA Reimbursement*	341	36,000	39,000	3,000
Total, M / M / PI	*1,021,083*	*1,171,961*	*1,196,961*	*25,000*
Quarters	8,000	8,000	8,000	0
TOTAL, COLLECTIONS	1,029,083	1,179,961	1,204,961	25,000
Special Diabetes Program for Indians	147,000	147,000	150,000	3,000
TOTAL, MANDATORY	147,000	147,000	150,000	3,000
TOTAL, PROGRAM LEVEL	**5,306,930**	**5,761,476**	**5,989,138**	227,662

* The FY 2014 President's Budget estimated VA Reimbursements at $52 million for federal and tribal reimbursements. Estimates are revised to $36 million for FY 2014 and $39 million for FY 2015 for federal and tribal reimbursements. The FY 2013 and FY 2014 actual federal collections to date may be an indication that the FY 2014 and FY 2015 collections are overestimated and future year estimates will need to be adjusted accordingly.

Detail of Changes
Indian Health Service

(Dollars in Thousands)

Feb 28, 2014

Program	FY 2013 Final	FY 2014 Enacted	Current Services: Adjustments [1]	Current Services: Medical Inflation	Current Services: Pay Costs	Current Services: Staffing for New Facilities	Current Services Subtotal	Increases: New Tribes	Increases: Program Increase	Increases Subtotal	FY 2015 Presidents Budget	FY 2015 +/- FY 2014 Enacted
SERVICES												
Hospitals & Health Clinics	1,749,072	1,790,904	3,000	20,836	2,572	41,605	68,013	3,584	0	3,584	1,862,501	71,597
Dental Services	156,653	165,290	0	1,672	0	8,224	9,896	468	0	468	175,654	10,364
Mental Health	74,131	77,980	0	880	0	2,846	3,726	319	0	319	82,025	4,045
Alcohol & Substance Abuse	185,154	186,378	0	2,843	0	4,314	7,157	289	0	289	193,824	7,446
Purchased/Referred Care	801,258	878,575	0	32,466	0	0	32,466	2,572	15,428	18,000	929,041	50,466
Total, Clinical Services	2,966,268	3,099,127	3,000	58,697	2,572	56,989	121,258	7,232	15,428	22,660	3,243,045	143,918
Public Health Nursing	66,282	70,909	0	713	0	4,474	5,187	257	0	257	76,353	5,444
Health Education	16,552	17,001	0	237	0	861	1,098	164	0	164	18,263	1,262
Community Health Representatives	58,304	58,345	0	917	0	0	917	124	0	124	59,386	1,041
Immunization AK	1,826	1,826	0	29	0	0	29	0	0	0	1,855	29
Total, Preventive Health	142,963	148,081	0	1,896	0	5,335	7,231	545	0	545	155,857	7,776
Urban Health	40,729	40,729	0	646	0	0	646	0	0	0	41,375	646
Indian Health Professions	38,467	33,466	5,000	0	0	0	5,000	0	0	0	38,466	5,000
Tribal Management Grants	2,442	1,442	1,000	0	0	0	1,000	0	0	0	2,442	1,000
Direct Operations	67,894	67,894	0	0	0	0		171	0	171	68,065	171
Self-Governance	5,727	4,727	1,000	0	0	0	1,000	0	0	0	5,727	1,000
Contract Support Costs	447,788	587,376	0	0	0	0		0	29,829	29,829	617,205	29,829
Total, Other Services	603,047	735,634	7,000	646		0	7,646	171	29,829	30,000	773,280	37,646
TOTAL, SERVICES	3,712,278	3,982,842	10,000	61,239	2,572	62,324	136,135	7,948	45,257	53,205	4,172,182	189,340
FACILITIES												
Maintenance & Improvement	50,919	53,614	0	0	0	0	0	0	0	0	53,614	0
Sanitation Facilities Construction	75,431	79,423	0	0	0	0	0	0	0	0	79,423	0
Health Care Facilities Construction	77,238	85,048	0	0	0	0	0	0	0	0	85,048	0
Facilities & Environmental Health Support	193,578	211,051	0	973	0	8,494	9,467	67	0	67	220,585	9,534
Equipment	21,404	22,537	0	788	0	0	788	0	0	0	23,325	788
TOTAL, FACILITIES	418,570	451,673		1,761	0	8,494	10,255	67	0	67	461,995	10,322
TOTAL, BUDGET AUTHORITY	**4,130,847**	**4,434,515**	**10,000**	**63,000**	**2,572**	**70,818**	**146,390**	**8,015**	**45,257**	**53,272**	**4,634,177**	**199,662**

[1] In order to fully fund estimated Contract Support Costs in FY 2014, IHS reduced funding for the Director's Emergency Fund, Tribal Management Grants, Self-Governance, and the Indian Health Professions program. The FY 2015 Budget restores these cuts so that these programs reflect FY 2013 funding levels.

INDIAN HEALTH SERVICE

ADDITIONAL STAFFING AND OPERATING COSTS FOR NEWLY-CONSTRUCTED HEALTHCARE FACILITIES -- Estimates

FY 2015 Budget Request

(Dollars in Thousands)

Revised Jan 30, 2014

	San Carlos, AZ		Hemet, CA		Choctaw, MS		Kayenta, AZ				
	San Carlos Health Care Center		Southern California Youth Treatment Center		Choctaw Alternative Rural Healthcare Center (JV)		Kayenta Alternative Rural Healthcare Center		TOTAL		
Sub Sub Activity	FTE	Amount	Pos	Amount	Pos	Amount	FTE	Amount	**FTE**	**Pos**	**AMOUNT**
Hospitals & Health Clinics	173	$17,646	0	$0	73	$7,708	152	$16,251	325	73	$41,605
Dental Health	33	$3,072	0	$0	15	$1,504	35	$3,648	68	15	$8,224
Mental Health	14	$1,340	0	$0	4	$339	12	$1,167	26	4	$2,846
Alcohol & Substance Abuse	8	$750	33	$2,888	0	$0	7	$676	15	33	$4,314
Total, Clinical Services	228	$22,808	33	$2,888	92	$9,551	206	$21,742	434	125	$56,989
Public Health Nursing	14	$1,708	0	$0	3	$379	19	$2,387	33	3	$4,474
Health Education	3	$281	0	$0	1	$97	5	$483	8	1	$861
Total, Preventive Health	17	$1,989	0	$0	4	$476	24	$2,870	41	4	$5,335
Total, Services	245	$24,797	33	$2,888	96	$10,027	230	$24,612	475	129	$62,324
Facilities Support	17	$2,509	2	$312	5	$931	20	$3,093	37	7	$6,845
Environmental Health Support	8	$1,089	0	$0	0	$0	4	$560	12	0	$1,649
Total, FEHS	25	$3,598	2	$312	5	$931	24	$3,653	49	7	$8,494
Total, Facilities	25	$3,598	2	$312	5	$931	24	$3,653	49	7	$8,494
Grand Total [1]	**270**	**$28,395**	**35**	**$3,200**	**101**	**$10,958**	**254**	**$28,265**	**524**	**136**	**$70,818**

[1] Includes utilities

Note: These estimates reflect new facilities anticipated to open in FY 2015.

Workload Projection	San Carlos, AZ	Hemet, CA*	Choctaw, MS	Kayenta, AZ	**TOTAL**
Inpatient Days	1,745	0	1,139	4,142	**7,026**
Outpatient Visits	98,963	0	84,202	102,196	**285,361**
User Population (est.)	12,675	0	11,068	19,017	**42,760**

(Dollars in Thousands)

Capital Invested (est.)					**TOTAL**
Tribes	$0	$0	$55,021	$0	**$55,021**
Federal Government	$116,000	$0	$0	$150,000	**$150,000**

* Workload projections for youth regional treatment centers are calculated differently than the medical facilities. The new facility in Hement, CA will have 32 beds for routine general residential treatment and 6 beds for a close observation unit for youth.

Statement of Personnel Resources
INDIAN HEALTH SERVICE

	FY 2013 Final	FY 2014 Enacted	FY 2015 Request
Direct:			
Hospitals & Health Clinics	6,495	6,638	6,686
Dental Health	684	712	747
Mental Health	205	218	231
Alcohol & Substance Abuse	195	200	208
Purchased/Referred Care	0	0	0
Total, Clinical Services	7,579	7,768	7,872
Public Health Nursing	227	239	256
Health Education	24	25	29
Community Health Reps	5	5	5
Immunization, AK	0	0	0
Total, Preventive Health	256	269	290
Urban Health	5	5	5
Indian Health Professions	22	22	22
Tribal Management	0	0	0
Direct Operations	280	280	280
Self Governance	11	11	11
Contract Support Costs	0	0	0
Total, SERVICES	8,153	8,355	8,480
Maint. & Improvement	0	0	0
Sanitation Facilities	195	195	195
Hlth Care Facs Construction	0	0	0
Facil. & Envir. Hlth Support	1,013	1,028	1,053
Facilities Support	384	396	415
Environ. Hlth. Support	561	564	570
OEHE Support	68	68	68
Equipment	0	0	0
Total, FACILITIES	1,208	1,223	1,248
Total, Direct FTE	9,361	9,578	9,728
Reimbursable:			
Buybacks	1,322	1,322	1,322
Medicare	753	753	753
Medicaid	3,383	3,383	3,383
Private Insurance	522	522	522
Quarters	29	29	29
Total, Reimbursable FTE	6,009	6,009	6,009
Trust Funds (Gift)	23	23	23
Health Reform non -add:	0	0	0
TOTAL FTE	**15,393**	**15,610**	**15,760**
Total, Civilian FTE	**13,310**	**13,518**	**13,673**
Total, Military FTE	**2,083**	**2,092**	**2,087**

Indian Health Service

Breakdown of Program Level

(Dollars in Thousands)

Feb 9, 2014

Sub Sub Activity	2013 Final Budget Authority	2013 Final Veterans Affairs*	2013 Final Private Insurance Collections	2013 Final Medicare/ Medicaid	2013 Final Personnel Quarters	2013 Final Total Program Level	2014 Enacted Budget Authority	2014 Enacted VA Reimb.	2014 Enacted Private Insurance Collections	2014 Enacted Medicare/ Medicaid	2014 Enacted Personnel Quarters	2014 Enacted Total Program Level
SERVICES:												
Hospitals & Health Clinics	1,749,072	341	85,303	935,439 [2/]	0	2,770,155	1,790,904	36,000	90,303	1,045,658 [2/]	0	2,962,865
Dental Health	156,653	0	0	0	0	156,653	165,290	0	0	0	0	165,290
Mental Health	74,131	0	0	0	0	74,131	77,980	0	0	0	0	77,980
Alcohol & Substance Abuse	185,154	0	0	0	0	185,154	186,378	0	0	0	0	186,378
Purchased/Referred Care	801,258	0	0	0		801,258	878,575	0	0	0	0	878,575
Total, Clinical Services	2,966,268	341	85,303	935,439	0	3,987,351	3,099,127	36,000	90,303	1,045,658	0	4,271,088
Public Health Nursing	66,282	0	0	0	0	66,282	70,909	0	0	0	0	70,909
Health Education	16,552	0	0	0	0	16,552	17,001	0	0	0	0	17,001
Comm. Health Reps.	58,304	0	0	0	0	58,304	58,345	0	0	0	0	58,345
Immunization AK	1,826	0	0	0	0	1,826	1,826	0	0	0	0	1,826
Total, Preventive Health	142,963	0	0	0	0	142,963	148,081	0	0	0	0	148,081
Urban Health	40,729	0	0	0	0	40,729	40,729	0	0	0	0	40,729
Indian Health Professions	38,467	0	0	0	0	38,467	33,466	0	0	0	0	33,466
Tribal Management	2,442	0	0	0	0	2,442	1,442	0	0	0	0	1,442
Direct Operations	67,894	0	0	0	0	67,894	67,894	0	0	0	0	67,894
Self-Governance	5,727	0	0	0	0	5,727	4,727	0	0	0	0	4,727
Contract Support Costs	447,788	0	0	0	0	447,788	587,376	0	0	0	0	587,376
Total, Other Services	603,047	0	0	0	0	603,047	735,634	0	0	0	0	735,634
TOTAL, SERVICES	3,712,278	341	85,303	935,439	0	4,733,361	3,982,842	36,000	90,303	1,045,658	0	5,154,803
FACILITIES:												
Maintenance & Improvement	50,919	0	0	0	8,000	58,919	53,614	0	0	0	8,000	61,614
Sanitation Facilities Construction	75,431	0	0	0	0	75,431	79,423	0	0	0	0	79,423
Health Care Facs. Constr.	77,238	0	0	0	0	77,238	85,048	0	0	0	0	85,048
Facil. & Envir. Health Support	193,578	0	0	0	0	193,578	211,051	0	0	0	0	211,051
Equipment	21,404	0	0	0	0	21,404	22,537	0	0	0	0	22,537
TOTAL, FACILITIES	418,570	0	0	0	8,000	426,570	451,673	0	0	0	8,000	459,673
TOTAL, IHS	4,130,847	341	85,303	935,439	8,000	5,159,930	4,434,515	36,000	90,303	1,045,658	8,000	5,614,476
Special Diabetes Program for Indians [1/]	147,000	0	0	0	0	147,000	147,000	0	0	0	0	147,000
GRAND TOTAL	4,277,847	341	85,303	935,439	8,000	5,306,930	4,581,515	36,000	90,303	1,045,658	8,000	5,761,476

*The FY 2014 President's Budget estimated VA Reimbursements at $52 million for federal and tribal reimbursements. Estimates are revised to $36 million for FY 2014 and $39 million for FY 2015 for federal and tribal reimbursements. The FY 2013 and FY 2014 actual federal collections to date may be an indication that the FY 2014 and FY 2015 collections are overestimated and future year estimates will need to be adjusted accordingly.

[1/] The Special Diabetes Program for Indians is $147,000,000 in FY 2013.

[2/] Includes $29,203,000 in Medicaid/Medicare for CMS estimates of tribal collections and $181,477,000 in FY 2013 and $198,710,000 in FY 2014 for tribal direct collection estimates, which began in FY 2002.

Indian Health Service

Breakdown of Program Level

(Dollars in Thousands)

Feb 9, 2014

Sub Sub Activity	2015 Request: Budget Authority	Veteran's Affairs*	Private Insurance Collections	Medicare/ Medicaid	Personnel Quarters	Total Program Level	Increase/Decrease of 2015 Over 2014: Budget Authority	VA Reimb.	Private Insurance Collections	Medicare/ Medicaid	Personnel Quarters	Total Program Level
SERVICES:												
Hospitals & Health Clinics	1,862,501	39,000	90,303	1,067,658 [2/]	0	3,059,462	71,597	3,000	0	22,000	0	96,597
Dental Health	175,654	0	0	0	0	175,654	10,364	0	0	0	0	10,364
Mental Health	82,025	0	0	0	0	82,025	4,045	0	0	0	0	4,045
Alcohol & Substance Abuse	193,824	0	0	0	0	193,824	7,446	0	0	0	0	7,446
Purchased/Referred Care	929,041	0	0	0	0	929,041	50,466	0	0	0	0	50,466
Total, Clinical Services	3,243,045	39,000	90,303	1,067,658	0	4,440,006	143,918	3,000	0	22,000	0	168,918
Public Health Nursing	76,353	0	0	0	0	76,353	5,444	0	0	0	0	5,444
Health Education	18,263	0	0	0	0	18,263	1,262	0	0	0	0	1,262
Comm. Health Reps.	59,386	0	0	0	0	59,386	1,041	0	0	0	0	1,041
Immunization AK	1,855	0	0	0	0	1,855	29	0	0	0	0	29
Total, Preventive Health	155,857	0	0	0	0	155,857	7,776	0	0	0	0	7,776
Urban Health	41,375	0	0	0	0	41,375	646	0	0	0	0	646
Indian Health Professions	38,466	0	0	0	0	38,466	5,000	0	0	0	0	5,000
Tribal Management	2,442	0	0	0	0	2,442	1,000	0	0	0	0	1,000
Direct Operations	68,065	0	0	0	0	68,065	171	0	0	0	0	171
Self-Governance	5,727	0	0	0	0	5,727	1,000	0	0	0	0	1,000
Contract Support Costs	617,205	0	0	0	0	617,205	29,829	0	0	0	0	29,829
Total, Other Services	773,280	0	0	0	0	773,280	37,646	0	0	0	0	37,646
TOTAL, SERVICES	4,172,182	39,000	90,303	1,067,658	0	5,369,143	189,340	3,000	0	22,000	0	214,340
FACILITIES:												
Maintenance & Improvement	53,614	0	0	0	8,000	61,614	0	0	0	0	0	0
Sanitation Facilities Construction	79,423	0	0	0	0	79,423	0	0	0	0	0	0
Health Care Facs. Constr.	85,048	0	0	0	0	85,048	0	0	0	0	0	0
Facil. & Envir. Health Support	220,585	0	0	0	0	220,585	9,534	0	0	0	0	9,534
Equipment	23,325	0	0	0	0	23,325	788	0	0	0	0	788
TOTAL, FACILITIES	461,995	0	0	0	8,000	469,995	10,322	0	0	0	0	10,322
TOTAL, IHS	4,634,177	39,000	90,303	1,067,658	8,000	5,839,138	199,662	3,000	0	22,000	0	224,662
Special Diabetes Program for Indians [1/]	150,000	0	0	0	0	150,000	3,000	0	0	0	0	3,000
GRAND TOTAL	4,784,177	39,000	90,303	1,067,658	8,000	5,989,138	202,662	3,000	0	22,000	0	227,662

*The FY 2014 President's Budget estimated VA Reimbursements at $52 million for federal and tribal reimbursements. Estimates are revised to $36 million for FY 2014 and $39 million for FY 2015 for federal and tribal reimbursements. The FY 2013 and FY 2014 actual collections to date may be an indication that the FY 2014 and FY 2015 federal collections are overestimated and future year estimates will need to be adjusted accordingly.

[1/] The Special Diabetes Program for Indians is reauthorized for a total of $150,000,000 in FY 2015.

[2/] Includes $29,203,000 in Medicaid/Medicare for CMS estimates of tribal collections and $202,708,000 in FY 2015 for tribal direct collection estimates, which began in FY 2002.

FY 2013 Crosswalk
Budget Authority
Estimated Distribution
(Dollars in Thousands)

Sub Activity	Federal Health Administration								Tribal Health Administration								
	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	FY 2013 Estimate
SERVICES																	
Hospitals & Health Clinics	773,130	0	0	0	0	0	0	773,130	975,942	0	0	0	0	0	0	975,942	1,749,072
Dental Health	65,990	0	0	0	0	0	0	65,990	90,663	0	0	0	0	0	0	90,663	156,653
Mental Health	27,271	0	0	0	0	0	0	27,271	46,860	0	0	0	0	0	0	46,860	74,131
Alcohol & Substance Abuse	40,013	0	0	0	0	0	0	40,013	145,141	0	0	0	0	0	0	145,141	185,154
Purchased/Referred Care	371,201	0	0	0	0	0	0	371,201	430,057	0	0	0	0	0	0	430,057	801,258
Subtotal (CS)	1,277,605	0	0	0	0	0	0	1,277,605	1,688,663	0	0	0	0	0	0	1,688,663	2,966,268
Public Health Nursing	0	0	25,751	0	0	0	0	25,751	0	40,531	0	0	0	0	0	40,531	66,282
Health Education	0	0	3,993	0	0	0	0	3,993	0	12,559	0	0	0	0	0	12,559	16,552
Community Health Repr.	0	0	4,216	0	0	0	0	4,216	0	54,088	0	0	0	0	0	54,088	58,304
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		0	0	0	0	33,960	0	109,004	0	0	0	0	0	109,003	142,963
Urban Health Project	0	16,084	0	0	0	0	0	16,084	0	0	24,645	0	0	0	0	24,645	40,729
Indian Health Professions	0	0	0	38,467	0	0	0	38,467	0	0	0	0	0	0	0	0	38,467
Tribal Management	0	0	0	159	0	0	0	159	0	0	0	2,283	0	0	0	2,283	2,442
Direct Operations	0	0	0	0	52,728	0	0	52,728	0	0	0	15,166	0	0	0	15,166	67,894
Self-Governance	0	0	0	0	0	3,782	0	3,782	0	0	0	0	1,945	0	0	1,945	5,727
Contract Support Costs	0	0	0	0	0	0	0	0	0	0	0	0	0	447,788	0	447,788	447,788
Subtotal (OS)	0	16,084	0	38,626	52,728	3,782	0	111,221	0	0	24,645	17,449	1,945	447,788	0	491,826	603,047
Total, Services	1,277,605	16,084	0	38,626	52,728	3,782	0	1,422,786	1,688,663	109,004	24,645	17,449	1,945	447,788	0	2,289,492	3,712,278
FACILITIES																	
Maintenance & Improvement	0	0	0	0	0	0	21,993	21,993	0	0	0	0	0	0	28,926	28,926	50,919
Sanitation Facilities Constr.	0	0	0	0	0	0	26,401	26,401	0	0	0	0	0	0	49,030	49,030	75,431
Health Care Facs. Constr.	0	0	0	0	0	0	35,749	35,749	0	0	0	0	0	0	41,489	41,489	77,238
Facs. & Env. Health Sup	0	0	0	0	0	0	101,859	101,859	0	0	0	0	0	0	91,719	91,719	193,578
Equipment	0	0	0	0	0	0	5,343	5,343	0	0	0	0	0	0	16,061	16,061	21,404
Total, Facilities	0	0	0	0	0	0	191,345	191,345	0	0	0	0	0	0	227,225	227,225	418,570
TOTAL, IHS	1,277,605	16,084	0	38,626	52,728	3,782	191,345	1,614,131	1,688,663	109,004	24,645	17,449	1,945	447,788	227,225	2,516,716	4,130,847
% Federal Health Admin.								39.1%									
% Tribal and Urban Health Admin.																	60.9%

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

Sub Activity	Federal Health Administration								Tribal Health Administration								
	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	FY 2014 Estimate
SERVICES																	
Hospitals & Health Clinics	770,130	0	0	0	0	0	0	770,130	1,020,774	0	0	0	0	0	0	1,020,774	1,790,904
Dental Health	65,990	0	0	0	0	0	0	65,990	99,300	0	0	0	0	0	0	99,300	165,290
Mental Health	27,271	0	0	0	0	0	0	27,271	50,709	0	0	0	0	0	0	50,709	77,980
Alcohol & Substance Abuse	40,013	0	0	0	0	0	0	40,013	146,365	0	0	0	0	0	0	146,365	186,378
Purchased/Referred Care	387,903	0	0	0	0	0	0	387,903	490,672	0	0	0	0	0	0	490,672	878,575
Subtotal (CS)	1,291,307	0	0	0	0	0	0	1,291,307	1,807,820	0	0	0	0	0	0	1,807,820	3,099,127
Public Health Nursing	0	0	25,751	0	0	0	0	25,751	0	45,158	0	0	0	0	0	45,158	70,909
Health Education	0	0	3,993	0	0	0	0	3,993	0	13,008	0	0	0	0	0	13,008	17,001
Community Health Repr.	0	0	4,216	0	0	0	0	4,216	0	54,129	0	0	0	0	0	54,129	58,345
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	33,960	0	0	0	0	33,960	0	114,121	0	0	0	0	0	114,121	148,081
Urban Health Project	0	16,084	0	0	0	0	0	16,084	0	0	24,645	0	0	0	0	24,645	40,729
Indian Health Professions	0	0	0	33,466	0	0	0	33,466	0	0	0	0	0	0	0	0	33,466
Tribal Management	0	0	0	(841)	0	0	0	(841)	0	0	0	2,283	0	0	0	2,283	1,442
Direct Operations	0	0	0	0	52,728	0	0	52,728	0	0	0	15,166	0	0	0	15,166	67,894
Self-Governance	0	0	0	0	0	2,782	0	2,782	0	0	0	0	1,945	0	0	1,945	4,727
Contract Support Costs	0	0	0	0	0	0	0	0	0	0	0	0	0	587,376	0	587,376	587,376
Subtotal (OS)	0	16,084	0	32,625	52,728	2,782	0	104,220	0	0	24,645	17,449	1,945	587,376	0	631,414	735,634
Total, Services	1,291,307	16,084	33,960	32,625	52,728	2,782	0	1,429,487	1,807,820	114,121	24,645	17,449	1,945	587,376	0	2,553,355	3,982,842
FACILITIES																	
Maintenance & Improvement	0	0	0	0	0	0	24,688	24,688	0	0	0	0	0	0	28,926	28,926	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	111,100	111,100	0	0	0	0	0	0	99,951	99,951	211,051
Equipment	0	0	0	0	0	0	6,476	6,476	0	0	0	0	0	0	16,061	16,061	22,537
Total, Facilities	0	0	0	0	0	0	242,610	242,610	0	0	0	0	0	0	209,063	209,063	451,673
TOTAL, IHS	1,291,307	16,084	33,960	32,625	52,728	2,782	242,610	1,672,097	1,807,820	114,121	24,645	17,449	1,945	587,376	209,063	2,762,418	4,434,515
% Federal Health Admin.								37.7%									
% Tribal and Urban Health Admin.																	62.3%

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

Sub Activity	Federal Health Administration								Tribal Health Administration								
	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	FY 2015 Estimate
SERVICES																	
Hospitals & Health Clinics	786,278	0	0	0	0	0	0	786,278	1,076,223	0	0	0	0	0	0	1,076,223	1,862,501
Dental Health	67,252	0	0	0	0	0	0	67,252	108,402	0	0	0	0	0	0	108,402	175,654
Mental Health	27,931	0	0	0	0	0	0	27,931	54,094	0	0	0	0	0	0	54,094	82,025
Alcohol & Substance Abuse	40,780	0	0	0	0	0	0	40,780	153,044	0	0	0	0	0	0	153,044	193,824
Purchased/Referred Care	421,395	0	0	0	0	0	0	421,395	507,646	0	0	0	0	0	0	507,646	929,041
Subtotal (CS)	1,343,635	0	0	0	0	0	0	1,343,635	1,899,410	0	0	0	0	0	0	1,899,410	3,243,045
Public Health Nursing	0	0	26,311	0	0	0	0	26,311	0	50,042	0	0	0	0	0	50,042	76,353
Health Education	0	0	4,214	0	0	0	0	4,214	0	14,049	0	0	0	0	0	14,049	18,263
Community Health Repr.	0	0	4,357	0	0	0	0	4,357	0	55,029	0	0	0	0	0	55,029	59,386
Immunization AK	0	0	0	0	0	0	0	0	0	1,855	0	0	0	0	0	1,855	1,855
Subtotal (PH)	0	0	34,882	0	0	0	0	34,882	0	120,975	0	0	0	0	0	120,975	155,857
Urban Health Project	0	16,304	0	0	0	0	0	16,304	0	0	25,071	0	0	0	0	25,071	41,375
Indian Health Professions	0	0	0	38,466	0	0	0	38,466	0	0	0	0	0	0	0	0	38,466
Tribal Management	0	0	0	159	0	0	0	159	0	0	0	2,283	0	0	0	2,283	2,442
Direct Operations	0	0	0	0	52,899	0	0	52,899	0	0	0	15,166	0	0	0	15,166	68,065
Self-Governance	0	0	0	0	0	3,782	0	3,782	0	0	0	0	1,945	0	0	1,945	5,727
Contract Support Costs	0	0	0	0	0	0	0	0	0	0	0	0	0	617,205	0	617,205	617,205
Subtotal (OS)	0	16,304	0	38,625	52,899	3,782	0	111,610	0	0	25,071	17,449	1,945	617,205	0	661,670	773,280
Total, Services	1,343,635	16,304	34,882	38,625	52,899	3,782	0	1,490,128	1,899,410	120,975	25,071	17,449	1,945	617,205	0	2,682,054	4,172,182
FACILITIES																	
Maintenance & Improvement	0	0	0	0	0	0	24,688	24,688	0	0	0	0	0	0	28,926	28,926	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	111,816	111,816	0	0	0	0	0	0	108,769	108,769	220,585
Equipment	0	0	0	0	0	0	6,673	6,673	0	0	0	0	0	0	16,652	16,652	23,325
Total, Facilities	0	0	0	0	0	0	253,296	253,296	0	0	0	0	0	0	208,699	208,699	461,995
TOTAL, IHS	1,343,635	16,304	34,882	38,625	52,899	3,782	253,296	1,743,424	1,899,410	120,975	25,071	17,449	1,945	617,205	208,699	2,890,753	4,634,177
% Federal Health Admin.								37.6%									
% Tribal and Urban Health Admin.																	62.4%

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*[1] 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, **[**$3,982,842,000**]** *$4,172,182,000*, 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 appropriated in this paragraph 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 **[**$878,575,000**]** *$929,041,000* 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 section 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 of the Act (25 U.S.C. 1616a-1) and shall remain available until expended and, notwithstanding section 108(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 shall be allocated at the discretion of the Director of the Indian Health Service and shall remain available until expended: *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, 2012.)*

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, [$451,673,000,] *$461,995,000*, 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 shall 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 shall 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 shall 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, 2012.)*

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 the House and Senate Committees on Appropriations through the reprogramming process: *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.

GENERAL PROVISIONS

SEC. 406. 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, 112-175, 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, 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.

Sec. XXX 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.[2]

Sec. XXX Amounts provided by this Act for fiscal year 2015 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 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. [3]

Language Analysis

Language Provision	Explanation
SERVICES PROVISIONS	
[1] 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, **[**$3,982,842,000**]** *$4,172,182,000*, 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:	Technical change to extend the correct legal language for the Indian Self-Determination and Education Assistance Act.
GENERAL PROVISIONS	
[2] *Sec. XXX 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.*	Added to ensure FY 2014 appropriation will not be used to pay prior year contract support costs claims or to repay the Judgment Fund for payments on prior year claims and to ensure that FY 2015 appropriation will not be available to pay for FY 2014 contract support costs.
[3] *Sec. XXX Amounts provided by this Act for fiscal year 2015 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 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 2015 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
SERVICES

Amounts Available for Obligations

	FY 2013	FY 2014	FY 2015
General Fund Discretionary Appropriation:			
Appropriation (Interior)	$3,914,599,000	$3,982,842,000	$4,172,182,000
Across-the-board reductions (Interior)	($202,321,000)	$0	$0
Subtotal, Appropriation (Interior)	$3,712,277,691	$3,982,842,000	$4,172,182,000
Subtotal, adjusted appropriation	$3,712,277,691	$3,982,842,000	$4,172,182,000
Mandatory Appropriation:			
Appropriation	$147,000,000	$147,000,000	$150,000,000
Offsetting Collections:			
Federal sources	($251,739,454)	($325,166,677)	($368,000,000)
Non-federal sources	($941,341,455)	($1,215,911,403)	($797,000,000)
Subtotal	($1,193,080,909)	($1,541,078,080)	($1,165,000,000)
Unobligated Balance, Discrentionary, Start of Year	514,188,212	577,000,000	408,000,000
Unobligated Balance, Mandatory, Start of Year	46,261,077	48,737,462	--
Unobligated Balance End of Year	579,309,761	408,000,000	209,000,000
Total Obligations	$3,805,955,832	$3,622,501,382	$3,356,182,000

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FACILITIES

Amounts Available for Obligations

	FY 2013	FY 2014	FY 2015
General Fund Discretionary Appropriation:			
Appropriation (Interior)	$441,605,000	$451,673,000	$461,995,000
Across-the-board reductions (Interior)	$23,035,272	$0	$0
Subtotal, Appropriation (Interior)	$418,569,729	$451,673,000	$461,995,000
Subtotal, adjusted appropriation	$418,569,729	$451,673,000	$461,995,000
Offsetting Collections:			
Federal sources	($55,360,885)	($70,000,000)	($6,000,000)
Subtotal	($55,360,885)	($70,000,000)	($6,000,000)
Unobligated Balance, Start of Year	156,999,944	144,022,408	105,000,000
Unobligated Balance End of Year	144,022,408	105,000,000	54,000,000
Total Obligations	$376,186,380	$420,695,408	$506,995,000

INDIAN HEALTH SERVICE

SERVICES

Summary of Changes

FY 2014 Enacted	$3,982,842,000
Total estimated budget authority	3,982,842,000
Less Obligations	(3,982,842,000)
FY 2015 Estimate	4,172,182,000
Less Obligations	(4,172,182,000)
Net Change	189,340,000
Less Obligations	(189,340,000)

	FY 2014 Enacted Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 Annualization of FY 2013 CO Pay Raise (3months)	--	n/a	--	282,000
2 FY 2014 Pay Raise CO (9months)	--	n/a	--	796,000
3 Annualization of FY 2013 CS Pay Raise (3months)	--	n/a	--	1,560,000
4 FY 2014 Pay Raise CS (9months)	--	n/a	--	4,183,000
5 One Days Pay	--	n/a	--	0
6 Tribal Pay Cost	--	n/a	--	9,286,000
7 Increased Cost of Travel	--	41,168,000	--	1,505,000
8 Increased Cost of Transportation & Things	--	6,195,000	--	1,473,000
9 Increased Cost of Printing	--	305,000	--	2,000
10 Increased Cost of Rents, Communications, & Utilities	--	20,303,000	--	418,000
11 Increased Cost of Health Care Provided under Contracts & Grants	--	500,783,000	--	18,211,000
12 Increased Cost of Supplies	--	103,011,000	--	4,004,000
13 Increased Cost of Medical or other Equipment	--	7,590,000	--	284,000
14 Increased Cost of Land & Structure	--	161,000	--	0
15 Increased Cost of Grants	--	1,974,528,000	--	53,534,000
16 Increased Cost of Insurance / Indemnities	--	617,000	--	8,000
17 Increased Cost of Interest / Dividends	--	32,000	--	1,000
18 Population Growth	--	n/a	--	60,913,000
Subtotal, Built-In	--	2,654,693,000	--	156,460,000
B. Phasing-In of Staff & Operating Cost of New Facilities:	--	0	604	62,324,000
C. New Tribes	--	0	--	7,948,000
D. Program Increases	--	0	--	45,257,000
TOTAL INCREASES	--	2,654,693,000	604	271,989,000
DECREASES				
A. Built-In				
Absoprtion of Built-In Increases	--	0	--	(82,649,000)
TOTAL DECREASES	--	0	--	(82,649,000)
NET CHANGE	--	**$2,654,693,000**	**604**	**$189,340,000**

INDIAN HEALTH SERVICE
CLINICAL Services
Summary of Changes

FY 2014 Enacted	$3,099,127,000
Total estimated budget authority	3,099,127,000
Less Obligations	(3,099,127,000)
FY 2015 Estimate	3,243,045,000
Less Obligations	(3,243,045,000)
Net Change	143,918,000
Less Obligations	(143,918,000)

		FY 2014 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2014 CO Pay Raise (3months)	--	n/a	--	256,000
2	FY 2015 Pay Raise CO (9months)	--	n/a	--	712,000
3	Annualization of FY 2014 CS Pay Raise (3months)	--	n/a	--	1,405,000
4	FY 2015 Pay Raise CS (9months)	--	n/a	--	3,690,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	8,315,000
7	Increased Cost of Travel	--	40,346,000	--	1,476,000
8	Increased Cost of Transportation & Things	--	5,225,000	--	1,450,000
9	Increased Cost of Printing	--	253,000	--	2,000
10	Increased Cost of Rents, Communications, & Utilities	--	19,406,000	--	381,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	479,511,000	--	17,763,000
12	Increased Cost of Supplies	--	99,530,000	--	3,899,000
13	Increased Cost of Medical or other Equipment	--	6,483,000	--	236,000
14	Increased Cost of Land & Structure	--	155,000	--	0
15	Increased Cost of Grants	--	1,784,909,000	--	43,157,000
16	Increased Cost of Insurance / Indemnities	--	547,000	--	8,000
17	Increased Cost of Interest / Dividends	--	32,000	--	1,000
18	Population Growth	--	n/a	--	57,394,000
	Subtotal, Built-In	--	2,436,397,000	--	140,145,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	559	56,989,000
C. New Tribes		--	0	--	7,232,000
D. Program Increases		--	0	--	15,428,000
TOTAL INCREASES		--	2,436,397,000	559	219,794,000
DECREASES					
A. Built-In					
	Absoprtion of Built-In Increases	--	0	--	(75,876,000)
TOTAL DECREASES		--	0	--	(75,876,000)
NET CHANGE		--	**$2,436,397,000**	**559**	**$143,918,000**

INDIAN HEALTH SERVICE
Hospitals & Health Clinics
Summary of Changes

FY 2014 Enacted	$1,790,904,000
Total estimated budget authority	1,790,904,000
Less Obligations	(1,790,904,000)
FY 2015 Estimate	1,862,501,000
Less Obligations	(1,862,501,000)
Net Change	71,597,000
Less Obligations	(71,597,000)

	FY 2014 Enacted Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 Annualization of FY 2014 CO Pay Raise (3months)	--	n/a	--	213,000
2 FY 2015 Pay Raise CO (9months)	--	n/a	--	583,000
3 Annualization of FY 2014 CS Pay Raise (3months)	--	n/a	--	1,189,000
4 FY 2015 Pay Raise CS (9months)	--	n/a	--	3,029,000
5 One Days Pay	--	n/a	--	0
6 Tribal Pay Cost	--	n/a	--	6,447,000
7 Increased Cost of Travel	--	2,946,000	--	109,000
8 Increased Cost of Transportation & Things	--	4,678,000	--	94,000
9 Increased Cost of Printing	--	201,000	--	2,000
10 Increased Cost of Rents, Communications, & Utilities	--	18,907,000	--	373,000
11 Increased Cost of Health Care Provided under Contracts & Grants	--	131,354,000	--	4,338,000
12 Increased Cost of Supplies	--	79,858,000	--	3,222,000
13 Increased Cost of Medical or other Equipment	--	4,879,000	--	133,000
14 Increased Cost of Land & Structure	--	6,000	--	0
15 Increased Cost of Grants	--	990,582,000	--	20,736,000
16 Increased Cost of Insurance / Indemnities	--	517,000	--	6,000
17 Increased Cost of Interest / Dividends	--	1,000	--	0
18 Population Growth	--	n/a	--	33,579,000
Subtotal, Built-In	--	1,233,929,000	--	74,053,000
B. Phasing-In of Staff & Operating Cost of New Facilities:	--	0	398	41,605,000
C. New Tribes	--	0	--	3,584,000
TOTAL INCREASES	--	1,233,929,000	398	119,242,000
DECREASES				
A. Built-In				
Absoprtion of Built-In Increases	--	0	--	(47,645,000)
TOTAL DECREASES	--	0	--	(47,645,000)
NET CHANGE	--	**$1,233,929,000**	**398**	**$71,597,000**

INDIAN HEALTH SERVICE
Dental Health
Summary of Changes

FY 2014 Enacted	$165,290,000
Total estimated budget authority	165,290,000
Less Obligations	(165,290,000)
FY 2015 Estimate	175,654,000
Less Obligations	(175,654,000)
Net Change	10,364,000
Less Obligations	(10,364,000)

		FY 2014 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2014 CO Pay Raise (3months)	--	n/a	--	37,000
2	FY 2015 Pay Raise CO (9months)	--	n/a	--	111,000
3	Annualization of FY 2014 CS Pay Raise (3months)	--	n/a	--	127,000
4	FY 2015 Pay Raise CS (9months)	--	n/a	--	380,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	599,000
7	Increased Cost of Travel	--	213,000	--	12,000
8	Increased Cost of Transportation & Things	--	179,000	--	7,000
9	Increased Cost of Printing	--	1,000	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	231,000	--	3,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	5,010,000	--	249,000
12	Increased Cost of Supplies	--	5,513,000	--	188,000
13	Increased Cost of Medical or other Equipment	--	527,000	--	17,000
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	87,945,000	--	1,255,000
16	Increased Cost of Insurance / Indemnities	--	1,000	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	3,028,000
	Subtotal, Built-In	--	99,620,000	--	6,013,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	83	8,224,000
C. New Tribes		--	0	--	468,000
	TOTAL INCREASES	--	99,620,000	83	14,705,000
DECREASES					
A. Built-In					
	Absoprtion of Built-In Increases	--	0	--	(4,341,000)
	TOTAL DECREASES	--	0	--	(4,341,000)
NET CHANGE		--	**$99,620,000**	**83**	**$10,364,000**

INDIAN HEALTH SERVICE
Mental Health
Summary of Changes

FY 2014 Enacted	$77,980,000
Total estimated budget authority	77,980,000
Less Obligations	(77,980,000)
FY 2015 Estimate	82,025,000
Less Obligations	(82,025,000)
Net Change	4,045,000
Less Obligations	(4,045,000)

		FY 2014 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2014 CO Pay Raise (3months)	--	n/a	--	4,000
2	FY 2015 Pay Raise CO (9months)	--	n/a	--	13,000
3	Annualization of FY 2014 CS Pay Raise (3months)	--	n/a	--	54,000
4	FY 2015 Pay Raise CS (9months)	--	n/a	--	164,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	310,000
7	Increased Cost of Travel	--	204,000	--	8,000
8	Increased Cost of Transportation & Things	--	258,000	--	5,000
9	Increased Cost of Printing	--	0	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	75,000	--	1,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	4,071,000	--	174,000
12	Increased Cost of Supplies	--	1,690,000	--	30,000
13	Increased Cost of Medical or other Equipment	--	100,000	--	4,000
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	47,869,000	--	703,000
16	Increased Cost of Insurance / Indemnities	--	0	--	2,000
17	Increased Cost of Interest / Dividends	--		--	0
18	Population Growth	--	n/a	--	1,438,000
	Subtotal, Built-In	--	54,267,000	--	2,910,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	30	2,846,000
C, New Tribes		--	0	--	319,000
	TOTAL INCREASES	--	54,267,000	30	6,075,000
DECREASES					
A. Built-In					
	Absoprtion of Built-In Increases	--	0	--	(2,030,000)
	TOTAL DECREASES	--	0	--	(2,030,000)
NET CHANGE		--	**$54,267,000**	**30**	**$4,045,000**

INDIAN HEALTH SERVICE
Alcohol and Substance Abuse
Summary of Changes

FY 2014 Enacted	$186,378,000
Total estimated budget authority	186,378,000
Less Obligations	(186,378,000)
FY 2015 Estimate	193,824,000
Less Obligations	(193,824,000)
Net Change	7,446,000
Less Obligations	(7,446,000)

		FY 2014 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2014 CO Pay Raise (3months)	--	n/a	--	2,000
2	FY 2015 Pay Raise CO (9months)	--	n/a	--	5,000
3	Annualization of FY 2014 CS Pay Raise (3months)	--	n/a	--	35,000
4	FY 2015 Pay Raise CS (9months)	--	n/a	--	117,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	959,000
7	Increased Cost of Travel	--	82,000	--	5,000
8	Increased Cost of Transportation & Things	--	110,000	--	2,000
9	Increased Cost of Printing	--	51,000	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	190,000	--	2,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	8,709,000	--	314,000
12	Increased Cost of Supplies	--	522,000	--	32,000
13	Increased Cost of Medical or other Equipment	--	251,000	--	9,000
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	160,095,000	--	2,513,000
16	Increased Cost of Insurance / Indemnities	--	29,000	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	3,535,000
	Subtotal, Built-In	--	170,039,000	--	7,530,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	48	4,314,000
C. New Tribes		--	0	--	289,000
	TOTAL INCREASES	--	170,039,000	48	12,133,000
DECREASES					
A. Built-In					
	Absoprtion of Built-In Increases	--	0	--	(4,687,000)
	TOTAL DECREASES	--	0	--	(4,687,000)
NET CHANGE		--	**$170,039,000**	**48**	**$7,446,000**

INDIAN HEALTH SERVICE
Purchased/Referred Care
Summary of Changes

FY 2014 Enacted	$878,575,000
Total estimated budget authority	878,575,000
Less Obligations	(878,575,000)
FY 2015 Estimate	929,041,000
Less Obligations	(929,041,000)
Net Change	50,466,000
Less Obligations	(50,466,000)

		FY 2014 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2014 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2015 Pay Raise CO (9months)	--	n/a	--	0
3	Annualization of FY 2014 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2015 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	--	36,901,000	--	1,342,000
8	Increased Cost of Transportation & Things	--	0	--	1,342,000
9	Increased Cost of Printing	--	0	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	3,000	--	2,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	330,367,000	--	12,688,000
12	Increased Cost of Supplies	--	11,947,000	--	427,000
13	Increased Cost of Medical or other Equipment	--	726,000	--	73,000
14	Increased Cost of Land & Structure	--	149,000	--	0
15	Increased Cost of Grants	--	498,418,000	--	17,950,000
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	31,000	--	1,000
18	Population Growth	--	n/a	--	15,814,000
	Subtotal, Built-In	--	878,542,000	--	49,639,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	--	0
C. New Tribes		--	0	--	2,572,000
D. PRC Increase		--	0	--	15,428,000
	TOTAL INCREASES	--	878,542,000	--	67,639,000
DECREASES					
A. Built-In					
	Absoprtion of Built-In Increases	--	0	--	(17,173,000)
	TOTAL DECREASES	--	0	--	(17,173,000)
NET CHANGE		--	**$878,542,000**	**--**	**$50,466,000**

INDIAN HEALTH SERVICE
PREVENTIVE Health
Summary of Changes

FY 2014 Enacted	$148,081,000
Total estimated budget authority	148,081,000
Less Obligations	(148,081,000)
FY 2015 Estimate	155,857,000
Less Obligations	(155,857,000)
Net Change	7,776,000
Less Obligations	(7,776,000)

		FY 2014 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2014 CO Pay Raise (3months)	--	n/a	--	11,000
2	FY 2015 Pay Raise CO (9months)	--	n/a	--	38,000
3	Annualization of FY 2014 CS Pay Raise (3months)	--	n/a	--	57,000
4	FY 2015 Pay Raise CS (9months)	--	n/a	--	187,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	708,000
7	Increased Cost of Travel	--	82,000	--	3,000
8	Increased Cost of Transportation & Things	--	832,000	--	19,000
9	Increased Cost of Printing	--	7,000	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	131,000	--	1,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	1,587,000	--	109,000
12	Increased Cost of Supplies	--	2,546,000	--	97,000
13	Increased Cost of Medical or other Equipment	--	301,000	--	17,000
14	Increased Cost of Land & Structure	--	6,000	--	0
15	Increased Cost of Grants	--	112,186,000	--	1,673,000
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	2,744,000
	Subtotal, Built-In	--	117,678,000	--	5,664,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	45	5,335,000
C. New Tribes		--	0	--	545,000
	TOTAL INCREASES	--	117,678,000	45	11,544,000
DECREASES					
A. Built-In					
	Absoprtion of Built-In Increases	--	0	--	(3,768,000)
	TOTAL DECREASES	--	0	--	(3,768,000)
NET CHANGE		--	**$117,678,000**	**45**	**$7,776,000**

INDIAN HEALTH SERVICE
Public Health Nursing
Summary of Changes

FY 2014 Enacted	$70,909,000
Total estimated budget authority	70,909,000
Less Obligations	(70,909,000)
FY 2015 Estimate	76,353,000
Less Obligations	(76,353,000)
Net Change	5,444,000
Less Obligations	(5,444,000)

	FY 2014 Enacted Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 Annualization of FY 2014 CO Pay Raise (3months)	--	n/a	--	11,000
2 FY 2015 Pay Raise CO (9months)	--	n/a	--	35,000
3 Annualization of FY 2014 CS Pay Raise (3months)	--	n/a	--	49,000
4 FY 2015 Pay Raise CS (9months)	--	n/a	--	162,000
5 One Days Pay	--	n/a	--	0
6 Tribal Pay Cost	--	n/a	--	268,000
7 Increased Cost of Travel	--	27,000	--	2,000
8 Increased Cost of Transportation & Things	--	772,000	--	18,000
9 Increased Cost of Printing	--	3,000	--	0
10 Increased Cost of Rents, Communications, & Utilities	--	120,000	--	1,000
11 Increased Cost of Health Care Provided under Contracts & Grants	--	942,000	--	59,000
12 Increased Cost of Supplies	--	2,108,000	--	79,000
13 Increased Cost of Medical or other Equipment	--	206,000	--	14,000
14 Increased Cost of Land & Structure	--	0	--	0
15 Increased Cost of Grants	--	40,456,000	--	561,000
16 Increased Cost of Insurance / Indemnities	--	0	--	0
17 Increased Cost of Interest / Dividends	--	0	--	0
18 Population Growth	--	n/a	--	1,281,000
Subtotal, Built-In	--	44,634,000	--	2,540,000
B. Phasing-In of Staff & Operating Cost of New Facilities:	--	0	36	4,474,000
C. New Tribes	--	0	--	257,000
TOTAL INCREASES	--	44,634,000	36	7,271,000
DECREASES				
A. Built-In				
Absoprtion of Built-In Increases	--	0	--	(1,827,000)
TOTAL DECREASES	--	0	--	(1,827,000)
NET CHANGE	--	**$44,634,000**	**36**	**$5,444,000**

INDIAN HEALTH SERVICE
Health Education
Summary of Changes

FY 2014 Enacted	$17,001,000
Total estimated budget authority	17,001,000
Less Obligations	(17,001,000)
FY 2015 Estimate	18,263,000
Less Obligations	(18,263,000)
Net Change	1,262,000
Less Obligations	(1,262,000)

		FY 2014 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2014 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2015 Pay Raise CO (9months)	--	n/a	--	2,000
3	Annualization of FY 2014 CS Pay Raise (3months)	--	n/a	--	7,000
4	FY 2015 Pay Raise CS (9months)	--	n/a	--	21,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	83,000
7	Increased Cost of Travel	--	43,000	--	1,000
8	Increased Cost of Transportation & Things	--	22,000	--	1,000
9	Increased Cost of Printing	--	4,000	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	9,000	--	0
11	Increased Cost of Health Care Provided under Contracts & Grants	--	306,000	--	28,000
12	Increased Cost of Supplies	--	427,000	--	17,000
13	Increased Cost of Medical or other Equipment	--	86,000	--	3,000
14	Increased Cost of Land & Structure	--	6,000	--	0
15	Increased Cost of Grants	--	12,779,000	--	189,000
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	318,000
	Subtotal, Built-In	--	13,682,000	--	670,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	9	861,000
C. New Tribes		--	0	--	164,000
	TOTAL INCREASES	--	13,682,000	9	1,695,000
DECREASES					
A. Built-In					
	Absoprtion of Built-In Increases	--	0	--	(433,000)
	TOTAL DECREASES	--	0	--	(433,000)
NET CHANGE		--	**$13,682,000**	**9**	**$1,262,000**

INDIAN HEALTH SERVICE
Community Health Representatives
Summary of Changes

FY 2014 Enacted	$58,345,000
Total estimated budget authority	58,345,000
Less Obligations	(58,345,000)
FY 2015 Estimate	59,386,000
Less Obligations	(59,386,000)
Net Change	1,041,000
Less Obligations	(1,041,000)

		FY 2014 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2014 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2015 Pay Raise CO (9months)	--	n/a	--	1,000
3	Annualization of FY 2014 CS Pay Raise (3months)	--	n/a	--	1,000
4	FY 2015 Pay Raise CS (9months)	--	n/a	--	4,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	357,000
7	Increased Cost of Travel	--	12,000	--	0
8	Increased Cost of Transportation & Things	--	38,000	--	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	--	339,000	--	22,000
12	Increased Cost of Supplies	--	11,000	--	1,000
13	Increased Cost of Medical or other Equipment	--	9,000	--	0
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	57,125,000	--	894,000
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	1,110,000
	Subtotal, Built-In	--	57,536,000	--	2,390,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	0	0
C. New Tribes		--	0	--	124,000
	TOTAL INCREASES	--	57,536,000	0	2,514,000
DECREASES					
A. Built-In					
	Absoprtion of Built-In Increases	--	0	--	(1,473,000)
	TOTAL DECREASES	--	0	--	(1,473,000)
NET CHANGE		--	**$57,536,000**	**0**	**$1,041,000**

INDIAN HEALTH SERVICE
Immunization AK
Summary of Changes

FY 2014 Enacted	$1,826,000
Total estimated budget authority	1,826,000
Less Obligations	(1,826,000)
FY 2015 Estimate	1,855,000
Less Obligations	(1,855,000)
Net Change	29,000
Less Obligations	(29,000)

	FY 2014 Enacted Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 Annualization of FY 2014 CO Pay Raise (3months)	--	n/a	--	0
2 FY 2015 Pay Raise CO (9months)	--	n/a	--	0
3 Annualization of FY 2014 CS Pay Raise (3months)	--	n/a	--	0
4 FY 2015 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	--	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	--	29,000
16 Increased Cost of Insurance / Indemnities	--	0	--	0
17 Increased Cost of Interest / Dividends	--	0	--	0
18 Population Growth	--	n/a	--	35,000
Subtotal, Built-In	--	1,826,000	--	64,000
B. Phasing-In of Staff & Operating Cost of New Facilities:	--	0	--	0
TOTAL INCREASES	--	1,826,000	--	64,000
DECREASES				
A. Built-In				
Absoprtion of Built-In Increases	--	0	--	(35,000)
TOTAL DECREASES	--	0	--	(35,000)
NET CHANGE	--	**$1,826,000**	**--**	**$29,000**

INDIAN HEALTH SERVICE
OTHER Services
Summary of Changes

FY 2014 Enacted	$735,634,000
Total estimated budget authority	735,634,000
Less Obligations	(735,634,000)
FY 2015 Estimate	773,280,000
Less Obligations	(773,280,000)
Net Change	37,646,000
Less Obligations	(37,646,000)

		FY 2014 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2013 CO Pay Raise (3months)	--	n/a	--	15,000
2	FY 2014 Pay Raise CO (9months)	--	n/a	--	46,000
3	Annualization of FY 2013 CS Pay Raise (3months)	--	n/a	--	98,000
4	FY 2014 Pay Raise CS (9months)	--	n/a	--	306,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	263,000
7	Increased Cost of Travel	--	740,000	--	26,000
8	Increased Cost of Transportation & Things	--	138,000	--	4,000
9	Increased Cost of Printing	--	45,000	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	766,000	--	36,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	19,685,000	--	339,000
12	Increased Cost of Supplies	--	935,000	--	8,000
13	Increased Cost of Medical or other Equipment	--	806,000	--	31,000
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	77,433,000	--	8,704,000
16	Increased Cost of Insurance / Indemnities	--	70,000	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	775,000
	Subtotal, Built-In	--	100,618,000	--	10,651,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	--	0
C. New Tribes		--	0	--	171,000
D. Progame Increase		--	0	--	29,829,000
TOTAL INCREASES		--	100,618,000	--	40,651,000
DECREASES					
A. Built-In					
Absoprtion of Built-In Increases		--	0	--	(3,005,000)
TOTAL DECREASES		--	0	--	(3,005,000)
NET CHANGE		--	**$100,618,000**	**--**	**$37,646,000**

INDIAN HEALTH SERVICE
Urban Indian Health
Summary of Changes

FY 2014 Enacted	$40,729,000
Total estimated budget authority	40,729,000
Less Obligations	(40,729,000)
FY 2015 Estimate	41,375,000
Less Obligations	(41,375,000)
Net Change	646,000
Less Obligations	(646,000)

		FY 2014 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2014 CO Pay Raise (3months)	--	n/a	--	1,000
2	FY 2015 Pay Raise CO (9months)	--	n/a	--	5,000
3	Annualization of FY 2014 CS Pay Raise (3months)	--	n/a	--	2,000
4	FY 2015 Pay Raise CS (9months)	--	n/a	--	8,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	163,000
7	Increased Cost of Travel	--	68,000	--	2,000
8	Increased Cost of Transportation & Things	--	17,000	--	0
9	Increased Cost of Printing	--	1,000	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	46,000	--	1,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	5,489,000	--	179,000
12	Increased Cost of Supplies	--	500,000	--	5,000
13	Increased Cost of Medical or other Equipment	--	115,000	--	7,000
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	32,828,000	--	517,000
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	775,000
	Subtotal, Built-In	--	39,064,000	--	1,665,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	--	0
	TOTAL INCREASES	--	39,064,000	--	1,665,000
DECREASES					
A. Built-In					
	Absoprtion of Built-In Increases	--	0	--	(1,019,000)
	TOTAL DECREASES	--	0	--	(1,019,000)
NET CHANGE		--	**$39,064,000**	**--**	**$646,000**

INDIAN HEALTH SERVICE
Indian Health Professions
Summary of Changes

FY 2014 Enacted	$33,466,000
Total estimated budget authority	33,466,000
Less Obligations	(33,466,000)
FY 2015 Estimate	38,466,000
Less Obligations	(38,466,000)
Net Change	5,000,000
Less Obligations	(5,000,000)

		FY 2014 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2014 CO Pay Raise (3months)	--	n/a	--	1,000
2	FY 2015 Pay Raise CO (9months)	--	n/a	--	2,000
3	Annualization of FY 2014 CS Pay Raise (3months)	--	n/a	--	3,000
4	FY 2015 Pay Raise CS (9months)	--	n/a	--	9,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	0
7	Increased Cost of Travel	--	28,000	--	1,000
8	Increased Cost of Transportation & Things	--	0	--	0
9	Increased Cost of Printing	--	0	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	38,000	--	1,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	2,732,000	--	20,000
12	Increased Cost of Supplies	--	3,000	--	0
13	Increased Cost of Medical or other Equipment	--	4,000	--	0
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	29,275,000	--	5,722,000
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	--	32,080,000	--	5,759,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	--	0
	TOTAL INCREASES	--	32,080,000	--	5,759,000
DECREASES					
A. Built-In					
	Absoprtion of Built-In Increases	--	0	--	(759,000)
	TOTAL DECREASES	--	0	--	(759,000)
NET CHANGE		--	**$32,080,000**	**--**	**$5,000,000**

INDIAN HEALTH SERVICE
Tribal Management
Summary of Changes

FY 2014 Enacted	$1,442,000
Total estimated budget authority	1,442,000
Less Obligations	(1,442,000)
FY 2015 Estimate	2,442,000
Less Obligations	(2,442,000)
Net Change	1,000,000
Less Obligations	(1,000,000)

		FY 2014 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2014 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2015 Pay Raise CO (9months)	--	n/a	--	0
3	Annualization of FY 2014 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2015 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	--	22,000	--	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	--	1,420,000	--	1,049,000
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	--	1,442,000	--	1,049,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	--	0
	TOTAL INCREASES	--	1,442,000	--	1,049,000
DECREASES					
A. Built-In					
	Absoprtion of Built-In Increases	--	0	--	(49,000)
	TOTAL DECREASES	--	0	--	(49,000)
NET CHANGE		--	**$1,442,000**	**--**	**$1,000,000**

INDIAN HEALTH SERVICE
Direct Operations
Summary of Changes

FY 2014 Enacted	$67,894,000
Total estimated budget authority	67,894,000
Less Obligations	(67,894,000)
FY 2015 Estimate	68,065,000
Less Obligations	(68,065,000)
Net Change	171,000
Less Obligations	(171,000)

		FY 2014 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2014 CO Pay Raise (3months)	--	n/a	--	13,000
2	FY 2015 Pay Raise CO (9months)	--	n/a	--	39,000
3	Annualization of FY 2014 CS Pay Raise (3months)	--	n/a	--	89,000
4	FY 2015 Pay Raise CS (9months)	--	n/a	--	278,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	100,000
7	Increased Cost of Travel	--	577,000	--	21,000
8	Increased Cost of Transportation & Things	--	115,000	--	4,000
9	Increased Cost of Printing	--	44,000	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	669,000	--	11,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	10,867,000	--	140,000
12	Increased Cost of Supplies	--	410,000	--	3,000
13	Increased Cost of Medical or other Equipment	--	677,000	--	24,000
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	12,111,000	--	363,000
16	Increased Cost of Insurance / Indemnities	--	70,000	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	0
	Subtotal, Built-In	--	25,540,000	--	1,085,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	--	0
C. New Tribes		--	0	--	171,000
	TOTAL INCREASES	--	25,540,000	--	1,256,000
DECREASES					
A. Built-In					
	Absoprtion of Built-In Increases	--	0	--	(1,085,000)
	TOTAL DECREASES	--	0	--	(1,085,000)
NET CHANGE		--	**$25,540,000**	**--**	**$171,000**

INDIAN HEALTH SERVICE
Self-Governance
Summary of Changes

FY 2014 Enacted	$4,727,000
Total estimated budget authority	4,727,000
Less Obligations	(4,727,000)
FY 2015 Estimate	5,727,000
Less Obligations	(5,727,000)
Net Change	1,000,000
Less Obligations	(1,000,000)

		FY 2014 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2014 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2015 Pay Raise CO (9months)	--	n/a	--	0
3	Annualization of FY 2014 CS Pay Raise (3months)	--	n/a	--	4,000
4	FY 2015 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	--	67,000	--	2,000
8	Increased Cost of Transportation & Things	--	6,000	--	0
9	Increased Cost of Printing	--	0	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	13,000	--	23,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	575,000	--	0
12	Increased Cost of Supplies	--	22,000	--	0
13	Increased Cost of Medical or other Equipment	--	10,000	--	0
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	1,799,000	--	1,053,000
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	--	2,492,000	--	1,093,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	--	0
	TOTAL INCREASES	--	2,492,000	--	1,093,000
DECREASES					
A. Built-In					
	Absoprtion of Built-In Increases	--	0	--	(93,000)
	TOTAL DECREASES	--	0	--	(93,000)
NET CHANGE		--	**$2,492,000**	**--**	**$1,000,000**

INDIAN HEALTH SERVICE

CONTRACT SUPPORT COSTS

Summary of Changes

FY 2014 Enacted	$587,376,000
Total estimated budget authority	587,376,000
Less Obligations	(587,376,000)
FY 2015 Estimate	617,205,000
Less Obligations	(617,205,000)
Net Change	29,829,000
Less Obligations	(29,829,000)

		FY 2014 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2014 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2015 Pay Raise CO (9months)	--	n/a	--	0
3	Annualization of FY 2014 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2015 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	--	129,588,000	--	97,000
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	--	457,788,000	--	8,952,000
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	--	587,376,000	--	9,049,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	--	0
C. Contract Support Costs		--	0	--	29,829,000
	TOTAL INCREASES	--	587,376,000	--	38,878,000
DECREASES					
A. Built-In					
	Absoprtion of Built-In Increases	--	0	--	(9,049,000)
	TOTAL DECREASES	--	0	--	(9,049,000)
NET CHANGE		--	**$587,376,000**	**--**	**$29,829,000**

INDIAN HEALTH SERVICE

FACILITIES

Summary of Changes

FY 2014 Enacted	$451,673,000
Total budget authority	451,673,000
Less Obligations	(451,673,000)
FY 2015 Estimate	461,995,000
Less Obligations	(461,995,000)
Net Change	10,322,000
Less Obligations	(10,322,000)

		FY 2014 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2014 CO Pay Raise (3months)	--	n/a	--	76,000
2	FY 2015 Pay Raise CO (9months)	--	n/a	--	249,000
3	Annualization of FY 2014 CS Pay Raise (3months)	--	n/a	--	156,000
4	FY 2015 Pay Raise CS (9months)	--	n/a	--	504,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	608,000
7	Increased Cost of Travel	--	1,971,000	--	43,000
8	Increased Cost of Transportation & Things	--	3,648,000	--	46,000
9	Increased Cost of Printing	--	41,000	--	0
10	Increased Cost of Rents, Communications, & Utilties	--	16,589,000	--	1,039,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	91,153,000	--	514,000
12	Increased Cost of Supplies	--	6,622,000	--	106,000
13	Increased Cost of Medical or other Equipment	--	9,347,000	--	330,000
14	Increased Cost of Land & Structure	--	81,594,000	--	500,000
15	Increased Cost of Grants	--	144,208,000	--	3,724,000
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	--	n/a	--	6,533,000
	Subtotal, Built-In	--	355,173,000	--	14,428,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	56	8,494,000
C. New Tribes		--	0	--	67,000
	TOTAL INCREASES	--	355,173,000		22,989,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(12,667,000)
B. Base Funding Reduction		--	0	--	0
	TOTAL DECREASES	--	0	--	(12,667,000)
NET CHANGE		**--**	**$355,173,000**	**56**	**$10,322,000**

INDIAN HEALTH SERVICE
Maintenance & Improvement
Summary of Changes

FY 2014 Enacted	$53,614,000
Total budget authority	53,614,000
Less Obligations	(53,614,000)
FY 2015 Estimate	53,614,000
Less Obligations	(53,614,000)
Net Change	0
Less Obligations	0

		FY 2014 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2014 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2015 Pay Raise CO (9months)	--	n/a	--	0
3	Annualization of FY 2014 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2015 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	--	41,000	--	0
8	Increased Cost of Transportation & Things	--	46,000	--	0
9	Increased Cost of Printing	--	0	--	0
10	Increased Cost of Rents, Communications, & Utilties	--	200,000	--	9,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	16,511,000	--	273,000
12	Increased Cost of Supplies	--	3,148,000	--	60,000
13	Increased Cost of Medical or other Equipment	--	228,000	--	13,000
14	Increased Cost of Land & Structure	--	2,373,000	--	102,000
15	Increased Cost of Grants	--	31,067,000	--	532,000
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	--	53,614,000	--	967,000
	TOTAL INCREASES	--	53,614,000	--	1,956,000
A.	Maintenance & Improvement	--	0	--	0
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(1,956,000)
	TOTAL DECREASES	--	0	--	(1,956,000)
NET CHANGE		**--**	**$53,614,000**	**--**	**$0**

INDIAN HEALTH SERVICE
Sanitation Facilities Construction
Summary of Changes

FY 2014 Enacted	$79,423,000
Total budget authority	79,423,000
Less Obligations	(79,423,000)
FY 2015 Estimate	79,423,000
Less Obligations	(79,423,000)
Net Change	0
Less Obligations	0

		FY 2014 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2014 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2015 Pay Raise CO (9months)	--	n/a	--	0
3	Annualization of FY 2014 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2015 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	--	69,000	--	2,000
8	Increased Cost of Transportation & Things	--	935,000	--	10,000
9	Increased Cost of Printing	--	8,000	--	0
10	Increased Cost of Rents, Communications, & Utilties	--	58,000	--	768,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	53,075,000	--	9,000
12	Increased Cost of Supplies	--	503,000	--	0
13	Increased Cost of Medical or other Equipment	--	107,000	--	0
14	Increased Cost of Land & Structure	--	3,251,000	--	191,000
15	Increased Cost of Grants	--	21,417,000	--	0
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	--	1,432,000
	Subtotal, Built-In	--	79,423,000	--	2,412,000
	TOTAL INCREASES	--	79,423,000	--	2,412,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(2,412,000)
	TOTAL DECREASES	--	0	--	(2,412,000)
NET CHANGE		**--**	**$79,423,000**	**--**	**$0**

INDIAN HEALTH SERVICE
Health Care Facilities Construction
Summary of Changes

FY 2014 Enacted	$85,048,000
Total budget authority	85,048,000
Less Obligations	(85,048,000)
FY 2015 Estimate	85,048,000
Less Obligations	(85,048,000)
Net Change	0
Less Obligations	0

	FY 2014 Enacted Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 Annualization of FY 2014 CO Pay Raise (3months)	--	n/a	--	0
2 FY 2015 Pay Raise CO (9months)	--	n/a	--	0
3 Annualization of FY 2014 CS Pay Raise (3months)	--	n/a	--	0
4 FY 2015 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	--	7,994,000	--	22,000
12 Increased Cost of Supplies	--	0	--	0
13 Increased Cost of Medical or other Equipment	--	0	--	0
14 Increased Cost of Land & Structure	--	75,951,000	--	191,000
15 Increased Cost of Grants	--	1,103,000	--	1,095,000
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	--	1,308,000
B. HCFC Increase	--	0	--	0
C. IHCIA Implementation	--	0	--	0
TOTAL INCREASES	--	85,048,000	--	1,308,000
DECREASES				
A. Built-In				
Absorption of Built-In Increases	--	0	--	(1,308,000)
B. Base Funding Reduction	--	0	--	0
TOTAL DECREASES	--	0	--	(1,308,000)
NET CHANGE	**--**	**$85,048,000**	**--**	**$0**

INDIAN HEALTH SERVICE
Facilities & Environmental Health Support
Summary of Changes

FY 2014 Enacted	$211,051,000
Total budget authority	211,051,000
Less Obligations	(211,051,000)
FY 2015 Estimate	220,585,000
Less Obligations	(220,585,000)
Net Change	9,534,000
Less Obligations	(9,534,000)

		FY 2014 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2014 CO Pay Raise (3months)	--	n/a	--	76,000
2	FY 2015 Pay Raise CO (9months)	--	n/a	--	249,000
3	Annualization of FY 2014 CS Pay Raise (3months)	--	n/a	--	156,000
4	FY 2015 Pay Raise CS (9months)	--	n/a	--	504,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	608,000
7	Increased Cost of Travel	--	1,857,000	--	41,000
8	Increased Cost of Transportation & Things	--	2,500,000	--	36,000
9	Increased Cost of Printing	--	33,000	--	0
10	Increased Cost of Rents, Communications, & Utilties	--	16,189,000	--	261,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	12,416,000	--	193,000
12	Increased Cost of Supplies	--	2,888,000	--	44,000
13	Increased Cost of Medical or other Equipment	--	2,151,000	--	43,000
14	Increased Cost of Land & Structure	--	18,000	--	16,000
15	Increased Cost of Grants	--	76,555,000	--	1,583,000
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	--	n/a	--	3,730,000
	Subtotal, Built-In	--	114,607,000	--	7,540,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	56	8,494,000
C. New Tribes		--	0	--	67,000
	TOTAL INCREASES	--	114,607,000	--	16,101,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(6,567,000)
B. Base Adjustment:		--	0	--	0
	TOTAL DECREASES	--	0	--	(6,567,000)
NET CHANGE		**--**	**$114,607,000**	**56**	**$9,534,000**

INDIAN HEALTH SERVICE
Equipment
Summary of Changes

FY 2014 Enacted	$22,537,000
Total budget authority	22,537,000
Less Obligations	(22,537,000)
FY 2015 Estimate	23,325,000
Less Obligations	(23,325,000)
Net Change	788,000
Less Obligations	(788,000)

	FY 2014 Enacted Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 Annualization of FY 2014 CO Pay Raise (3months)	--	n/a	--	0
2 FY 2015 Pay Raise CO (9months)	--	n/a	--	0
3 Annualization of FY 2014 CS Pay Raise (3months)	--	n/a	--	0
4 FY 2015 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	--	4,000	--	0
8 Increased Cost of Transportation & Things	--	167,000	--	0
9 Increased Cost of Printing	--	0	--	0
10 Increased Cost of Rents, Communications, & Utilties	--	142,000	--	1,000
11 Increased Cost of Health Care Provided under Contracts & Grants	--	1,157,000	--	17,000
12 Increased Cost of Supplies	--	83,000	--	2,000
13 Increased Cost of Medical or other Equipment	--	6,861,000	--	274,000
14 Increased Cost of Land & Structure	--	1,000	--	0
15 Increased Cost of Grants	--	14,066,000	--	514,000
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	--	404,000
Subtotal, Built-In	--	22,481,000	--	1,212,000
TOTAL INCREASES	--	22,481,000	--	1,212,000
DECREASES				
A. Built-In				
Absorption of Built-In Increases	--	0	--	(424,000)
B. Base Funding Reduction	--	0	--	0
TOTAL DECREASES	--	0	--	(424,000)
NET CHANGE	**--**	**$22,481,000**	**--**	**$788,000**

INDIAN HEALTH SERVICE

Budget Authority by Activity

(Dollars in Thousands)

February 12, 2014

	2013 Final		2014 Enacted		2015 Request	
	FTE	Amount	FTE	Amount	FTE	Amount
SERVICES:						
Hospitals & Health Clinics	6,495	$1,749,072	6,638	#########	6,686	$1,862,501
Dental Services	684	156,653	712	165,290	747	175,654
Mental Health	205	74,131	218	77,980	231	82,025
Alcohol & Substance Abuse	195	185,154	200	186,378	208	193,824
Contract Health Services	0	801,258	0	878,575	0	929,041
Total, Clinical Services	7,579	2,966,268	7,768	3,099,127	7,872	3,243,045
Public Health Nursing	227	66,282	239	70,909	256	76,353
Health Education	24	16,552	25	17,001	29	18,263
Comm. Health Reps.	5	58,304	5	58,345	5	59,386
Immunization AK	0	1,826	0	1,826	0	1,855
Total, Preventive Health	256	142,963	269	148,081	290	155,857
Urban Health	5	40,729	5	40,729	5	41,375
Indian Health Professions	22	38,467	22	33,466	22	38,466
Tribal Management	0	2,442	0	1,442	0	2,442
Direct Operations	280	67,894	280	67,894	280	68,065
Self-Governance	11	5,727	11	4,727	11	5,727
Contract Support Costs	0	447,788	0	587,376	0	617,205
Total, Other services	318	603,047	318	735,634	318	773,280
Total, Services	8,153	3,712,278	8,355	3,982,842	8,480	4,172,182
FACILITIES:						
Maintenance & Improvement	0	50,919	0	53,614	0	53,614
Sanitation Facilities Constr.	195	75,431	195	79,423	195	79,423
Health Care Facs. Constr.	0	77,238	0	85,048	0	85,048
Facil. & Envir. Health Supp.	1,013	193,578	1,028	211,051	1,053	220,585
Equipment	0	21,404	0	22,537	0	23,325
Total, Facilities	1,208	418,570	1,223	451,673	1,248	461,995
Total IHS	9,361	$4,130,847	9,578	#########	9,728	$ 4,634,177

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

INDIAN HEALTH SERVICE

Authorizing Legislation

(Dollars in Thousands)

February 10, 2014

	FY 2013		FY 2014		FY 2015	
	Amount Authorized	Enacted	Amount Authorized	Enacted	Amount Authorized	Budget Request
1. Services Appropriation:	3,712,278	3,712,278	3,982,842	3,982,842	4,172,182	4,172,182
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.						
2. Contract Support Costs Appropriation:					0	0
Indian Self Determination and Education Assistance Act (P.L. 93-638), as amended, 25 U.S.C. 450 *et seq.*						
3. Facilities Appropriation:	418,570	418,570	451,673	451,673	461,995	461,995
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).	8,000	8,000	8,000	8,000	8,000	8,000
4. Public and Private Collections:	1,021,083	1,021,083	1,171,961	1,171,961	1,196,961	1,196,961
IHCIA sec. 206, 25 U.S.C. 1621e.						
Social Security Act, sec. 1880 & 1911, 42 U.S.C. 1395qq & 1396j.						
5. Special Diabetes Program for Indians:	147,000	147,000	147,000	147,000	150,000	150,000
42 U.S.C. 245c-3.						
Unfunded authorizations:	0	0	0	0	0	0
Total appropriations:	5,306,931	5,306,931	5,761,476	5,761,476	5,989,138	5,989,138
Total appropriations against Definite authorizations:	5,306,930	5,306,930	5,761,476	5,761,476	5,989,138	5,989,138

INDIAN HEALTH SERVICE
Appropriation History Table
Services

February 10, 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	$4,172,182,000			

INDIAN HEALTH SERVICE
Appropriation History Table
Facilities

February 10, 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	$461,995,000			

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

CLINICAL SERVICES

(Dollars in Thousands)

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$2,966,268	$3,099,127	$3,243,045	+$143,918
FTE*	7,579	7,768	7,872	+104

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

SUMMARY OF THE BUDGET REQUEST

The FY 2015 budget request for Clinical Services of $3,243,045,000 is an increase of $143,918,000 above the FY 2014 Enacted level. The detailed explanation of the request is described in each of the budget narratives that follow.

- $1.863 billion for **Hospitals and Health Clinics** to support access to quality healthcare in IHS and Tribal hospitals, clinics and health stations and to help address health priorities such as diabetes, cardiovascular disease, obesity, maternal and child health, physical trauma and behavioral health issues.

- $175.7 million for **Dental Health** to provide primarily preventive and basic care, with about 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.

- $82.0 million for **Mental Health** to provide a community-oriented clinical and preventive mental health service program that provides outpatient mental health and related services, crisis triage, case management, prevention programming, and outreach services.

- $193.8 million for **Alcohol and Substance Abuse** to provide overall program support. The program exists as part of an integrated behavioral health team that works collaboratively to reduce the incidence of alcoholism and other drug dependencies in AI/AN communities.

- $929.0 million for **Purchased/Referred Care** (PRC; formerly known as Contract Health Services) 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

168 Federal and Tribal Service Units (local level) for 632 healthcare facilities providing care to 2.1 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 2013: 22.8% FY 2013 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 2007: 95.3 FY 2006 Target: 93.8 (Target Not Met)	FY 2015: 95.3 (Results available Dec 2019)

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

HOSPITALS AND HEALTH CLINICS

(Dollars in Thousands)

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$1,749,072	$1,790,904	$1,862,501	+$71,597
FTE*	6,495	6,638	6,686	+48

*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 2015 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 2.1 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 programs for 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.

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 these individual and community health services. The remainder is managed by direct federal programs providing health care at the Service Unit (SU) and community level.

Although the health status of AI/ANs has improved significantly in the past 58 years since the inception of the IHS, the average life expectancy at birth is 73.6 years (data years 2005-2007) compared to the U.S. all races life expectancy of 77.7 years)[1]. The IHS and Tribes primarily serve small, rural populations with mainly primary medical care and community-health services at more than 600 locations, 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 and orthopedics. Of the 45 IHS and Tribal hospitals, only one

[1] *Life Expectancy: American Indians and Alaska Natives, Data Years 2003-2005*. Indian Health Service Division of Program Statistics, Indian Health Service, United States Department of Health and Human Services. Released October 2010.

has an average daily census of greater than 45 patients. Nineteen of these 45 hospitals have operating rooms, which demonstrates the IHS focus on primary and community based care rather than secondary or tertiary care.

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 – There are 132 sites that have participated in the Improving Patient Care (IPC) Program, which is IHS' implementation of the patient centered medical home (PCMH) model. The current goal is to expand to 170 sites by FY 2015. The aim of the IPC Program is to transform the Indian health system by developing high-performing, innovative health care teams to improve the quality of and access to care that is more patient centered. New standards for health care delivery will result in improved health and wellness of AI/AN people by utilizing a PCMH. This will strengthen the positive relationships among the health care system, care team, individual, family, community, and Tribes.

Assessment is conducted in the following domains: clinical prevention screenings, management and prevention of chronic conditions, patient experience of care, and access to care. Improvements have occurred in clinical prevention screenings for hypertension, depression, domestic violence/intimate partner violence and in patient satisfaction. IPC implements continuous quality improvement strategies and focuses on measuring improvements in access to and quality of care. Preliminary analysis of combined IPC sites reporting from October 2012 to October 2013 reveal improvements in screening/prevention rates regarding patients eligible for screenings such as depression, alcohol misuse, domestic violence / intimate partner violence, and tobacco users who received tobacco cessation counseling. Additionally, emphasis on assuring cardiovascular care and diabetes standards of care are met promotes early detection and prevention of co-morbid conditions. The IPC teams are collectively having a positive impact on providing care for patients with multiple chronic condition care. IPC teams are also measuring improvements in the process of care, including reduced waiting times in clinics and quicker access to appointments. Implementation of IPC is an important contribution to the Agency's implementation of the Affordable Care Act.

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 2013 IHS Scholarship, Loan Repayment Program, Recruitment and Retention Program, Office of Public Health Services report, 2,102 registered nurses (RN) are employed with IHS. The IHS Nurse Position Report identified an Registered Nurse (RN)and Advanced Practice Nurse (APN) vacancy rate of 15 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. APRNs have strengthened IHS multidisciplinary medical teams and improved access to efficient, high quality care.

Nursing addresses all agency priorities, but focuses heavily on the agency priority of improving quality and access to care for AI/ANs. Nurses are important leaders and contributors to every facet of clinical care for AI/ANs. Nurses are critical to the success of the IPC and Partnership for Patients Initiative as they are well positioned to help transform the health care system into one that places more emphasis on prevention, wellness, and coordination of care. Nurses are often the first point of contact for patients. They conduct intake screening measures (e.g., blood pressure, tobacco use, depression) throughout the continuum of health care, and often initiate, implement,

or reinforce quality care for patients. Nurses are leading the IHS Baby Friendly Hospital Initiative (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. The IHS aims to designate all IHS operated hospitals that provide obstetric care as "baby friendly" by the end of 2014. Seven of the 13 IHS federally operated obstetric hospitals have been designated: Claremore Indian Hospital (Oklahoma), Phoenix Indian Medical Center (Arizona), Quentin N. Burdick Memorial Health Care Facility (North Dakota), Pine Ridge Hospital (South Dakota), Rosebud Indian Hospital (South Dakota), Zuni Comprehensive Community Health Center (New Mexico), and Whiteriver Service Unit (Arizona). This means 54 percent of IHS obstetric hospitals currently performing births have become "Baby Friendly". Nationally, fewer than 6 percent of all US hospitals are Baby-Friendly designated.

Ambulatory Care, Inpatient, and Public Health Nursing are also focused on quality measurements identified in the President's Partnership for Patients Initiative. By the end of FY 2013, this initiative aimed to reduce re-hospitalization within 30 days of discharge by 20 percent (as compared to FY 2010) and to reduce hospital acquired conditions by 40 percent within the next 3 years.

Trauma Care – The IHS continues to focus attention on trauma care and injury prevention. Trauma is the largest cause of death and disability in Indian Country for those under age 45, and AI/AN trauma death rates are three times higher than U.S. all races rates. 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 capabilities as well as state of the art equipment are essential. Emergency medicine physicians, nurses, and other highly trained staff are essential for improving patient care and disaster management. In 2013, Gallup Indian Medical Center achieved a Level 3 Trauma Center Designation that is effective for three years which has led to an increased focus on injury prevention. Tuba City Regional Health Care Cooperation achieved a Level 4 Trauma designation in FY 2013 and is currently working on obtaining a Level 3 Trauma designation. In FY 2013, the Navajo Area Trauma Nurse Capstone Program expanded training to include population specific services, pediatric emergency services, and geriatric trauma. Trauma care nurse training is ongoing in the IHS Navajo Area Service Units, and will be replicated for other IHS Areas.

Domestic Violence Prevention Initiative (DVPI) – 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 65 pilot projects to expand outreach advocacy programs into AI/AN communities, expand the Domestic Violence and Sexual Assault Pilot project, and provide for training and the purchase of forensic equipment to support the Sexual Assault Nurse Examiner and Sexual Assault Forensic Examiner Programs. The 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. The completion of a national evaluation of the DVPI 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 (I/T/U) projects to collect a rich and wide range of data informed by knowledge gained through process measures and vastly improved in terms of outcome measurements. A new data mart has been developed to eliminate the need for contract services to perform data collection and analytics.

Domestic and intimate partner violence has a large impact on AI/AN communities. According to the Centers for Disease Control and Prevention, 39 percent of AI/AN women have experienced intimate partner violence – the highest rate of any race or ethnicity in the U.S.[2] In addition, one out of every three AI/AN women will be sexually assaulted in her lifetime,[3] 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.[4] 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 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. For example, people who have been victimized are more likely to smoke cigarettes, drink alcohol, use drugs, and engage in risky sexual behaviors.[5]

Given this, IHS is collaborating with other agencies working in the field of domestic violence and sexual assault. IHS and the Department of Justice (DOJ) Office for Victims of Crime (OVC) established an Interagency Agreement to provide training and technical assistance to address the needs of sexual assault victims. The OVC has established a coordinated, multidisciplinary project, the Sexual Assault Nurse Examiner and Sexual Assault Response Team AI/AN Initiative, which will involve IHS, the Bureau of Indian Affairs, the Federal Bureau of Investigation, and the DOJ 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 will support victim recovery, satisfaction, and cooperation with the federal criminal justice system, as well as support victims of sexual assault and tribal communities' need for justice.

FUNDING HISTORY

Fiscal Year	Amount
2010 Enacted	$1,754,383,000
2011 Enacted	$1,762,865,000
2012 Enacted	$1,810,966,000
2013 Final	$1,749,072,000
2014 Enacted	$1,790,904,000

BUDGET REQUEST

The FY 2015 budget request for Hospitals and Health Clinics of $1,862,501,000 is an increase of $71,597,000 above the FY 2014 Enacted level.

The Hospitals and Health Clinics (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.

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[2] *Adverse health conditions and health risk behaviors associated with intimate partner violence-United States, 2005.* MMWR Centers for Disease Control and Prevention. (2008). (February 8, 2008) available at, http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5705a1.htm.

[3] *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).

[4] *American Indians and Crime, 1992-96 Report*. Bureau of Justice Statistics, Office of Justice Programs, US Department of Justice.

[5] *Ibid.*

Base Funding of $1,790,904,000 – The base funding is necessary to support the primary health care services provided by IHS and Tribal programs and maintain the Agency's progress in addressing: prevention, acute care, trauma, and chronic health care needs; improving the health care delivery system by raising the quality of and access to care in our clinical programs, limiting or preventing acute, traumatic, and chronic diseases through a variety of health promotion / disease prevention efforts; continuing recruitment of health care professionals to meet workforce needs; and working to meet or exceed agency performance targets.

The $71,597,000 increase includes $68,597,000 funding for:

- Medical Inflation +$20,836,000 to cover inflationary costs of providing health care services.

- Pay Costs +$2,572,000 for pay costs increase at the IHS and Tribal service delivery level.

- Additional Staffing and Operating Costs for Newly-Constructed and Expanded Healthcare Facilities +$41,605,000 – There are 3 new and expanded healthcare facilities and 1 youth treatment facility that are planned to open in FY 2015. The youth treatment facility does not receive funding from Hospitals and Health Clinics. These facilities reflect the 398 additional staffing needs that IHS has determined as its minimum potential request for FY 2015. One of the 3 facilities is a Joint Venture Construction Program (JVCP) project where the Tribe is fulfilling its responsibility under the JVCP agreement to fund the construction and equipment for the healthcare facility. IHS' responsibility is to request the funds for the additional staff and to operate the healthcare facility. Increases in H&HC funding are required for additional staffing since it is recurring funding to the facility in subsequent years.

Additional Staff for New Healthcare Facility – Request for FY 2015*	Amount	Additional Positions to be Funded
Choctaw Alternative Rural Healthcare Center (JV), MS	$7,708,000	73
Kayenta Alternative Healthcare Center, AZ	$16,251,000	152
San Carlos Health Center, AZ	$17,646,000	173
Grand Total:	**$41,605,000**	**398**

*Although there are four new facilities, the Southern California Youth Regional Treatment Center (YRTC) receives $0 funding from Hospitals and Health Clinics because the YRTC only provides alcohol and substance abuse treatment services.

- New Tribes +$3,584,000 to partially fund 5 new federally recognized Tribes. This level establishes baseline funding for each tribe and recurs in out years. Approximately 4.630 tribal members will gain access to care through this funding.

The remaining $3,000,000 increase restores the Director's Emergency Fund to the FY 2013 level. This restoration will allow IHS to address some of the emergencies involving the IHS facilities and IHS or Tribal delivery of health services. Examples include response activities for natural disasters, infectious diseases and unforeseen facility emergencies.

Outputs and Outcomes

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
5: Diabetes: Nephropathy Assessment: Proportion of patients with diagnosed diabetes assessed for nephropathy. IHS-All	FY 2013: 68.2% Target: 64.2% (Target Exceeded)	Baseline	TBD	N/A (Baseline in FY 2014)

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
5: Tribally Operated Health Programs	FY 2013: 61.3% Target: 55.6% (Target Exceeded)	Baseline	TBD	N/A (Baseline in FY 2014)
20: 100% of hospitals and outpatient clinics operated by the Indian Health Service are accredited (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 2013: 57.6% Target: 56.8% (Target Exceeded)	58.6%	59.6%	1.0%
6: Tribally Operated Health Programs	FY 2013: 54.5% Target: 53.6% (Target Exceeded)	55.5%	56.5%	1.0%
7: Pap Smear Rates: Proportion of eligible women who have had a Pap screen within the previous four years. IHS-All	FY 2013: 61.7% Target: Baseline (Target Met)	Baseline	TBD	N/A (Baseline in FY 2014)
7: Tribally Operated Health Programs	FY 2013: 61.7% Target: Baseline (Target Met)	Baseline	TBD	N/A (Baseline in FY 2014)
8: Mammogram Rates: Proportion of eligible women who have had mammography screening within the previous two years. IHS-All	FY 2013: 53.8% Target: 49.7% (Target Exceeded)	54.7%	54.8%	0.1%
8: Tribally Operated Health Programs	FY 2013: 54.9% Target: 50.7% (Target Exceeded)	55.8%	55.9%	0.1%
9: Colorectal Cancer Screening Rates: Proportion of eligible patients who have had appropriate colorectal cancer screening. IHS-All	FY 2013: 35.0% Target: Baseline (Target Met)	35.0%	35.2%	0.2%
9: Tribally Operated Health Programs	FY 2013: 36.2% Target: Baseline (Target Met)	36.2%	36.4%	0.2%
TOHP-2: Number of designated annual clinical performance goals met. (Outcome)	FY 2013: 16/16 Target: 13/17 (Target Exceeded)	13/16	13/16	0
44: Years of Potential Life Lost (YPLL) in the American Indian/Alaska Native (AI/AN) population (Outcome) IHS-All	N/A	N/A	TBD	N/A
24: American Indian and Alaska Native Childhood Combined (4:3:1:3*:3:1:4) immunization rates: American Indian/Alaska Native patients aged 19-35 months, are immunized against preventable childhood diseases. IHS - All (Outcome)	FY 2013: 74.8% Target: Baseline (Target Met)	74.8%	73.9%	-0.9%
24: Tribally Operated Health Programs	FY 2013: 68.8%	68.8%	68.0%	-0.8%

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
	Target: Baseline (Target Met)			
45: Hospital Admissions per 100,000 service population for long term complications of diabetes. (Efficiency) IHS-All	N/A (No results available until 2014)	N/A	TBD	N/A
16: Domestic (Intimate Partner) Violence Screening: Proportion of women who are screened for domestic violence at health care facilities. IHS-All	FY 2013: 62.4% Target: 58.3% (Target Exceeded)	64.1%	61.6%	-2.5%
16: Tribally Operated Health Programs	FY 2013: 56.7% Target: 53.6% (Target Exceeded)	58.0%	56.0%	-2.0%
25: Adult Immunizations: Influenza: Influenza vaccination rates among adult patients aged 65 years and older. IHS-All	FY 2013: 68.0% Target: 62.3% (Target Exceeded)	69.1%	67.2%	-1.9%
25: Tribally Operated Health Programs	FY 2013: 65.4% Target: 59.0% (Target Exceeded)	66.5%	64.6%	-1.9%
26: Adult Immunizations: Pneumovax: Pneumococcal vaccination rates among adult patients aged 65 years and older. IHS-All	FY 2013: 89.2% Target: 84.7% (Target Exceeded)	Baseline	TBD	N/A (Baseline in FY 2014)
26: Tribally Operated Health Programs	FY 2013: 85.9% Target: 81.8% (Target Exceeded)	Baseline	TBD	N/A (Baseline in FY 2014)
33: HIV Screening: Proportion of pregnant women screened for HIV.	FY 2013: 87.7% Target: 82.3% (Target Exceeded)	89.1%	86.6%	-2.5%
32: Tobacco Cessation Intervention**:** Proportion of tobacco-using patients that receive tobacco cessation intervention. IHS-All	FY 2013: 45.7% Target: Baseline (Target Met)	45.7%	46.3%	0.6%
32: Tribally Operated Health Programs	FY 2013: 42.8% Target: Baseline (Target Met)	42.8%	43.4%	0.6%
30: CVD Comprehensive Assessment: Proportion of CHD patients who have a comprehensive assessment for all CVD-related risk factors. IHS-All	FY 2013: 46.7% Target: 32.3% (Target Exceeded)	51.0%	47.3%	-3.7%
30: Tribally Operated Health Programs	FY 2013: 45.4% Target: 27.2% (Target Exceeded)	49.7%	46.0%	-3.7%
43: Breastfeeding Rates: Proportion of infants 2 months old (45-89 days old) that are exclusively or mostly breastfed.	FY 2013: 29.0% Target: Baseline (Target Met)	29.0%	29.0%	0.0%
43: Tribally Operated Health Programs	FY 2013: 27.8% Target: Baseline	27.8%	27.8%	0.0%

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
	(Target Met)			
46: Million Hearts -- Controlling High Blood Pressure. IHS-All	N/A	Baseline	TBD	N/A (Baseline in FY 2014)
46: Tribally Operated Health Programs	N/A	Baseline	TBD	N/A (Baseline in FY 2014)
H&HC 4: Inpatient Admissions - IHS Direct *(Output)*	FY 2012: 20,707 Target: 22,500 (Target Not Met)	22,700	19,900	-2,800
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 2013: 61.9% Target: 63.4% (Target Not Met)	84.0%	61.9%	-22.1%
H&HC 2: Percent of sexual assault community developed model (SACDM) programs that have an active interdisciplinary Sexual Assault Response Team (SART) *(Output)*	FY 2013: 42.1% Target: 84.6% (Target Not Met)	100%	42.1%	-57.9%
H&HC 3: Percent of SANE/SART Programs with written sexual assault response policies and procedures *(Output)*	FY 2013: 87.5% Target: 85.7% (Target Exceeded)	100%	87.5%	-12.5%

GRANTS AWARDS

H&HC funds support two grant programs: the Healthy Youth Lifestyle Grant, a $1 million limited cooperative agreement with the National Congress of American Indians, and the $500,000 National Indian Health Board Cooperative Agreement.

	FY 2013 Final	FY 2014 Enacted	FY 2015 Request
Number of Awards	2	2	2
Average Award	$750,000	$750,000	$750,000
Range of Awards	$500,000-$1,000,000	$500,000-$1,000,000	$500,000-$1,000,000
Total Awards	**$1,500,000**	**$1,500,000**	**$1,500,000**

AREA ALLOCATION – Hospitals and Health Clinics *(dollars in thousands)*

Discretionary SERVICES	**FY 2013 Final**	**FY 2014 Enacted**	**FY 2015 Request**	**FY 2015 +/- FY 2014**
Alaska	$252,264	$293,838	$297,672	$3,834
Albuquerque	76,297	76,297	77,293	996
Bemidji	97,468	97,468	98,740	1,272
Billings	62,854	62,854	63,674	820
California	69,636	69,636	71,692	2,056
Great Plains*	166,046	166,046	168,213	2,167

Nashville	54,325	54,325	57,471	3,146
Navajo	221,753	221,753	224,647	2,894
Oklahoma	319,124	320,627	332,519	11,892
Phoenix	156,603	158,358	194,321	35,963
Portland	73,839	73,839	74,802	963
Tucson	19,567	19,567	19,822	255
Headquarters	179,296	179,296	181,636	5,340
Total, H&HC	**$1,749,072**	**$1,790,904**	**$1,862,501**	**$71,597**

Note: Allocation amounts are estimates.

* The Great Plains Area is the new name for the former Aberdeen Area. The area office name was changed at the request of the Tribes served by the Aberdeen Area Indian Health Service. Notification can be found in the January 10, 2014, issue of the Federal Register, *available at* http://www.gpo.gov/fdsys/pkg/FR-2014-01-10/pdf/2014-00264.pdf.

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 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$1,749,072	$1,790,904	$1,862,501	+$71,597
EPI Centers	$4,433	$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 2015 Authorization.....Permanent

Allocation Method .....Cooperative Agreements

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The Indian Health Service (IHS) Tribal Epidemiology Center (TEC) Program was 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. 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 GPRA, agency performance reports, and monitoring of the Healthy People 2020 objectives at the Tribal level. 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.

FUNDING HISTORY

Over 90 percent of the TEC Program budget is distributed through cooperative agreements. Up to $1,000,000 in funding for each TEC is authorized by the Indian Health Care Improvement Act. Initially, four Tribal organizations competed and received $155,000 each in funding based on recommendations from an objective review panel. In FY 2006, the IHS TEC Program

expanded to 11 TECs with an average award of $380,000. In FY 2008, a TEC was established in the California Area and was funded through the Director's budget in the amount of $350,000 until the next 5-year cooperative agreement award cycle in FY 2011. In FY 2011, through another competitive 5-year cooperative agreement award process, all 12 TECs were again awarded and the average award has been $360,000. All 12 existing TECs now serve a major portion of the AI/AN population in 12 regions comparable to the IHS Administrative Area service population.

Fiscal Year	Amount *
2010 Enacted	*$4,686,346*
2011 Enacted	*$4,686,346*
2012 Enacted	*$4,678,847*
2013 Final	*$4,433,361*
2014 Enacted	*$4,678,847*

* Funded under the H&HC budget.

BUDGET REQUEST

The FY 2015 budget request for the Tribal Epidemiology Centers Program of $4,679,000 (funded within Hospitals and Health Clinics budget line) is the same as the FY 2014 Enacted level.

The TEC base budget addresses 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 establish 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.
4) Ensure that our work is transparent, accountable, fair and inclusive – The DEDP continues to make all our work transparent, accountable, fair and inclusive to IHS, Tribes, TECs, other federal agencies, and the public through reports, meetings and the recent TEC Program evaluation.

DEDP/TEC projects promote three HHS High Priority Performance Goals: Tobacco–Supportive Policy & Environments; Emergency Preparedness; and Health Information Technology.

Outputs and Outcomes

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
EPI-1: Health Status & Monitoring* **Measured by surveys, assessments, reports (Output)*	FY 2013 Final: 12 of 12 TECs Target: 12 of 12 TECs (Target Met)	12 of 12 TECs	12 of 12 TECs	0
EPI-2: Provide regional health profiles *(Output)*	FY 2013 Final: 12 of 12 TECs Target: 12 of 12 TECs (Target Met)	12 of 12 TECs	12 of 12 TECs	0
EPI-3: Tribal support - technical training in public health practice *(Output)*	FY 2013 Final: 12of 12 TECs Target: 12 of 12 TECs (Target Met)	12 of 12 TECs	12 of 12 TECs	0

GRANTS AWARDS

	FY 2013 Enacted	FY 2014 Enacted	FY 2015 Request
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 2015 Tribal Epidemiology Centers Allocation (Estimated)			
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	$358,847
	TOTAL		**$4,678,847**

* The Great Plains Area is the new name for the former Aberdeen Area. The area office name was changed at the request of the Tribes served by the Aberdeen Area Indian Health Service. Notification can be found in the January 10, 2014, issue of the Federal Register, *available at* http://www.gpo.gov/fdsys/pkg/FR-2014-01-10/pdf/2014-00264.pdf.

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 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$1,749,072	$1,790,904	$1,862,501	$71,597
HIT	*$172,149*	*$172,149*	*$172,149*	*$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 2015 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 approximately 2.1 million American Indian and Alaska Natives (AI/AN) 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 that are fully integrated with the Agency's programs and critical to carrying out the IHS mission and priorities:

1) **Resource and Patient Management System (RPMS)** is the key IHS enterprise health information system that underlies the clinical, practice management and revenue cycle business processes at I/T/U facilities across the country. The RPMS EHR is certified according to the 2011 certification criteria published by the Office of the National Coordinator for Health Information Technology and is in use at nearly 400 health care facilities across the country. IHS has completed development and testing against the criteria for 2014 Certification, which will enable eligible hospitals and providers to continue to participate in the meaningful use incentive programs for the next three years.
2) **Infrastructure, Office Automation and Telecommunications (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, a national e-mail and telecommunications capability, 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 innovative opportunities.

3) **National Patient Information Reporting System (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 is evolving to become the data source for agency-level quality measurement, performance reporting, and enterprise analytics, residing in a private cloud environment.

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 and serve to promote compliance with federal laws and mandates and to improve the efficiency and security of the IHS HIT Program.

FY 2012 and FY 2013 Accomplishments

The IHS Office of Information Technology (OIT) realized numerous accomplishments during FY 2012 and 2013, including:

- Deployment of the 2011 Certified RPMS EHR throughout IHS that has resulted in substantial benefit to IHS hospitals and clinics through the collection of meaningful use incentive payments. By the end of FY 2013, $49.2 million had been received as a result of adoption and/or meaningful use of the RPMS EHR by IHS eligible hospitals and providers. A portion (25 percent) of these funds are assessed by IHS Headquarters to support continued development of the RPMS to meet new Meaningful Use requirements. The remainder are used at the Service Unit to support the HIT workforce, address technical deficiencies, or for other program needs at the discretion of local management.
- 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) by the beginning of FY 2015.
- IHS completed the virtualization infrastructure for the OIT Data Centers, and continues to virtualize appropriate systems to improve efficiency and performance of enterprise technologies.
- IHS deployed the first two practice management applications in a new suite of tools that use true Service Oriented Architecture (SOA) technologies to modernize legacy character-based user interfaces.
- The IHS e-mail team deployed a new system for the secure exchange of encrypted messages and for large file transfer in support of IHS business operations.
- Increased bandwidth capacity at IHS data centers, improving access to centrally hosted IT and HIT applications as well as connectivity to external business partners that support IHS health care services. A contract was completed that will produce aggregated performance measures from the National Data Warehouse in preparation for the expansion of NPIRS to include national performance and quality measurement capabilities.

Collaboration with 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), Department of Defense, 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) 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.

FUNDING HISTORY

Fiscal Year	Amount *
2010 Enacted	$172,405,000
2011 Enacted	$169,024,509
2012 Enacted	$172,149,000
2013 Final	$172,149,000
2014 Enacted	$172,149,000

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

Immediate Priorities and Challenges

The IHS HIT Program will face increased workload and costs in FY 2014, principally in testing, deploying and supporting the new technologies and services developed for Stage 2 meaningful use, as well as completion of development, testing and deployment of the multiple system changes required for the transition to ICD-10. Because of the timing of the 2014 EHR Certification and Stage 2 Meaningful Use Final Rules, most IHS facilities will not receive MU incentive payments in 2014 or 2015, greatly reducing funding available to the IHS HIT Program for further development.

In FY 2015 a significant deployment and support imperative for MU and ICD-10 will continue, and the HIT Program will be catching up on the highest priority system fixes and enhancements that were deferred from 2014 and before. In addition, sometime in 2015 HHS will publish new requirements for 2017 EHR Certification, initiating a new cycle of analysis and software development. Additional demands on IHS HIT in FY 2015 will include:

- Operational support for existing technology infrastructure and HIT systems in order to ensure continuity of care and services at all customer sites across the country. The breadth and complexity of these systems, RPMS in particular, has been increasing exponentially over the past several years in response to initiatives such as meaningful use, and the demands for training and support will continue to be significant.
- Management and operations for new enterprise services that have been developed in response to meaningful use and other initiatives. These include, at a minimum, health information exchange, secure email messaging between patients and providers, the Personal Health Record patient portal, electronic prescribing, terminology services, and more.
- Continued expansion of the NPIRS national data warehouse to serve as the enterprise data analytics and performance measurement hub for IHS, including data from non-RPMS systems.
- Continued modernization of legacy user interfaces for both business and clinical applications.
- The IHS network will continue to require upgrades in order to achieve the necessary bandwidth and reliability recommended by the Federal Communications Commission in order to support robust health information exchange required by meaningful use and expanding telehealth initiatives.
- IHS HIT will be expected to respond in a timely way to new security threats, regulatory mandates for government IT systems, and industry standards and best practices.

- IHS HIT will be expected to support provisions of the Affordable Care Act 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.

The IHS HIT Program will provide the highest 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.

BUDGET REQUEST

The FY 2015 budget request for Health Information Technology, within Hospitals and Health Clinics budget line, of $172,149,000 is the same as the FY 2014 Enacted level.

HIT in IHS is an instrument to support health care efficiency and quality. The IHS HIT Program has made substantial strides in the past several years by using innovative solutions to improve IHS' infrastructure and to give healthcare providers with the tools and information they need to make life-saving decisions at the point of care. The FY 2015 budget request will absorb inflationary costs and allow the IHS HIT Program to support high priority existing systems which are critical to maintaining the health care services and revenue streams for I/T/U health care facilities. In the absence of additional funding some cost-shifting to clinical programs and reduction in lower priority services can be expected.

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.

IHS Investments

(Dollars in Thousands)

Program Name	IT Investment Title	Unique Investment Identifier	FY 2013	FY 2014	FY 2015 Request
Hospitals & Health Clinics	IHS Resource and Patient Management System – Maintenance & Enhancements	009-17-01-02-01-1010-00	$101,625	$96,625	$100,857
Hospitals & Health Clinics	IHS National Patient Information and Reporting System – Maintenance & Enhancements	009-17-01-02-01-1020-00	$9,285	$9,448	$ 9,761
Hospitals & Health Clinics	IHS Infrastructure, Office Automation, & Telecommunications (IOAT)	009-17-02-00-01-1040-00	$55,858	$56,218	$ 57,454
Hospitals & Health Clinics	Non-major Investments including Security and Enterprise Architecture Programs	N/A	$9,707	$9,858	$4,077
Total			**$176,475**	**$172,149**	**$172,149**

Outputs and Outcomes

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
RPMS-2: Derive all clinical measures from RPMS and integrate with EHR (Clinical Measures/Areas) (RPMS Program Assessment)	FY 2013: 73/12 Target: 69/12 (Target Exceeded)	73/12	73/12	0/0

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 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$156,653	$165,290	$175,654	+$10,364
FTE*	684	712	747	+35

*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 2015 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 Dental Health Program 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 Dental Health Program 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 2013, the dental program provided a total of 3,652,658 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 203,943 dental services provided in FY 2013.

By age eight, 90 percent of AI/AN children suffer from dental caries, while only 50 percent of the U.S. population has experienced cavities by that age. In addition to this disparity in prevalence, there is a significant disparity in severity of dental disease. AI/AN children ages 2-5 exhibit an average of six decayed teeth, while the same age group in the U.S. population averages one decayed tooth. Thus, the demand for dental treatment remains high due to the high incidence of dental caries in AI/AN children. 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 reduce both the amount and the cost of subsequent dental care and improve oral health.

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. Our performance with respect to delivering preventive services is 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. 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. In conducting the screening surveys, the IHS utilized Bureau of Indian Education-operated elementary schools.

In contrast, the IHS ECC initiative targets pre-school age children, ages 0 – 5 years, out of necessity, as it is in this age group that ECC originates. The IHS is in the midst of the final year of the 5-year IHS Early Childhood Caries Collaborative, aimed at preventing early childhood caries through increased preventive services. Data necessary for the final evaluation of this current initiative will be collected in the fall of 2014.

The dental program maintains data and tracks three key program objectives: (1) increase the number of dental sealants placed; (2) increase the number of patients who receive at least one topical fluoride application; and (3) increase access to care. In GPRA Year 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 in the GPRA years as of July 1, 2013. Topical fluorides and dental sealants are extensively researched and documented in the dental literature as safe and effective preventive interventions to reduce tooth decay. The high prevalence of sealants represents a notable accomplishment for the IHS Dental Health Program as significant numbers of susceptible tooth surfaces are now protected by dental sealants. Access to dental services is a prerequisite to the control of oral disease in susceptible or high-risk populations. The access to care GPRA objective is currently assessed in accord with Healthy People 2020 methodology as a percentage of patients who have visited the dentist.

In recent years, the IHS Dental Health Program 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 the AI/AN community. Currently there are eight DSCs, four funded by program awards and four 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 the AI/AN community. 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.

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, 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 Dental Health Program will continue its efforts to recruit and retain dental providers to improve dental access and to meet all annual performance objectives. Recent activities to support improvements in meeting annual performance objectives include:

- The Division of Oral Health (DOH) conducted an evaluation of the Oral Health Program in 2010 and also oversees an ongoing annual surveillance of oral health. DOH convened an expert review committee assessment of the Alaska Dental Health Aide Therapist Initiative. Recently DOH also began an assessment of the dental support centers project. At present, 6 of 8 support centers have undergone comprehensive, on-site evaluations. 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 insure the timely response of program data to field programs.

- Using the quarterly GPRA Dashboard, specific lagging measures are targeted for a national webinar to discuss measure performance as well as provide ideas and allow for brainstorming to improve measure performance. The dental GPRA objectives were recently revised to more closely align with Healthy People 2020 objectives. This allows us to assess our performance with respect to these objectives relative to the national norms.

FUNDING HISTORY

Fiscal Year	Amount
2010 Enacted	$152,634,000
2011 Enacted	$152,634,000
2012 Enacted	$159,440,000
2013 Final	$156,653,000
2014 Enacted	$165,290,000

BUDGET REQUEST

The FY 2015 budget request for Dental Health Services of $175,654,000 is an increase of $10,364,000 above the FY 2014 Enacted level.

Base Funding of $165,290,000 – The base funding is necessary to support the oral health care services provided by IHS and Tribal programs, maintain the programs 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.

The $10,364,000 increase includes funding for:

- Medical Inflation +$1,672,000 to cover inflationary costs of providing health care services.

- Additional Staffing and Operating Costs for Newly-Constructed Healthcare Facilities +$8,224,000 – There are 3 new and expanded healthcare facilities and 1 youth treatment facility that are planned to open in FY 2015. The youth regional treatment facility does not receive funding from Dental. These facilities reflect the 83 additional staffing needs that IHS has determined as its minimum potential request for FY 2015. One of the 3 facilities is a Joint Venture Construction Program (JVCP) project where the Tribe is fulfilling its responsibility under the JVCP agreement to fund the construction and equipment for the

healthcare facility. IHS' responsibility is to request the funds for the additional staff and to operate the healthcare facility. Increases in Dental Health funding are required for additional staffing since it is recurring funding to the facility in subsequent years.

Additional Staff for New Healthcare Facility – Request for FY 2015*	Amount	Additional Positions to be Funded
Choctaw Alternative Rural Healthcare Center (JV), MS	$1,504,000	15
Kayenta Alternative Healthcare Center, AZ	$3,648,000	35
San Carlos Health Center, AZ	$3,072,000	33
Grand Total:	**$8,224,000**	**83**

*Although there are four new facilities, the Southern California Youth Regional Treatment Center (YRTC) receives $0 funding from Dental because the YRTC only provides alcohol and substance abuse treatment services.

- New Tribes +$468,000 to partially fund 5 new federally recognized Tribes. This establishes baseline funding for each tribe and recurs in out years. Approximately 4,630 tribal members will gain access to care through this funding.

Outputs and Outcomes

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
12: **Topical Fluorides:** Percentage of American Indian and Alaska Native patients receiving one or more topical fluoride applications.	FY 2013: 26.7% Target: Baseline (Target Met)	26.7%	26.4%	-0.3%
13: **Dental Access:** Percent of patients who receive dental services.	FY 2013: 28.3% Target: 26.9% (Target Exceeded)	29.2%	27.9%	-1.3%
14: **Dental Sealants:** Percentage of American Indian/Alaska Native patients with at least one or more intact dental sealant.	FY 2013: 13.9% Target: Baseline (Target Met)	13.9%	14.1%	+0.2%

GRANTS AWARDS

	FY 2013 Final	FY 2014 Enacted	FY 2015 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-$250,000
Total Awards	**$1,000,000**	**$1,000,000**	**$1,000,000**

AREA ALLOCATION – Dental Services *(dollars in thousands)*

Discretionary SERVICES	FY 2013 Final	FY 2014 Enacted	FY 2015 Request	FY 2015 +/- FY 2014
Alaska	$18,061	$19,057	$19,307	$250
Albuquerque	8,059	8,503	8,588	85
Bemidji	4,127	4,355	4,398	43
Billings	7,211	7,609	7,685	76
California	1,894	1,998	2,117	119
Great Plains*	16,562	17,475	17,649	174
Nashville	2,730	2,881	3,279	398
Navajo	28,469	30,039	33,986	3,947
Oklahoma	34,199	36,085	37,958	1,873
Phoenix	13,003	13,720	16,930	3,210
Portland	7,381	7,788	7,866	78
Tucson	1,795	1,894	1,913	19
Headquarters	13,162	13,888	13,980	92
Total, DENTAL	**$156,653**	**$165,290**	**$175,654**	**+$10,364**

Note: Allocation amounts are estimates.

* The Great Plains Area is the new name for the former Aberdeen Area. The area office name was changed at the request of the Tribes served by the Aberdeen Area Indian Health Service. Notification can be found in the January 10, 2014, issue of the Federal Register, *available at* http://www.gpo.gov/fdsys/pkg/FR-2014-01-10/pdf/2014-00264.pdf

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

MENTAL HEALTH

(Dollars in Thousands)

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$74,131	$77,890	$82,025	+$4,045
FTE*	205	218	231	+13

*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 2015 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. 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.

The MH/SS Program addresses the Agency's priorities and works to integrate behavioral health into primary care. Tribal contracting and compacting has enabled behavioral health programs to transition from IHS to local community control. As a result, over half the Tribes now administer and deliver their own mental health programs. The IHS MH/SS Program assists Tribes in bringing programs and program collaborations to their own communities.

Across Indian Country today, the high incidence of alcohol and substance abuse, mental health disorders, suicide, violence, and behavior-related chronic diseases is well documented. 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. American Indians and Alaska Natives (AI/AN) are at higher risk for certain mental health disorders than other racial/ethnic groups. For example, the Office of Minority Health reports that AI/AN individuals experience higher rates of occurrence than all races in the following areas:

- Serious psychological distress;
- Feelings of sadness, hopelessness, and worthlessness;
- Feelings of nervousness or restlessness; and
- Suicide.

AI/ANs are also overrepresented among high-need populations requiring mental health services (e.g., people who are homeless, incarcerated, drug/alcohol abusers, and exposed to trauma as well as children who are in foster care).[1] Behavioral health issues are a top tribal priority for both treatment and prevention.

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 problem 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 screening for alcohol and substance use, depression, domestic violence, and smoking, alcohol screening and brief intervention practices and suicide data collection.

Child/Family Protection: Child abuse and the cycle of repeat abuse in adulthood are well documented in the AI/AN literature. 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.

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.

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[1] *See* Surgeon General's Report, 1999.
[2] IHS Newsroom: Mortality Disparity Rates. Available at http://www.ihs.gov/newsroom/factsheets/disparities/

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. This effort seeks to establish effective long-term strategic approaches to address mental health and suicide prevention in Indian Country.

On September 10, 2010, Department of Health and Human Services Secretary Kathleen Sebelius and Department of Defense Secretary Robert M. Gates announced the creation of the National Action Alliance for Suicide Prevention. On September 10, 2012 the Action Alliance, along with then U.S. Surgeon General, Dr. Regina Benjamin, released the revised National Strategy for Suicide Prevention. The IHS co-leads the AI/AN Task Force that was also formed to advance suicide prevention efforts in AI/AN communities.

Training is also an essential part of effectively addressing mental health of AI/AN communities. Established in 2008, the Telebehavioral Center of Excellence (TBHCE) in Albuquerque, New Mexico provides a range of behavioral health services, technical assistance, and training via televideo. In 2013 and in partnership with the University of New Mexico, the TBHCE conducted webinar training for over 2,400 participants on current and pressing behavioral health issues through a series of webinars, including a concentrated focus on substance use disorders. The TBHCE is also evaluating models of care delivery, access to care, and sustainability. A toolkit was developed for sites to prepare the infrastructure to have telebehavioral health services. Critical video infrastructure components were purchased and installed. Intra-Agency agreements were established with IHS Billings, Great Plains and Nashville Areas. TBHCE sites for direct clinical services are Spirit Lake, Great Plains Area; Fort Peck (Wolf Point clinic and Poplar clinics) and Fort Belknap, Billings Area; Elko, Phoenix Area; Acoma-Canoncito-Laguna, New Sunrise Regional Treatment Center, To'hajiilee clinic, Mescalero, Albuquerque Indian Health Center, and the Santa Clara clinic, Albuquerque Area; and Catawba, Nashville Area.

In FY 2015, IHS will continue to focus on integration of behavioral health into primary care. IHS supports changing the paradigm of mental health 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. There will continue to be a focus on a comprehensive and integrated approach to reducing the loss and suffering from suicide and suicidal behaviors. This effort will continue to bring together multiple disciplines, perspectives, and resources to create an integrated system where services can be accessed across multiple settings. To help victims of violence, IHS provides direct services, advocacy, interagency consultation, and collaboration with other federal agencies to provide child and family protection services to AI/AN children and families. Plans also include improving the RPMS to support clinical best practices and disease surveillance.

FUNDING HISTORY

Fiscal Year	Amount
2010 Enacted	$72,786,000
2011 Enacted	$72,786,000
2012 Enacted	$72,786,000
2013 Final	$74,131,000
2014 Enacted	$77,980,000

BUDGET REQUEST

The FY 2015 budget request for Mental Health of $82,025,000 is an increase of $4,045,000 above the FY 2014 Enacted level.

Base Funding of $77,980,000 – The base funding is necessary to maintain the program's progress in addressing the behavioral health needs; improving access to behavioral health services; addressing suicide prevention, intervention, and postvention in communities; supporting suicide surveillance; and clinical best practices.

The $4,045,000 increase includes funding for:

- Medical Inflation +$880,000 to cover inflationary costs of providing health care services.

- Additional Staffing and Operating Costs for Newly-Constructed Healthcare Facilities +$2,846,000 – There are 3 new and expanded healthcare facilities and 1 youth treatment facility that are planned to open in FY 2015. The youth treatment facility does not receive funding from Mental Health. These facilities reflect the 30 additional staffing needs that IHS has determined as its minimum potential request for FY 2015. One of the 3 facilities is a Joint Venture Construction Program (JVCP) project where the Tribe is fulfilling its responsibility under the JVCP agreement to fund the construction and equipment for the healthcare facility. IHS' responsibility is to request the funds for the additional staff and to operate the healthcare facility. Increases in Mental Health funding are required for additional staffing since it is recurring funding to the facility in subsequent years.

Additional Staff for New Healthcare Facility – Request for FY 2015*	Amount	Additional Positions to be Funded
Choctaw Alternative Rural Healthcare Center (JV), MS	$339,000	4
Kayenta Alternative Healthcare Center, AZ	$1,167,000	12
San Carlos Health Center, AZ	$1,340,000	14
Grand Total:	**$2,846,000**	**30**

*Although there are four new facilities, the Southern California Youth Regional Treatment Center (YRTC) receives $0 funding from Mental Health because the YRTC only provides alcohol and substance abuse treatment services.

New Tribes +$319,000 to partially fund 5 new federally recognized Tribes. This level establishes baseline funding for each tribe and recurs in out years. Approximately 4,630 tribal members will gain access to care through this funding.

Outputs and Outcomes

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
29. **Suicide Surveillance:** Increase the incidence of suicidal behavior reporting by health care (or mental health) professionals.	FY 2013: 1,438 Target: 1,376 (Target Exceeded)	1,668	1,419	-249

18. **Behavioral Health:** Proportion of adults ages 18 and over who are screened for depression. IHS-All	FY 2013: 65.1% Target: 58.6% (Target Exceeded)	66.9%	64.3%	-2.6%
18. Tribally Operated Health Programs	FY 2013: 60.0% Target: 53.8% (Target Exceeded)	61.5%	59.2%	-2.3%

During the past few years the program has experienced positive performance results. Depression screening for early detection, diagnosis, and treatment increased from 61.9 percent in FY 2012 to 65.1 percent in FY 2013. While the FY 2015 targets for depression screening are ambitious, depression screening is needed to improve detection of mental health needs. 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 250 clinical sites across the country.

The Suicide Reporting Form (SRF) performance target was met in FY 2013. The FY 2013 target was 1,376 forms; the FY 2013 actual results were 1,438 forms. The FY 2013 results reflect a de-duplicated count and better represents provider reporting of suicide and suicide-related events.

In FY 2012, it was noted during a data quality review that data exports received at the National Data Warehouse (NDW) from the IHS Areas may be comprised of duplicate records. The IHS has resolved this issue through the Indian Health Performance Evaluation System (IHPES) by identifying duplicate records and following a process that involves: sorting, cross-referencing and removing duplicate records. De-duplicated trend data from 2004 through 2012 exhibited uniform variance and a reliable upward trend.

As a result of the de-duplication process, however, the overall count of submitted SRF for FY 2013 decreased from the FY 2012 results of 1,709 completed forms. Additionally, tribes within an entire IHS Service Area informed IHS in FY 2012 that they objected to the collection and reporting of suicide surveillance data. In consideration of Tribal data ownership and given the sensitive nature of suicide reporting, IHPES was directed to no longer collect and report on suicide surveillance data for that one IHS Area. To date, the Tribes within that IHS Service Area have continued with their decision to not submit suicide surveillance data. The decrease in SRF submissions may also be accounted for some tribal programs migrating from the IHS RPMS system to non-RPMS systems.

In FY 2015, IHS will increase and improve awareness of the form and 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 be made aware of the suicide reporting form 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.

Data collected from the Suicide Reporting Form is beginning to provide a more detailed picture of who is completing or attempting suicide and identifies salient factors contributing to the events. Completion of forms should provide more detailed information about the incidence of suicidal ideation, attempts, and completions which will provide far more accurate and timely data and will allow interventions to be evaluated for effectiveness in ways not previously possible.

Due to the transition to de-duplicated SRF data, one IHS Area no longer exporting SRF data to the NDW, and increasing numbers of tribes migrating from RPMS to non-RPMS platforms, it is very likely that the FY 2015 target will not be achieved. Once two years of de-duplicated SRF data are collected from FY 2013 and FY 2014, a firmer benchmark can be calculated for future target measures and actual metrics will align more closely. The impact of absorbing current service cost increases will reduce access to behavioral health screening, diagnosis, and treatment. This may increase untreated depression and the morbidity burden on the individual, family, and community.

GRANT AWARDS – The program does not anticipate any grant awards for FY 2015.

AREA ALLOCATION – Mental Health *(dollars in thousands)*

Discretionary SERVICES	**FY 2013 Final**	**FY 2014 Enacted**	**FY 2015 Request**	**FY 2015 +/- FY 2014**
Alaska	$6,030	$6,343	$6,444	$101
Albuquerque	4,193	4,411	4,460	49
Bemidji	2,199	2,313	2,339	26
Billings	3,727	3,921	3,964	43
California	1,928	2,028	2,228	200
Great Plains*	9,324	9,808	9,917	109
Nashville	1,680	1,767	1,928	161
Navajo	13,867	14,587	15,916	1,329
Oklahoma	13,082	13,761	14,261	500
Phoenix	7,279	7,657	9,083	1426
Portland	3,972	4,178	4,224	46
Tucson	1,407	1,480	1,496	16
Headquarters	5,443	5,726	5,765	39
Total, MENTAL HEALTH	**$74,131**	**$77,980**	**$82,025**	**+$4,045**

Note: Allocation amounts are estimates.

* The Great Plains Area is the new name for the former Aberdeen Area. The area office name was changed at the request of the Tribes served by the Aberdeen Area Indian Health Service. Notification can be found in the January 10, 2014, issue of the Federal Register, *available at* http://www.gpo.gov/fdsys/pkg/FR-2014-01-10/pdf/2014-00264.pdf

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Indian Health Service

Services: 75-0390-0-1-551

ALCOHOL AND SUBSTANCE ABUSE

(Dollars in Thousands)

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$185,154	$186,378	$193,824	+$7,446
FTE*	195	200	208	+8

*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 2015 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.

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 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 an unborn baby during pregnancy are permanent. Methamphetamine and other drug abuse are becoming more serious problems among AI/AN people, compounding the current adverse effects of alcohol

[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.

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]

Over the last 15 years, ASAP programs have transitioned from IHS Direct Care to local community control via tribal contracting and compacting. In FY 2012, the majority of the ASAP programs were managed by Tribes. To support this trend, IHS is transitioning from direct service only to primarily direct service support to enable communities to plan, develop, and implement culturally-informed ASAP programming. Organized to develop programs and program leadership, the major ASAP activities and focus areas are:

Behavioral Health Integration into Primary Care: IHS continues to support the integration of behavioral health into primary care through its Improving Patient Care Program. This integration offers new opportunities for interventions that identify high-risk individuals before their actions or behavior become more clinically significant. One primary care based behavioral health intervention is the Alcohol Screening and Brief Intervention (ASBI) which IHS is broadly promoting as an integral part of a primary care-based behavioral health program.

Youth Regional Treatment Centers (YRTCs): YRTCs provide 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 and staffing costs are included in this Budget. The Budget also funds construction of the Northern California YRTC, see the Health Care Facilities Construction section. 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): IHS supports two projects that target FASD through the Northwest Portland Area Indian Health Board. The FASD Training Project with the University of Washington School of Medicine is a research-based project that focuses on FASD interventions. The Parent Child Assistance Program is an intervention that serves high-risk, substance-abusing pregnant and parenting women and their families at 10 sites throughout the State of Washington.

Methamphetamine and Suicide Prevention Initiative (MSPI): The MSPI is a nationally-coordinated demonstration/pilot program, focusing on 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. In the last phase of the demonstration project, national program evaluation is a central component to the MSPI and is currently underway to identify successful practice-based and evidenced interventions

[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.

that can be replicated across the Indian health system. The MSPI program utilizes a data collection tool for IHS, Tribal, and Urban projects to collect a rich and wide range of data informed by knowledge gained through process and outcome measurement. A new data mart is under the planning stages to eliminate the need for contract services to perform data collection and analytics.

Telebehavioral Health: The ASAP incorporates telebehavioral health technology as a means to increase access to behavioral health services. Over 50 IHS and tribal facilities in 8 IHS Areas have incorporated telebehavioral health as part of their services. In FY 2013, the MSPI delivered 3,261 behavioral health encounters via telehealth platforms. Established in 2008, the TeleBehavioral Health Center of Excellence (TBHCE) in Albuquerque provides a range of behavioral health services, technical assistance, and training opportunities via televideo. In 2013 and in partnership with the University of New Mexico, the TBHCE conducted webinar training for over 2,400 participants on current and pressing behavioral health issues through a series of webinars, including a concentrated focus on substance use disorders. The TBHCE is also evaluating models of care delivery, access to care, and sustainability. A toolkit was developed for sites to prepare the infrastructure to have telebehavioral health services. Critical video infrastructure components were purchased and installed. Intra-Agency agreements were established with IHS Billings, Great Plains and Nashville Areas. TBHCE sites for direct clinical services are Spirit Lake, Great Plains Area; Fort Peck (Wolf Point clinic and Poplar clinics) and Fort Belknap, Billings Area; Elko, Phoenix Area; Acoma-Canoncito-Laguna, New Sunrise Regional Treatment Center, To'hajiilee clinic, Mescalero, Albuquerque Indian Health Center, and the Santa Clara clinic, Albuquerque Area; and Catawba, Nashville Area.

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 screening for alcohol and substance use, depression, domestic violence, and smoking, ASBI practices and suicide data collection.

Partnerships: IHS has devoted considerable effort to developing and sharing 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.

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 Centers for Medicare and Medicaid Services 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. Through this MOA, BIA, BIE, and IHS will coordinate and implement plans in cooperation with Tribes and will 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 a significant amount of 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 with those established under the 1986 Act.

In FY 2015, the ASAP will continue to focus on integration of behavioral h**e**alth into primary care. IHS supports changing the paradigm of mental health services from being fragmented, episodic, stigmatized, specialty, and 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 paradigm offers new opportunities for interventions that identify high-risk individuals before their actions or behavior become more clinically significant. IHS will continue to promote the ASBI as an integral part of a primary care based behavioral health program. IHS will provide support to YRTCs in meeting the needs of youth. There will continue to be a focus on the MSPI pilot program, which provides methamphetamine and suicide prevention and intervention resources to communities in Indian Country with the greatest need for these programs. Plans also include ongoing improvements for the RPMS to support clinical best practices and disease surveillance in collaboration with tribal and federal partners.

FUNDING HISTORY

Fiscal Year	Amount
2010 Enacted	$194,409,000
2011 Enacted	$194,409,000
2012 Enacted	$194,297,000
2013 Final	$185,154,000
2014 Enacted	$186,378,000

BUDGET REQUEST

The FY 2015 budget request for Alcohol & Substance Abuse of $193,824,000 is an increase of $7,446,000 above the FY 2014 Enacted level.

Base Funding of $186,378,000 – The base funding is necessary to maintain the program's progress in addressing the alcohol and substance abuse needs by improving access to behavioral health services through telebehavioral health efforts and providing a comprehensive array of preventive, educational, and treatment services.

The $7,446,000 increase includes funding for:

- Medical Inflation +$2,843,000 to cover inflationary costs of providing health care services.

- Additional Staffing and Operating Costs for Newly-Constructed Healthcare Facilities +$4,314,000 – There are 3 new and expanded healthcare facilities and 1 youth treatment facility that are planned to open in FY 2015. Only 3 of these facilities receive funding from Alcohol and Substance Abuse. These facilities reflect the 48 additional staffing needs that IHS has determined as its minimum potential request for FY 2015. IHS' responsibility is to request the funds for the additional staff and to operate the healthcare facility. Increases in Alcohol & Substance Abuse funding are required for additional staffing since it is recurring funding to the facility in subsequent years.

Additional Staff for New Healthcare Facility – Request for FY 2015*	Amount	Additional Positions to be Funded
Kayenta Alternative Healthcare Center, AZ	$676,000	7
San Carlos Health Center, AZ	$750,000	8
Southern California Youth Treatment Center, CA	$2,888,000	33
Grand Total:	**$4,314,000**	**48**

*Although there are four new facilities, the Choctaw Alternative Rural Healthcare Center receives $0 funding from Alcohol and Substance Abuse because the facility does not provide alcohol and substance abuse treatment services funded by IHS.

- New Tribes +$289,000 to partially fund 5 new federally recognized Tribes. This level establishes baseline funding for each tribe and recurs in out years. Approximately 4,630 tribal members will gain access to care through this funding.

Outputs and Outcomes

Measure	Year and Most Recent Result/ Target for Recent Result (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
10. **YRTC Improvement/ Accreditation:** Accreditation rate for Youth Regional Treatment Centers (in operation 18 months or more)	FY 2013: 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 2013: 65.7% Target: 61.7% (Target Exceeded)	65.9%	66.7%	0.8%
11. Tribally Operated Health Programs	FY 2013: 61.5% Target: 57.5% (Target Exceeded)	61.6%	62.4%	0.8%

Measure	Year and Most Recent Result/ Target for Recent Result (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
Methamphetamine and Suicide Prevention Initiative (MSPI)				
ASA – 1: The number of identified meth using patients who enter methamphetamine treatment program *(Output)*	FY 2013: 2,583 Target: 1,240 (Target Exceeded)	2,177	2,583	406
ASA – 2: The number of youth (ages 6 – 21) who participate in evidence-based and/or promising practice prevention or intervention programs *(Output)*	FY 2013: 161,651 Target: 42,895 (Target Exceeded)	133,970	161,651	27,681
ASA – 3: The number of individuals trained in suicide crisis response* *(Output)*	FY 2013: 3,178 Target:674 (Target Exceeded)	2,857	3,178	321
ASA – 4: Increase Telebehavioral health encounters** *(Output)*	FY 2013: 3,261 Target: 2,255 (Target Exceeded)	3,094	3,261	197

* Number of individuals trained has been reported instead of teams trained due to inconsistencies around definitions. Both measures will be collected in progress reporting for 2011.
** Many programs did not have their telebehavioral health equipment operational until the final months of the base year resulting in fewer encounters than would be expected from a full year of telebehavioral health data reporting.

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 2013 as a result of the ongoing difficulties experienced by one Tribally operated YRTC that is continuing to experience challenges with completing CARF accreditation. The YRTC hoped to obtain accreditation in 2013; however due to internal delays, the YRTC has established a revised action plan with a tentative CARF site visit for April-May 2014.

The FY 2013 performance measure was also impacted when a tribally operated YRTC closed its doors as of July 31, 2013. With this closure, the total number of operating YRTC facilities is now ten; therefore, accreditation of the nine out of the ten YRTCs results in a FY 2013 actual of 90 percent.

The FY 2015 performance target for the YRTCs is 100 percent accreditation and certification status.

Heavy drinking during pregnancy can cause significant birth defects including Fetal Alcohol Syndrome (FAS) and thus is tracked as part of the Alcohol and Substance Abuse Program. FAS is the leading known, and preventable, cause of mental retardation. Rates of FAS are higher amoung AI/AN individuals then the general population.[4] Screening with intervention has been shown to be effective in reducing alcohol misuse during pregnancy and to reduce the incidence of FAS.

In FY 2013, the 61.7 percent target for FAS Prevention was exceeded. There have been significant increases in results since FY 2005, due to increased provider awareness, and an agency emphasis on behavioral health screening.

GRANT AWARDS

	FY 2013 Final	FY 2014 Enacted	FY 2015 Request*
Number of Awards	15	15	15
Average Award	$100,000	$100,000	$100,000
Range of Awards	n/a	n/a	n/a
Total Awards	$1,500,000	$1,500,000	$1,500,000

*FY 2015 funding distribution and number of awards are pending final decision.

AREA ALLOCATION – Alcohol & Substance Abuse *(dollars in thousands)*

Discretionary SERVICES	**FY 2013 Final**	**FY 2014 Enacted**	**FY 2015 Request**	**FY 2015 +/- FY 2014**
Alaska	$29,685	$29,881	$30,383	$502
Albuquerque	11,885	11,964	12,159	195
Bemidji	9,813	9,878	10,039	161
Billings	10,819	10,891	11,068	177
California	10,655	10,725	13,905	3180
Great Plains*	13,661	13,751	13,773	22
Nashville	8,601	8,658	8,971	313
Navajo	18,454	18,576	19,555	979
Oklahoma	15,054	15,154	15,409	255
Phoenix	16,193	16,300	17,317	1017
Portland	15,822	15,927	16,186	259
Tucson	3,050	3,070	3,120	50
Headquarters	21,462	21,604	21,940	336
Total, A&SA	**$185,154**	**$186,378**	**$193,824**	**$7,446**

Note: Allocation amounts are estimates.

* The Great Plains Area is the new name for the former Aberdeen Area. The area office name was changed at the request of the Tribes served by the Aberdeen Area Indian Health Service. Notification can be found in the January 10, 2014, issue of the Federal Register, *available at* http://www.gpo.gov/fdsys/pkg/FR-2014-01-10/pdf/2014-00264.pdf

[4] Centers for Disease Control and Prevention. 2002. Fetal alcohol syndrome—Alaska, Arizona, Colorado, and New York, 1995–1997. *MMWR* 51(20):433-435. www.cdc.gov/mmwr/preview/mmwrhtml/mm5120a2.htm

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

PURCHASED/REFERRED CARE

(Dollars in Thousands)

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$801,258	$878,575	$929,041	$50,466
FTE*	0	0	0	0

*Purchased/Referred Care funds are not used to support federal FTE.

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 2015 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 in providing comprehensive health care services to eligible AI/ANs. The Indian health system delivers care through direct care services provided in an IHS, Tribal or Urban facility (e.g., hospitals, clinics) and through PRC services delivered by non-IHS providers. The purpose of the PRC Program is to purchase services from private health care providers in situations where:

- No IHS direct care facility exists,
- The direct care element is not capable of providing required emergency and/or specialty care,
- The direct care element has an overflow of medical care workload, and
- 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.[5]

In addition to meeting the requirements for direct services at an IHS or tribal facility, PRC eligibility is determined based on five requirements: (1) documentation of American Indian and/or Alaska Native descent from a federally recognized tribe; (2) proof of residency within the tribal Contract Health Service Delivery Area (CHSDA); (3) authorization of the individual

[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] On July 10, 2012, the House of Representatives, Committee on Appropriations, Interior, Environment and Related Agencies subcommittee recommended IHS propose a new name in its FY 2014 budget request for the "Contract Health Services" program "in order to be more clear and consistent with the program's activities" (H.Rpt. 112-589, p. 81). In the FY 2014 President's Budget, IHS proposed the program name change to "Purchased/Referred Care," and the FY 2014 Omnibus appropriations bill accepted this change.
[5] For CHS authorized referrals, IHS cannot require eligible American Indians and Alaska Natives treated at non-IHS or tribal facilities to pay cost sharing or copays where they are required by the facility. Thus, the PRC program will provide funding to cover amounts due above what other resources like Medicare or private insurance will pay for the health care services provided.

medical service by a PRC authorizing official for payment of services; (4) medical necessity of the service and inclusion within the established Area IHS medical/dental priorities; and (5) 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 generally the payer of last resort.[6] Services purchased may include hospital, specialty physician, outpatient, laboratory, dental, radiological, pharmaceutical, or transportation services.

When funds are not sufficient to provide the volume of PRC services as needed by the eligible population residing in the PRC delivery area of the local facility, IHS PRC regulations require IHS-operated PRC programs to use a medical priority system to fund the most urgent referrals first. Medical priority of care is determined as levels, I, II, III, IV, and V. A Medicare-Like Rate is used to purchase all inpatient health care services and allows IHS to purchase care at a lower cost than if each service were negotiated individually. Outpatient rates are paid at billed charges unless contracts are negotiated with individual providers of care. Program funds are administered and managed by PRC staff located at IHS headquarters, at each of the 12 IHS Areas, and at IHS and Tribal facilities across the nation. Tribes manage about 55 percent of the PRC budget and must adhere to the same regulations as the IHS-managed PRC programs.

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.[7] CHEF reimburses high costs cases (e.g., burn victims, motor vehicle accidents, high risk obstetrics, cardiology, etc.) after a threshold payment amount is met. CHEF is centrally managed at IHS headquarters and is available to IHS and tribally-managed PRC programs.

The PRC Program contracts with Blue Cross/Blue Shield of New Mexico as its fiscal intermediary (FI) 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.

In recent years, the PRC Program has experienced an increased demand for services, due in part to an aging population, and a rise in the cost of health care and transportation services. These factors both impact purchasing power and the level of services IHS can provide. The PRC Program is interdependent with the funding and need for the overall Indian health care system. For example, under the Health Care Facilities Construction Program, facilities planned to be replaced by ambulatory health centers with no inpatient services will likely be required to purchase inpatient care from the private sector in order to maintain the same level of services; increasing demand for PRC inpatient funding.

PRC funding provides access to essential health care services and remains a critical priority for tribes. The PRC Program supports HHS strategic goal 1: Strengthen Health Care and supports the IHS Priority to improve the quality of and access to care.

Purchased/Referred Care – Recent program funding increases have allowed some of the IHS and tribally- managed PRC programs to approve referrals in other priority categories, including some preventive care services, thus increasing access to patient care services. In FY 2013, 77 percent of IHS-operated PRC programs were only able to purchase Medical Priority I – Emergency/Acute

[6] 25 U.S.C. § 1621e, 1623; 42 CFR 136.61 (2010)
[7] 25 U.S.C. § 1621a

Urgent Care Services throughout the year. These programs purchase care for emergency care services (i.e., those necessary to address the immediate threat to life, limb, or senses) and are unable to purchase care beyond Level I, which includes preventive services such as mammograms or colonoscopies. In FY 2013, PRC denied an estimated $760,855,000 for an estimated 146,928 services needed by eligible American Indian and Alaska Native individuals. 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 total unmet need for the entire system. Therefore, the denied services estimate is based on actual data from federal programs and estimated tribal data.

Catastrophic Health Emergency Fund (CHEF) – In FY 2013, 1,534 high cost cases were reimbursed from CHEF funds on a rolling basis at a total cost of $48,992,261; however, there were 743 submitted cases that were not reimbursed by the CHEF Program at a total cost of $17,866,064. 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 2013. When CHEF funds are depleted, requests for reimbursements are denied. In FY 2013, funding increases helped ensure CHEF funds were depleted later than in previous years; however, funding was still fully depleted in late August.

FUNDING HISTORY

Fiscal Year	PRC	CHEF	TOTAL
2010 Enacted	$731,347,000	$48,000,000	**$779,347,000**
2011 Enacted	$731,927,000	$48,000,000	**$779,927,000**
2012 Enacted	$792,157,000	$51,418,000	**$843,575,000**
2013 Final	$752,420,000	$48,838,000	**$801,258,000**
2014 Enacted	$827,075,000	$51,500,000	**$878,575,000**

BUDGET REQUEST

The FY 2015 budget request for Purchased/Referred Care of $929,041,000 is an increase of $50,466,000 above the FY 2014 Enacted level.

Base Funding of $878,575,000 – The recurring base funding provides the following services:

- $51,500,000 for CHEF high cost cases
- $827,075,000 to purchase:
  - 41,100 Inpatient admissions
  - 1,276,000 Outpatient visits
  - 50,100 One-way patient travel trips

The $50,466,000 increase includes funding for:

- Medical Inflation +$32,466,000 to cover inflationary costs to maintain the purchase of the current level of services.

- New Tribes +$2,572,000 to partially fund 5 new federally recognized tribes. This level establishes baseline funding for each tribe and recurs in out years. Approximately 4,630 tribal members will gain access to care through this funding.

- Program Increase +$15,428,000 to purchase an additional estimated:
  - +800 Inpatient admissions
  - +23,800 Outpatient visits, and
  - +900 One-way patient travel trips

The PRC Program is critical to ensuring access to health care and is essential in achieving the mission of the IHS. The FY 2015 budget request will ensure the Indian health care system is able to maintain its current level of services and purchase additional medical services for patients who need it most. The PRC recurring base and the increase of $50.5 million will maintain and ensure greater purchasing power for the PRC Program. The CHEF program ($51.5 million) improves access to quality patient care and lessens the burden of high costs cases, particularly for those smaller IHS and tribally managed PRC programs with limited budgets.

Outputs and Outcomes

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
PRC-1: Average Days between Service End and Purchase Order Issued *(outcome)*	FY 2013 Final: 81.7 days Target: 74 days (Target Not Met)	74 days	74 days*	0

*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.

GRANT AWARDS. This program does not award grants.

AREA ALLOCATION – Purchased/Referred Care *(dollars in thousands)*

Discretionary SERVICES	**FY 2013 Final**	**FY 2014 Enacted**	**FY 2015 Request**	**FY 2015 +/- FY 2014**
Alaska	$77,911	$85,429	$90,336	$4,907
Albuquerque	38,271	41,964	44,683	2,427
Bemidji	54,154	59,380	62,967	3,420
Billings	56,677	62,146	66,711	3,624
California	42,691	46,810	49,500	2,689
Great Plains*	79,859	87,565	93,293	5,068
Nashville	30,778	33,748	35,852	1,948
Navajo	87,232	95,649	101,697	5,524
Oklahoma	98,536	108,044	114,864	6,239
Phoenix	64,710	70,954	75,468	4,099
Portland	85,281	93,510	98,993	5,377
Tucson	17,034	18,678	19,935	1,083
Headquarters	68,124	74,698	74,742	4,061
Total, PRC	**$801,258**	**$878,575**	**$929,041**	**+$50,466**

Note: Allocation amounts are estimates.
* The Great Plains Area is the new name for the former Aberdeen Area. The area office name was changed at the request of the Tribes served by the Aberdeen Area Indian Health Service. Notification can be found in the January 10, 2014, issue of the Federal Register, *available at* http://www.gpo.gov/fdsys/pkg/FR-2014-01-10/pdf/2014-00264.pdf.

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

(Dollars in Thousands)

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$142,963	$148,081	$155,857	+$7,776
FTE*	256	269	290	+21

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

SUMMARY OF THE BUDGET REQUEST

The FY 2015 budget request for Preventive Health programs of $155,857,000 is an increase of $7,776,000 above the FY 2014 Enacted level.

- $76.4 million for **Public Health Nursing** (PHN) base funding supports 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 and activities are aimed at preventing the onset of disease in high risk populations through education, health awareness, immunizations, and risk reduction. For example, the PHNs provide childhood obesity prevention activities through breastfeeding promotion to the prenatal patient and during the postpartum time in 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 may make a home visit after a patient is discharged from a hospital to help reduce preventable complications and hospital readmissions.

- $18.3 million for **Health Education** base funding will be used 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.

- $59.4 million for **Community Health Representatives** (CHRs) base funding helps 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.

- $1.9 million for **Hepatitis B and Haemophilus Immunization Programs (Alaska)** base funding will continue 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. Public Health Nursing provides community based clinical services which directly contribute to overall performance achievement activities such as 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 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$66,282	$70,909	$76,353	+$5,444
FTE*	227	239	256	+17

*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 2015 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 disease from causing other problems (complications) by providing optimal care for the patient with the disease. Examples include chronic disease case management, self-management education, medication management, and care coordination.

PHNs play a critical role in the surveillance of communicable diseases. The PHN expertise in communicable disease assessment, outreach, investigation, surveillance and monitoring interventions helps to manage and prevent the spread of disease in communities. 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).

PHN home visiting nursing services include 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 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. The intent of this project is to make available an array of PHN Best Practices/Promising Practices to support a PHN Case Management Program through the cooperative agreement grant & program award process.

The FY 2013 target for the PHN performance measure was 405,962 encounters.[1] The final result of 388,590 encounters did not meet the target by 17,372 encounters, a 4.3 percentage decrease. While the FY 2014 target remains the same (425,679 encounters), the FY 2015 target is set at 425,679 encounters as data collection issues are resolved in 2014 to avoid future issues.

The FY 2013 performance decrease is due to changes in the data collection process. Several large service units have migrated away from the IHS Resource Patient Management System (RPMS) to a commercial off the shelf package which changed the way PHN visits were coded and exported to the agency's National Data Warehouse (NDW) database. 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 national PHN program staff is working to resolve this issue so as to report the most accurate data and describe the important services provided by the national Public Health Program.

FUNDING HISTORY

Fiscal Year	Amount
2010 Enacted	$64,071,000
2011 Enacted	$63,943,000
2012 Enacted	$66,632,000
2013 Final	$66,282,000
2014 Enacted	$70,909,000

BUDGET REQUEST

The FY 2015 budget request for Public Health Nursing of $76,353,000 is an increase of $5,444,000 above the FY 2014 Enacted level.

Base Funding of $70,909,000 – 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.

The impact of this increase on the PHN Program will be most impactful in the following areas:

- Individual patient encounters will increase;
- PHN progress towards GPRA measures in tobacco screening, domestic violence screening, depression screening, pap smear follow-up, adult influenza vaccinations, childhood immunizations, and adult pneumococcal vaccinations will increase;
- Valuable PHN services such as community immunizations and immunizations to homebound individuals will improve; and
- other services will be improved or sustained.

[1] Total number of public health activities captured by the PHN data system includes an emphasis on primary, secondary, and tertiary prevention activities provided by the PHN Program to individuals, families, and community groups.

The $5,444,000 increase includes funding for:

- Medical Inflation +$713,000 to cover inflationary costs of providing health care services.

- Additional Staffing and Operating Costs for Newly-Constructed Healthcare Facilities +$4,474,000 – There are 3 new and expanded healthcare facilities and 1 youth treatment facility that are planned to open in FY 2015. The youth treatment facility does not receive funding from Public Health Nursing. These facilities reflect the 36 additional staffing needs that IHS has determined as its minimum potential request for FY 2015. One of the 3 facilities is a Joint Venture Construction Program (JVCP) project where the Tribe is fulfilling its responsibility under the JVCP agreement to fund the construction and equipment for the healthcare facility. IHS' responsibility is to request the funds for the additional staff and to operate the healthcare facility. Increases in Public Health Nursing funding are required for additional staffing since it is recurring funding to the facility in subsequent years.

Additional Staff for New Healthcare Facility – Request for FY 2015*	Amount	Additional Positions to be Funded
Choctaw Alternative Rural Healthcare Center (JV), MS	$379,000	3
Kayenta Alternative Healthcare Center, AZ	$2,387,000	19
San Carlos Health Center, AZ	$1,708,000	14
Grand Total:	**$4,474,000**	**36**

*Although there are four new facilities, the Southern California Youth Regional Treatment Center (YRTC) receives $0 funding from Public Health Nursing because the YRTC only provides alcohol and substance abuse treatment services.

- New Tribes +$257,000 to partially fund 5 new federally recognized Tribes. This level establishes baseline funding for each tribe and recurs in out years. Approximately 4,630 tribal members will gain access to care through this funding.

With the FY 2015 budget request, the PHN Program will continue working towards achieving its performance targets of:

1. Providing approximately 411,206 health activities and nursing services to AI/AN patients in FY 2015;
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. Integrating PHN Case Management best practices into the cooperative agreement grant and program awards; and
4. Implementing best practices identified as a result of participating in the President's Partnership for Patients initiative by reducing hospital readmissions by 20 percent by the end of calendar year 2013 as compared to 2010.

The PHN Program will continue to coordinate and collaborate with related federal, state, local and private programs to promote efforts to expand and improve maternal and child-health services. The PHN Program will also continue its focus on case management to include the client, family, and other members of the health care team. In addition to reducing the cost of health care, case management has proven its worth in terms of improving rehabilitation, improving quality of life, increasing client satisfaction and compliance by promoting client self-determination.

All PHN programs will continue to report on new 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. One such measure IHS is focusing on

reflects that by the end of calendar year 2013, preventable complications during a transition from one care setting to another will decrease, thereby reducing all hospital readmissions. Achieving this goal would mean patients would recover from illness without suffering a preventable complication requiring re-hospitalization within 30 days of discharge.

The IHS PHN Program will continue to work closely with other federal 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.

GRANTS AWARDS

	FY 2013 Enacted	FY 2014 Enacted	FY 2015 Request
Number of Awards	15	15	15
Average Award	$150,000	$150,000	$150,000
Range of Awards	$150,000	$150,000	$150,000

Outputs and Outcomes

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
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 2013: 388,590 Target: 405,962 (Target Not Met)	425,679	425,679	0

AREA ALLOCATION – Public Health Nursing *(dollars in thousands)*

Discretionary **SERVICES**	**FY 2013 Final**	**FY 2014 Enacted**	**FY 2015 Request**	**FY 2015 +/- FY 2014**
Alaska	$3,670	$3,926	$3,994	$68
Albuquerque	3,287	3,516	3,551	35
Bemidji	2,101	2,248	2,270	22
Billings	4,052	4,335	4,378	43
California	889	951	1,077	126
Great Plains*	8,966	9,592	9,687	95
Nashville	1,026	1,098	1,249	151
Navajo	12,852	13,749	16,272	2,523
Oklahoma	12,180	13,030	13,549	519
Phoenix	6,812	7,288	9,069	1,781
Portland	2,845	3,044	3,074	30
Tucson	981	1,049	1,059	10
Headquarters	6,621	7,083	7,124	41
Total, PHN	**$66,282**	**$70,909**	**$76,353**	**+$5,444**

Note: Allocation amounts are estimates.

* The Great Plains Area is the new name for the former Aberdeen Area. The area office name was changed at the request of the Tribes served by the Aberdeen Area Indian Health Service. Notification can be found in the January 10, 2014, issue of the Federal Register, *available at* http://www.gpo.gov/fdsys/pkg/FR-2014-01-10/pdf/2014-00264.pdf

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

HEALTH EDUCATION

(Dollars in Thousands)

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$16,552	$17,001	$18,263	+$1,262
FTE*	24	25	29	+4

*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 2015 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. Good patient care includes the provision of education and accreditation requirements specifically require the provision of and documentation of 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 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 2,765,973 visits in 2012 to 2,953,473 visits in 2013, a 7 percent increase in documentation of education.

The Health Education Program partners with other IHS disciplines and programs to ensure 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 education encounters are documented and coded in the Resource and Patient Management System (RPMS). 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 IHS Health Education Program demonstrates accountability through the development of the Patient Education Protocols and Codes (PEPC), 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. Since FY 2011, there have been 1,394 edits and eleven new codes added to existing Patient Education and Protocol Codes. The IHS Health Education Program makes use of all available resources to implement critically important initiatives that are focused on meeting accreditation requirements, patient safety, and Healthy People 2020 Objectives, all of which assist in improving the overall delivery of care provided by IHS.

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: (1) the number of clients who received health education services; (2) provider type delivering the health education; (3) where the education took place; (4) what information the patient was provided; (5) the amount of time spent providing this education; (6) whether the patient understood the education provided; and (7) whether the patient set a behavior goal change. These IHS statistics are currently available from the RPMS system.

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) Standardize, coordinate and integrate education within IHS including health literacy for clients, professional education and training, as well as 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.

The Health Education Program has identified the need to continue focusing on the following areas of emphasis in FY 2015:

- Continuing to strengthen 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 (PCC) and the Electronic Health Record (EHR), with the continued provision of ongoing training to IHS and Tribal staff on the documentation and coding of patient and health education.

- Increasing focus on 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.

FUNDING HISTORY

Fiscal Year	Amount
2010 Enacted	$16,682,000
2011 Enacted	$16,649,000
2012 Enacted	$17,057,000
2013 Final	$16,552,000
2014 Enacted	$17,001,000

BUDGET REQUEST

The FY 2015 budget request for Health Education of $18,263,000 is an increase of $1,262,000 above the FY 2014 Enacted level.

Base Funding of $17,001,000 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.

The $1,262,000 increase includes funding for:

- Medical Inflation +$237,000 to cover inflationary costs of providing health care services.

- Additional Staffing and Operating Costs for Newly-Constructed Healthcare Facilities +$861,000 – There are 3 new and expanded healthcare facilities and 1 youth treatment facility that are planned to open in FY 2015. The youth treatment facility does not receive funding from Health Education. These facilities reflect the 9 additional staffing needs that IHS has determined as its minimum potential request for FY 2015. One of the 4 facilities is a Joint Venture Construction Program (JVCP) project where the Tribe is fulfilling its responsibility under the JVCP agreement to fund the construction and equipment for the healthcare facility. IHS' responsibility is to request the funds for the additional staff and to operate the healthcare facility. Increases in Health Education funding are required for additional staffing since it is recurring funding to the facility in subsequent years.

Additional Staff for New Healthcare Facility – Request for FY 2015*	Amount	Additional Positions to be Funded
Choctaw Alternative Rural Healthcare Center (JV), MS	$97,000	1
Kayenta Alternative Healthcare Center, AZ	$483,000	5
San Carlos Health Center, AZ	$281,000	3
Grand Total:	**$861,000**	**9**

*Although there are four new facilities, the Southern California Youth Regional Treatment Center (YRTC) receives $0 funding from Health Education because the YRTC only provides alcohol and substance abuse treatment services.

- New Tribes +$164,000 to partially fund 5 new federally recognized Tribes. This level establishes baseline funding for each tribe and recurs in out years. Approximately 4,630 tribal members will gain access to care through this funding.

Outputs and Outcomes

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
Number of Visits with Health/Patient Education *(Output)*	FY 2013: 3,657,235 Target: 2,858,268 (Target Exceeded)	2,874,290	3,430,486	556,196

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

AREA ALLOCATION – Health Education *(dollars in thousands)*

Discretionary SERVICES	**FY 2013 Final**	**FY 2014 Enacted**	**FY 2015 Request**	**FY 2015 +/- FY 2014**
Alaska	$1,804	$1,853	$1,884	$31
Albuquerque	1,160	1,191	1,207	16
Bemidji	601	617	626	9
Billings	1,165	1,197	1,214	17
California	244	251	333	82
Great Plains*	1,866	1,917	1,943	26
Nashville	491	504	596	92
Navajo	2,225	2,285	2,800	515
Oklahoma	2,634	2,705	2,841	136
Phoenix	1,729	1,776	2,082	306
Portland	902	926	939	13
Tucson	211	217	220	3
Headquarters	1,520	1,561	1,577	16
Total, HEALTH ED	**$16,552**	**$17,001**	**$18,263**	**+$1,262**

Note: Allocation amounts are estimates.

* The Great Plains Area is the new name for the former Aberdeen Area. The area office name was changed at the request of the Tribes served by the Aberdeen Area Indian Health Service. Notification can be found in the January 10, 2014, issue of the Federal Register, *available at* http://www.gpo.gov/fdsys/pkg/FR-2014-01-10/pdf/2014-00264.pdf

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

COMMUNITY HEALTH REPRESENTATIVES

(Dollars in Thousands)

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$58,304	$58,345	$59,386	+$1,041
FTE*	5	5	5	+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 2015 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 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/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] HRs are a vital part of the Indian health system care team and help provide needed public health services to the community.

Program accomplishments during FY 2013 include:

- Training 552 CHRs on the IHS Resource Patient and Management System (RPMS) CHR Patient Care Component (PCC) using onsite, archived and live online learning formats;

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

- Training 61 CHRs in Basic and Refresher courses;
- Having 45 CHRs attend online webinars for gatekeeper suicide prevention and 82 for influenza prevention;
- Having 60 CHRs complete Fundamentals of Diabetes Care in partnership with the American Association of Diabetes Educators and the IHS Division of Diabetes Treatment and Prevention.
- Enhancing collaboration with various disciplines and offices such as those with:
  - The Improving Patient Care Initiative which focuses on patient-centered care in a medical home model and incorporates community based programs and services.
  - Federal and non-governmental organizations, by incorporating existing training modules, toolkits, patient education or other materials into existing CHR curricula or by offering these materials via webinars, thus maximizing available resources.
  - Tribes and Area staff by providing technical assistance.
  - The Office of Information Technology (OIT) staff regarding RPMS CHR Patient Care Component enhancements and project management, along with coordination of the IHS CHR website and listserv.
- Implementing IHS RPMS CHR Patient Care Component version 2 data application with the second iteration officially released April 15, 2013. Additionally CHR and OIT staff at IHS Headquarters, Areas, and local facilities began to identify and address the challenges of dual entry into both RPMS CHR Patient Care Component and the RPMS Electronic Health Record and resulting functionality and enhancement needs
- Submission of the CHR Resource and Requirements Methodology (RRM) for leadership review.

For FY 2013, 41 percent of CHR programs reported on the types of services provided. This data demonstrated that:

- Approximately 20 percent of services involved collection patient data (e.g., taking vital signs, delivering medication, delivering medical equipment, providing emotional support).
- Approximately 16 percent of services were collecting case findings or screenings.
- Approximately 15 percent of services were performing case management activities.
- Over 13 percent of services were providing health education to individuals and communities.
- Over 12 percent of services were monitoring patients.
- Approximately 8 percent of services were providing transportation services.
- Approximately 4 percent of services were providing other necessary patient services, such as making or assisting with funeral arrangements and completing CHR Patient Care Component data entries.

FUNDING HISTORY

Fiscal Year	Amount
2010 Enacted	$61,628,000
2011 Enacted	$61,505,000
2012 Enacted	$61,407,000
2013 Final	$58,304,000
2014 Enacted	$58,345,000

BUDGET REQUEST

The FY 2015 budget request for Community Health Representatives of $59,386,000 is an increase of $1,041,000 above the FY 2014 Enacted level.

Base Funding of $58,345,000 – The funding for Community Health Representatives will be used to provide:

- $57,294,790 for self-determination contracts and compacts with Tribes for direct health care, health promotion and disease prevention services in homes and other community-based settings as identified in Tribal funding agreements and scopes of work to 2.1 million AI/AN population throughout 12 Areas.
- $1,050,210 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 2015, but are not limited to:
    - Providing online CHR basic and refresher training modules. Online CHR basic and refresher training will reduce travel and per diem expenses for CHRs whose programs left Headquarters shares for training rather than retaining the funds to provide the training at the tribal level. Funds will be used to develop, test, implement and sustain new training formats.
    - Using funds to pay for online training development, testing, implementation and maintenance.
    - Continuing to provide training, web management, listserv, and other program administrative, technical and logistical assistance to Tribes and Areas.
    - Continuing investments in health information technology development, refinement, and data support to enhance the CHR data application in RPMS.
    - Training CHRs nationally on the CHR Patient Care Component data system.
    - Continuing efforts to provide CHR education on the Improving Patient Care Initiative and Model for Improvement, testing and refinement of an assessment tool to identify improvements for CHR programs, and dissemination of information related to CHR involvement and integration into each patient's health care team and medical home.
    - Updating the 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.

Also, the CHR Program will strive to continue to address the following challenges:

- Refinement of an appropriate online training system;
- Coordinating data validations, exploring CHR Patient Care Component and EHR integration, and promoting broader use of the RPMS CHR Patient Care Component data application by Tribes. The CHR Patient Care Compenent is a data application for budget performance and program management;
- Improving connectivity for remote sites; and
- Education on necessary Federal security requirements for Tribal CHRs to request and maintain access to RPMS.

The $1,041,000 increase includes funding for:

- Medical Inflation +$917,000 to cover the inflationary cost of providing health care services.

- New Tribes: +$124,000 to partially fund 5 new federally recognized Tribes. This level establishes baseline funding for each tribe and recurs in out years. Approximately 4,630 tribal members will gain access to care trhough this funding.

Outputs and Outcomes

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
CHR-2: CHR patient contacts for Chronic Disease Services [1, 2, 3]	FY 2013: 373,628 Target: 390,000 (Target Not Met)	362,951	347,848	-19,103
CHR-1: Number of patient contacts [3, 4]	FY 2013: 855,789 Target: 900,000 (Target Not Met)	831,333	796,740	-34,593
CHR-3: Number of CHRs trained [5]	FY 2013: 613 Target: 433 (Target Exceeded)	414	400	-14

[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 from using extrapolated data and service hours respectively to actual services and approved for FY 2013.
[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. Testing and implementation is expected to increase participation as training transitions from onsite to online formats. Local CHR programs will be responsible to validate learned skills and competencies.

GRANTS AWARDS – No grant awards are anticipated for FY 2015.

AREA ALLOCATION – Community Health Representatives *(dollars in thousands)*

Discretionary SERVICES	**FY 2013 Final**	**FY 2014 Enacted**	**FY 2015 Request**	**FY 2015 +/- FY 2014**
Alaska	$4,202	$4,205	$4,271	$66
Albuquerque	3,336	3,338	3,390	52
Bemidji	4,586	4,589	4,661	72
Billings	4,244	4,247	4,314	67
California	1,909	1,910	1,940	30
Great Plains*	6,908	6,913	7,022	109
Nashville	3,299	3,301	3,477	176
Navajo	6,564	6,569	6,672	103
Oklahoma	8,529	8,535	8,671	136
Phoenix	5,955	5,959	6,053	94
Portland	4,462	4,465	4,535	70
Tucson	1,874	1,875	1,904	29
Headquarters	2,436	2,438	2,475	37
Total, CHR	**$58,304**	**$58,345**	**$59,386**	**+$1,041**

Note: Allocation amounts are estimates.
* The Great Plains Area is the new name for the former Aberdeen Area. The area office name was changed at the request of the Tribes served by the Aberdeen Area Indian Health Service. Notification can be found in the January 10, 2014, issue of the Federal Register, *available at* http://www.gpo.gov/fdsys/pkg/FR-2014-01-10/pdf/2014-00264.pdf.

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 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$1,826	$1,826	$1,855	+$29
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 2015 Authorization.....Permanent

Allocation Method ..... Self-Governance Compact

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The Hepatitis B Program and the Haemophilus Immunization (Hib) Program of the Alaska Native Tribal Health Consortium (ANTHC) in collaboration with partners within the Alaska Tribal Health Care System provide clinical expertise and consultation, trainings, research, evaluation and surveillance.

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.

Hepatitis and other liver disease continues to be a health disparity in American Indian and Alaska Native (AI/AN) people. To address this disparity, the program provides:

- Regular medical monitoring and clinical care follow-up of chronic liver disease patients;
- Consultation on immunization and hepatitis issues;
- Follow-up of persons with autoimmune and non-alcoholic fatty liver disease; and
- Follow-up of large cohorts of persons vaccinated with hepatitis A and B vaccine to determine duration of immunity and if booster doses will be needed in the future.

The program follows patients Statewide with chronic hepatitis B with the goal of reducing the lifetime risk of death from liver cancer or cirrhosis from 25 percent to less than 10 percent by early detection and removal of hepatocellular cancer and treatment with antiviral medications.

In 2013, at least 58 percent of AI/ANs with chronic hepatitis B or C infection were screened for liver cancer and for liver aminotransferase levels (58 percent and 61 percent of the population, respectively). Although the program maintains its practice of encouraging hepatitis patients to have regular, bi-annual screening, this percentage has dropped from previous years as several regional clinics are no longer sending specimens to the ANTHC laboratory for screening tests. This decline is correlated with the implementation of electronic health records in the regions and

it will be proposed that data sharing agreements be established with Tribal partners which will provide the program with access to screening test results.

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. The Program conducts activities through e-mail, phone consultation, onsite training, teleconferences, web-based trainings, written guidelines, presentations, and site visits. 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. 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 2012-2013, the Program accomplished the following:

- Immunization Coverage for Alaska Native 19-35 month olds was 80 percent on September 30, 2013 which meets 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 (95 percent) which is much higher than the US all-races 2012 rate of 80.9 percent.
- Assisted tribal facilities using the RPMS immunization package in achieving interface to share vaccine records with the State Immunization Information System (SIIS).
- Provided consultation with 3 facilities who were implementing new electronic health records on immunization documentation and SIIS interface implementation of new EHRs at 3 tribal facilities and the development of alternative reminder-recall systems and reporting of vaccine coverage using the SIIS.
- Assisted Indian Health Service Immunization Program with development and testing of a new immunization forecaster for the RPMS immunization software.
- The Immunization Nurse consultant chaired the planning committee for a statewide Maternal Child Health/Immunization Conference.
- Published five articles (5) on lower respiratory infection hospitalization rates, impact of PCV13 vaccine, cost-effectiveness of RSV monoclonal antibodies, bronchiectasis, and varicella in peer-reviewed journals.
- Collaborated with Tribal organizations and federal agencies in a Healthy Homes study to evaluate the impact of reducing indoor air pollution from woodstoves and improper ventilation on respiratory visits and symptoms in high risk Alaska Native children.

A summary of immunization results is included below:

Immunization Measure	Age Group	Alaska Native coverage as of 9/30/2013
4:3:1:3:3:1:4	19-35 months	80%
4:3:1:3:3:1	19-35 months	81%
3 Hib vaccines doses		95%
3 PCV (pneumococcal conjugate vaccine)	19-35 months	95%
1+ HPV	13-17 years female	81%
Pneumococcal vaccine	65+ years	93% (6/30/2013)
Tdap	19-64 years	71% (6/30/2013)

FUNDING HISTORY

Fiscal Year	Amount
2010 Enacted	$1,934,000
2011 Enacted	$1,930,000
2012 Enacted	$1,927,000
2013 Final	$1,826,000
2014 Enacted	$1,826,000

BUDGET REQUEST

The FY 2015 budget request for the Hepatitis B Program and the *Haemophilus* Immunization (Hib) Program of $1,855,000 is an increase of $29,000 above the FY 2014 Enacted level.

Base Funding of $1,826,000 would 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 Electronic Health Records, 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.

The $29,000 increase includes funding for:

Medical Inflation +$29,000 to cover inflationary cost of providing health care services.

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.

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.

The program supports the HHS Strategic Plan through its activities: preventing disease through immunization; improving maternal and infant health; and planning and preparing for public health emergencies by providing an infrastructure to maintain high immunization coverage for basic vaccines and have a rapid response to emergencies such as pandemic flu.

Outputs during FY 2015 will include the activities listed in the "Program Description" section., technical support to Tribal agencies developing Electronic Health Records (EHR) to meet meaningful use requirements, and networking with other departments and agencies for emergency preparedness.

New strategies include collaboration with other agencies such as CDC in developing media materials, networking with IHS and other agencies to provide technical assistance regarding EHRs, and obtaining grant funding and technical assistance to support uncovered program

activities such as emergency preparedness. The diversity of EHRs employed by Tribal agencies poses challenges that may result in a temporary loss or delay of Area-wide reporting of immunization coverage and this will continue to be addressed through coordinated technology efforts by IHS and Tribes.

Outputs and Outcomes

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
Hepatitis Program (Targeted/Known Cases = T and Screened = S)				
Sum of Hepatitis Patients Targeted for Screening	FY 2013 Final Result: 3,228 Target: 3,191 (Target Exceeded)	3,327	3,327	0
AK-1: Chronic Hepatitis B Patients Screened/Targeted*	FY 2013 Final Result: T=1,075, S=622 Target: T=1,060, S=693 (T Target Exceeded and S Target Not Met)	T=1,060 S=628	T=1,060 S=628	T= 0 S= 0
AK-2: Chronic Hepatitis C Patients Screened/Targeted	FY 2013 Final Result: T=1,604, S=979 Target: T=1,531, S=900 (T Target Exceeded 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 2013 Final Result: T=549, S=421 Target: T=600, S=456 (T Target Not Met and S Target Not Met)	T=667 S=501	T=667 S=501	T= 0 S= 0
AK-4: Hepatitis A vaccinations***	FY 2013 Final Result: HepA=90% Target: HepA=90% (Target Met)	90%	90%	0
AK-5: Hepatitis B vaccinations***	FY 2013 Final Result: HepB=96% 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, primary biliary cirrhosis, and nonalcoholic fatty liver disease.
***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%.
All data reported is that which is available to the Alaska Native Tribal Health Consortium.

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

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

URBAN INDIAN HEALTH

(Dollars in Thousands)

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$40,729	$40,729	$41,375	+$646
FTE*	5	5	5	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 2015 Authorization.....Permanent

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The Urban Indian Health Program (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 55 sites throughout the United States. Urban Indian Organizations (UIOs) define their scope of work and services based upon the 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). UIOs provide unique access to culturally appropriate and quality health care to AI/ANs living in urban areas.

The UIOs provide primary medical care and public health case management wrap-around services for approximately 51,000 urban Indians who do not have access to the resources offered through IHS and Tribally operated health care facilities. The UIO health program sizes and services vary. Twenty-one UIOs are full ambulatory programs providing direct medical care to the population served for 40 or more hours per week. Seven UIOs limited ambulatory programs provide direct medical care to the population served for less than 40 hours per week. Five UIOs outreach and referral programs provide behavioral health counseling and education services, health promotion/disease prevention education, and immunization counseling but not direct medical care services. One UIO is a residential treatment facility. Another provides national education and research services for UIO and the OUIHP.

The UIOs are evaluated in accordance with IHCIA legislation requirements and the program is coordinated by the Office of Urban Indian Health Programs (OUIHP) in IHS Headquarters. The IHS Urban Indian Health Program Review Manual is used by the IHS Area Urban Coordinators to conduct annual onsite reviews for 34 of the IHS Area funded UIOs. The results are submitted to the OUIHP for review and follow-up to ensure that corrective action plans are successfully completed prior to continuation funding.

Accomplishments – The UIOs fulfill IHS data reporting requirements including the IHS Government Performance and Results Act (GPRA) report, the Uniform Data System (UDS) report, and the Diabetes Non-Clinical Audit report. Twelve UIO programs currently participate in the IHS Improving Patient Care (IPC) initiative.

The UIO 2013 GPRA cycle (July 1, 2012 – June 30, 2013) accomplishments include:

- 100 percent of the UIO reported on 20 of the 20 performance measures,
- 24 UIOs reported through the Clinical Reporting System (CRS), and
- 9 UIOs reported using 100 percent review of appropriate data source (as opposed to sampling a smaller percentage of records).

The UIO report amounts and purposes for which funding is used, identify the number of eligible urban Indians for whom services are provided, and the number and type of services provided to urban Indians. The 2012 UDS report is the most recent year for which data is available.

As of March 2013, 24 UIOs have implemented the IHS Resource and Patient Management System (RPMS)/Electronic Health Record (EHR), four UIOs are implementing RPMS, and six UIOs utilize non-RPMS health information technology systems. Eleven UIOs had providers that registered and attested for meaningful use; six UIO received CMS incentive payments. OUIHP works collaboratively with and funds IHS Headquarters and Area Offices to provide support and deliver IT technical assistance to 27 UIOs.

Five significant program challenges exist: (1) obtaining resources for UIOs to hire new staff, train existing staff and conduct community outreach events and educational activities to help uninsured individuals gain appropriate health insurance coverage; (2) increasing demand for training for those UIOs using RPMS/EHR; (3) increased need for training and technical assistance on third party billing and ICD-10 as UIOs prepare to implement the ACA; (4) addressing UIO facilities maintenance and repair improvement needs at the current funding level; and (5) implementation of new program authorities with the reauthorization of IHCIA without new appropriations, including: 25 U.S.C. § 1659 Facilities Renovation; 25 U.S.C. § 1660e Expanded Program Authority for Urban Indian Organizations; 25 U.S.C. § 1660f Community Health Representatives; 25 U.S.C. § 1660g Use of Federal Government Facilities and Sources of Supply; and 25 U.S.C. § 1660h Health Information Technology.

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

FUNDING HISTORY

Fiscal Year	Amount
2010 Enacted	$36,189,000
2011 Enacted	$43,139,000
2012 Enacted	$43,053,000
2013 Final	$40,729,000
2014 Enacted	$40,729,000

BUDGET REQUEST

The FY 2015 budget request for the Urban Indian Health program of $41,375,000 is an increase of $646,000 above the FY 2014 Enacted level.

Base Funding of $40,729,000 – The base funding is necessary to support the UIHP funding and accomplishments to strengthen and enhance the HHS Strategic Plan for Fiscal Years 2010-2015. The funding addresses Goal 1, Transform Health Care; Goal 3, Advance the Health, Safety, and Well-Being of the American People; Goal 4, Increase Efficiency, Transparency, and Accountability of Health and Human Service (HHS) Programs; and Goal 5, Strengthen the Nation's HHS Infrastructure and Workforce, 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, 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. Six UIOs are currently accredited; 4 are working towards accreditation. Fifteen UIO are participating in the Improving Patient Care (IPC) 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)
- 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.

The $646,000 increase includes funding for:

- Medical Inflation +646,000 to cover the inflationary cost of providing health care services.

Outputs and Outcomes

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
UIHP-2: Percent of AI/AN patients with diagnosed diabetes served by urban health programs that achieve good blood sugar control. (Outcome)	FY 2013: 49.1% Target: Baseline (Target Met)	48.3%	47.7%	-0.6%
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 2013: 19.9% FY 2013 Reportable Year Target: 24.0% (Target Exceeded)	N/A	N/A	N/A
UIHP-6: Increase the number of diabetic AI/ANs that achieve ideal blood pressure control (Outcome)	FY 2013: 71% Target: Baseline (Target Met)	71%	70.1%	-0.9%
UIHP-7: Number of AI/ANs served at Urban Indian Clinics. (Outcome)	FY 2012: 51,646 Target: 51,167 (Target Exceeded)	51,425	51,167	-258

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

GRANTS AWARDS - Funding for UIOs for FY 2013 included both grants and contracts awarded to the programs.

	FY 2013 Final	FY 2014 Enacted	FY 2015 Request
Number of Awards	33	33	*34
Average Award	$227,856	$227,856	$484,862
Range of Awards	$122,832 - $626,765	$122,832 - $626,765	$122,832 - $800,000

*The Headquarters amount includes funds for 34 UIO grants.

AREA ALLOCATION – Urban Health *(dollars in thousands)*

Discretionary SERVICES	**FY 2013 Final**	**FY 2014 Enacted**	**FY 2015 Request**	**FY 2015 +/- FY 2014**
Alaska	$0	$0	$0	$0
Albuquerque	2,298	2,298	2,334	36
Bemidji	3,935	3,935	3,997	62
Billings	2,165	2,165	2,199	34
California	6,218	6,218	6,317	99
Great Plains*	1,449	1,449	1,472	23
Nashville	894	894	908	14
Navajo	684	684	695	11
Oklahoma	1,961	1,961	1,992	31
Phoenix	2,353	2,353	2,390	37
Portland	5,245	5,245	5,328	83
Tucson	489	489	497	8
Headquarters	13,038	13,038	13,246	208
Total, Urban Health	**$40,729**	**$40,729**	**$41,375**	**+$646**

Note: Allocation amounts are estimates.

* The Great Plains Area is the new name for the former Aberdeen Area. The area office name was changed at the request of the Tribes served by the Aberdeen Area Indian Health Service. Notification can be found in the January 10, 2014, issue of the Federal Register, *available at* http://www.gpo.gov/fdsys/pkg/FR-2014-01-10/pdf/2014-00264.pdf.

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

INDIAN HEALTH PROFESSIONS

(Dollars in Thousands)

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$38,467	$33,466	$38,466	+$5,000
FTE*	22	22	22	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 2015 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, health professions training related grants, and recruitment and retention activities for IHS. The IHS made their first Scholarship Program awards in 1978 when Congress appropriated funds for the IHP Program.

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

- Enabling American Indians and Alaska Natives (AI/AN) 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/AN to enter the mental health field.
- Assisting AI/AN health programs to recruit and retain qualified health professionals.

Loan Repayment Program (Section 108): The Loan Repayment Program is an invaluable tool for recruiting and retaining healthcare professionals, offers these professionals the opportunity to reduce their student loan debts and places them in 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 employed in an Indian health program, while those who decline job offers because they do not receive loan repayment funding are deemed "unmatched unfunded." Applicants denied funding can also include those without suitable assignments. In FY 2012 the number of "matched unfunded" applicants was near 0. In FY 2013 IHS

reported the number of matched but unfunded applications for FY 2012 which refers to applicants who are currently working for IHS and who were not able to be funded due to budget. In FY 2012 that number was near 0 indicating improved support for retention of health professionals within the Indian health care system. The inability to fund 577 applicants who were not currently working for IHS is a significant challenge for the recruitment efforts of the agency. It is estimated that an additional $29.685 million would be needed to fund the 577 unmatched unfunded applicants from FY 2013. A more detailed breakout of loan repayment awards in FY 2013 by discipline is included in a table at the end of the narrative.

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 service obligations and payback requirements. A detailed breakout of scholarships awarded by discipline in FY 2013 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
2010 Enacted	$40,743,000
2011 Enacted	$40,661,000
2012 Enacted	$40,596,000
2013 Final	$38,467,000
2014 Enacted	$33,466,000

BUDGET REQUEST

The FY 2015 budget request for the Indian Health Professions program of $38,466,000 is an increase of $5,000,000 above the FY 2014 Enacted level.

Base Funding of $33,466,000 – The base funding is necessary to enable AI/AN 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 $5,000,000 increase includes funding to restore the Indian Health Professions to the FY 2013 funding level. This restoration will allow IHS to award an additional:

- 32 continuing and 20 new scholarships
- 10 contract loan repayment contract extensions and 245 new contracts
- 135 temporary clinical assignments for health professions students

AREA ALLOCATION – This program does not allocate funds to the IHS Areas.
The table below specifies the expected performance of each budget request by section.

Sec	Title	FY 2014 Enacted	FY 2015 Request	FY 2015 +/- FY 2014	Expected Performance*
103	Health Professions Preparatory and Pre-Graduate Scholarships	$2,302,494	$3,687,137	+$1,384,643	52 continuing and 33 new student agreements
104	Health Professions Scholarship	$10,034,760	$10,034,760	0	171 continuing and 57 new student contracts
105	Extern Program	$0	$1,115,357	+$1,115,357	135 temporary clinical assignments
108	Loan Repayment Program	$17,646,607	$20,146,607	+$2,500,000	250 contract extensions and 425 new contracts.
112	Quentin N. Burdick American Indians Into Nursing Program	$1,669,697	$1,669,697	0	4 grants
114	Indians into Medicine (INMED) Program	$1,097,364	$1,097,364	0	3 grants
217	American Indians Into Psychology Program	$715,078	$715,078	0	3 grants
	TOTAL	**$33,466,000**	**$38,466,000**	**+$5,000,000**	

*Expected performance does not include awards funded with Hospital and Health Clinics funds.

In FY 2013, the LRP received $4,875,597 of Hospitals and Health Clinics (H&HC) funds, which continues the funding support for loan repayment awards first appropriated in FY 2001. Based on IHS staffing needs, along with number of FY 2013 "matched unfunded" as described previously, the LRP awarded 116 new LRP contracts to various health professionals, including nurses, dentists, pharmacists, and mid-level practitioners from H&HC.

For FY 2015, the IHS LRP will continue to use the additional H&HC funds to meet IHS priority staffing needs.

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

Outputs and Outcomes

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
42: Scholarships: Proportion of Health Professionals Scholarship recipients placed in Indian health settings within 90days of graduation.	FY 2013 Final: 67% Target:78% (Target Not Met)	78%	78%	0
Number of Scholarship Awards – Total				

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
IHP-1: Section 103 *(Outputs)*	FY 2013 Final: 51 Target:45 (Target Exceeded)	23	85	+62
IHP-2: Section 104 *(Outputs)*	FY 2013 Final: 236 Target: 245 (Target Not Met)	228	228	0
IHP—3: Number of Externs (Section 105) *(Outputs)*	FY 2013 Final: 178 Target: 135 (Target Exceeded)	0	135	+135
Number of Loan Repayments Awarded – Total (Section 108)* *(Outputs)*	FY 2013 Final: 810 Target: 685 (Target Exceeded)	440	503	+63
IHP-4: New Awards (2 Year Awards) *(Outputs)*	FY 2013 Final: 520 Target: 425 (Target Exceeded)	180	243	+63
IHP-5: Contract Extensions (1 Year Awards) *(Outputs)*	FY 2013 Final: 290 Target: 260 (Target Exceeded)	260	260	0
IHP-6: Continuation Awards (Funded in Previous Fiscal Year) *(Outputs)*	FY 2013 Final: 504 Target: 176 (Target Exceeded)	500	180	-320

* Loan repayment figures include awards funded with Hospital & Health Clinics funds (100 new 2-year awards anticipated in FY 2015.

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

GRANT AWARDS

	FY 2013 Enacted	FY 2014 Enacted	FY 2015 Request
Indians into Nursing (Section 112)			
Number of Awards	5	4	4
Average Award	$334,211	$414,924	$414,924
Range of Awards	$300,000 - $350,000	$300,000 - $415000	$300,000 - $415,000
Indians Into Medicine(Section 114)			
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
Indians Into Psychology (Section 217)			
Number of Awards	3	3	3
Average Award	$238,359	$238,359	$238,359
Range of Awards	$200,000-$340,000	$200,000-$253,000	$200,000-$253,000

Scholarship Awards -- Students in the following disciplines received funding during FY 2013:

Section 103 Preprofessional - 24 students			
Pharmacy	9	Medical Technology	1
Nursing	7	Occupational Therapy	2
Clinical Psychology	1	Social Work	2
Physical Therapy	2		

Section 103 Preprofessional - 24 students				
Section 103 Pregraduate - 27 students				
Medicine	13		Optometry	3
Dentistry	10		Podiatry	1
Section 104 Health Professions - 236 students				
Physician (DO and MD)	56		Dental Hygienist	1
Nurse (ADN, BS and MS)	53		Dietitian	3
Pharmacist	38		Occupational Therapist	2
Dentist	20		Chemical Abuse Counseling	1
Physical Therapist	14		Health Care Administration	0
Physician Assistant	10		Health Education	0
Clinical Psychologist	10		Health Records	2
Optometrist	8		Nurse Anesthetist	1
Nurse Practitioner	6		Podiatrist	0
X-Ray Technology	2		Respiratory Therapist	0
Engineer	2		Sanitarian	1
Medical Technology	0		Women's Health Nursing	2
Social Work	4		Biomedical Engineering	0

Loan Repayment Awards – As of September 5, 2013 the IHS LRP made 2013 awards to the following disciplines:

Awards by Profession	Total Awards**	New Awards	Contract Extensions	Matched Not Awarded
Nurses	216	186	30	11
Dental*	96	46	50	6
Pharmacists	172	80	92	1
Physicians	61	27	34	3
PA/APN	60	47	13	3
Behavioral Health	60	47	13	5
Optometrists	32	9	23	0
Podiatrists	13	0	13	0
Rehabilitative Services	31	13	18	2
Other Professions	69	65	4	12
TOTAL	**810**	**520**	**290**	**43**

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

Other Professions	Total Awards	Matched Not Awarded	By Pay System	Awards
Medical Lab Scientist	8	2	Tribal Employees	386
Dietician	14	4	Civil Service	272
Medical Technician	5	1	Commissioned Corps	133
Engineer	10	1	Urban Health Employees	18
Diag. Radiology Tech	15	3	Buy Indian	1
Sanitarian	9	1		
Respiratory Therapist	5	0		
Chiropractor	1	0		
Chiropractor	1	0		
Acupuncturist	1	0		
Certified Coder	1	0		
TOTAL	**69**	**12**	**Total**	**810**

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

TRIBAL MANAGEMENT GRANT PROGRAM

(Dollars in Thousands)

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$2,442	$1,442	$2,442	+$1,000
FTE*	0	0	0	0

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

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

FY 2015 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 Tribes and/or Tribal organizations (T/TO) to plan and prepare for assumption 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/or enhance infrastructure systems to manage or organize PFSA.

All federally-recognized Indian Tribes and Tribally-sanctioned Tribal organizations are eligible to apply for a TMG. 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. Most applicants submit projects under this funding priority to perform feasibility studies, implement planning or evaluation projects, or improve their management capabilities.

The TMG funds are distributed primarily for direct grant awards. Approximately 3 percent of the appropriated 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/TO who

participate in TMG training and technical assistance sessions score higher in the objective review than those with no grant training.

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

(1) Planning and (2) Evaluation Study projects are funded up to $50,000 with project periods not to exceed 12 months.
- The Planning Project allows T/TO to establish goals and performance measures for current health programs or to design their health programs and management systems.
- 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 studies are funded 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.

FUNDING HISTORY

Fiscal Year	Amount
2010 Enacted	$2,586,000
2011 Enacted	$2,581,000
2012 Enacted	$2,577,000
2013 Final	$2,442,000
2014 Enacted	$1,442,000

BUDGET REQUEST

The FY 2015 budget request for the Tribal Management Grants program of $2,442,000 is an increase of $1,000,000 above the FY 2014 Enacted level.

Base Funding of $1,442,000 – The base funding is necessary to maintain the Tribal Management Grant program allowing for:
- The building of health management infrastructure for tribes and tribal organizations including, but not limited to, EHR conversion, third-party billing, and health accreditation, all of which impacts the provision of health care.
- Increasing the tribes' and tribal organizations' 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 assimilation 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 should they choose to do so.

The $1,000,000 increase includes funding to restore the Tribal Management Grant program to the FY 2013 funding level. This restoration will allow IHS to fund 14 additional new grants over the FY 2014 level.

Outputs and Outcomes

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
Planning Grants	FY 2013: 2 Target: 1 (Target Exceeded)	2	2	0
Health Management Structure (HMS) Grants	FY 2013: 23 Target: 28 (Target Not Met)	28	26	-2

GRANTS AWARDS

	FY 2013 Final	FY 2014 Enacted	FY 2015 Request
Number of Awards[1]	$2,442,000 11 Noncompeting Continuations and 15 New	$1,422,000 13 Noncompeting Continuations and 3 New	$2,422,000 10 Noncompeting Continuations and 17 New
Average Award	$93,923	$90,125	$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 2013 Final**	**FY 2014 Enacted**	**FY 2015 Request**	**FY 2015 +/- FY 2014**
Headquarters	$2,442	$1,442	$2,442	+$1,000
Total, TMG	**$2,442**	**$1,442**	**$2,442**	**+$1,000**

Note: Funds are not allocated on a recurring basis to Areas but awarded on a competitive basis to Tribes and Tribal organizations 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 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$67,894	$67,894	$68,065	+$171
FTE*	280	280	280	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 2015 Authorization.....Permanent

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The IHS Headquarters provides Agency-wide leadership, oversight, and executive direction to ensure that comprehensive health care services are provided to American Indians and Alaska Natives (AI/ANs). In addition, 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. The Direct Operations budget provides critical support in the overall administration, oversight and delivery of health programs and services throughout the IHS and its funding is allocated to IHS Headquarters, 12 Area Offices, and Tribal Shares.

The IHS Headquarters authorities and operations are set forth by statute and administrative requirements by HHS, the Administration, and Congress. The IHS Headquarters provides general program direction 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.

By delegation from the IHS Director, the 12 Area Offices 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 supports the leadership, overall management, and inherent federal functions and activities of the IHS to ensure effective support for the IHS mission. This includes oversight of human resources, financial resources, facilities, information technology and 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.

Overall leadership and direction is focused on the Agency's four priorities:

1. To renew and strengthen the partnership with Tribes;
2. To reform the IHS;
3. To improve the quality of and access to care for patients who are served by the IHS; and
4. To be as transparent, accountable, fair, and inclusive as possible in the work performed.

Agency priority number one is largely addressed through Tribal consultation, which is a fundamental part of how IHS is changing and improving the management and operation of the overall IHS organization and processes. One example of recent accomplishments is implementation of a total of fifteen recommendations from Tribes to improve the Tribal consultation process in FY 2013. Since then the IHS has consulted with Tribes on numerous issues that are tracked as Tribal priorities. On February 18, 2014, IHS issued the second IHS Tribal Consultation Activities Summary to Tribes; the first summary was issued in August 2012. The summary lists all IHS Tribal consultation activities since June 2009 and includes the status and followup of 19 topics/issues that are tracked and reported to Tribes. Furthermore, Tribal consultations results in effective decisions for the future of IHS and help to improve patient care. For example, significant work has been accomplished through a Tribal workgroup on improving the Purchased/Referred Care (PRC) Program that resulted in recommendations and sharing of best practices to improve management of IHS operated PRC programs and third-party collections.

The IHS continues comprehensive improvements, reforms and oversight in management and administration of key Agency-wide systems, including financial management, property management, performance management, and hiring reforms, which includes improved suitability determinations for new hires and ongoing oversight and improvements in healthcare provider credentialing and facility accreditation. These reforms are a part of corrective actions in response to the Agency's overall internal reform, Area management reviews, and program integrity activities. One example of a recent improvement is that IHS is now ensuring that employment and background verification requirements are fully met prior to bringing employees on board. The IHS continues to check the Office of Inspector General's exclusion list for all its employees and has standard security pre-clearance language for use in IHS solicitations that involve contractor access to IHS facilities and systems. A critical example of improvement is IHS working closely with HHS on maintaining progress and completion of addressing the major audit findings for cash management and suspense reconciliations. The most recent focus is on refining and formalizing processes to ensure routine accomplishment of cash and suspense reconciliations. In the 2013 audit, the IHS achieved a clean opinion on the portion in which IHS participates. Also, the IHS continues to maintain 100 percent accreditation/certification for IHS-operated hospitals, ambulatory clinics, and regional youth treatment centers and works in collaboration with national healthcare organizations to remain accredited/certified.

The Direct Operations budget supports leadership and oversight for the accomplishment of the Agency's program performance. Direction includes specific focus on the Secretary's Key Initiatives and priorities and the HHS Strategic Plan for Fiscal Years 2014-2018. The IHS exceeded both of its FY 2013 targets for its Agency-specific performance goals − depression screening and improving the Tribal consultation process − that are tracked as a part of the

implementation of the HHS Strategic Plan. The IHS implemented four process improvements in FY 2013, exceeding the target of three annually, and raised the total number of improvements to fifteen since IHS first started tracking improvements in FY 2011.

Direct Operations includes a critical focus on oversight, program integrity and accountability, ensuring that appropriated funds are effectively and efficiently expended to obtain the highest quality of outcomes for the Agency mission. This focus includes the establishment of an oversight component to provide continuous and special monitoring of all financial, human resources, acquisitions, grants, and information technology management systems at all levels of the Agency. This oversight component will provide regular and special reports on the performance of administrative and management systems that support the delivery of health care throughout the Indian health system. Program integrity is a priority for IHS and includes responsiveness to key stakeholders (e.g., the Administration, Congress, Tribal partners) and furthers the Agency priority on accountability and transparency.

The improvement of the Human Resource Management and Servicing systems is a high priority for the IHS and includes the following:

- The FY 2014 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.
- The Agency is working on improvements in pay systems and retention strategies to improve more timely recruitment and retention of healthcare providers because it has been historically difficult for IHS to recruit and retain healthcare personnel due to remote locations and noncompetitive salaries.
- The collaborative work IHS continues with the Health Resources and Services Administration (HRSA) and has resulted in approval of 638 IHS, Tribal and Urban Indian health care delivery sites for placement of National Health Service Corps (NHSC) health care providers, and the number of placements has increased to 364 providers in as of January 2014. The progress was made possible by the IHS and HRSA's NHSC working collaboratively to develop a process for a pre-approved method for site eligibility.
- IHS continues to make improvements in its training of supervisors and performance management processes to ensure an effective workforce that is accountable to the IHS mission and that demonstrates progress in IHS reforms.

Priorities for improvements in Direct Operations also include ongoing leadership of oversight and implementation of the Affordable Care Act (ACA) and the Indian Health Care Improvement Act (IHCIA) within the IHS. The IHS is collaborating with HHS and other federal agencies on implementation of provisions in the ACA that impact American Indians and Alaska Natives and also is the lead on implementation of the new permanent authorities of the IHCIA. IHS is consulting with Tribes on an ongoing basis regarding implementation of ACA and IHCIA provisions and provides updates on implementation progress. Implementation continues to focus on preparations for the expansion of health insurance and Medicaid coverage for patients served by IHS as well as planning for enhanced business office and health care delivery system improvements necessary to fully implement ACA and IHCIA provisions in the IHS.

FUNDING HISTORY

Fiscal Year	Amount
2010 Enacted	$68,720,000
2011 Enacted	$68,583,000
2012 Enacted	$71,653,000

2013 Final	$67,894,000
2014 Enacted	$67,894,000

BUDGET REQUEST

The FY 2015 budget request for the Direct Operations program of $68,065,000 is an increase of $171,000 above the FY 2014 Enacted level.

Base Funding of $67,894,000 – The base 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 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.
- 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, and, in addition to implementing a corrective action plan to address findings in the Aberdeen 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.

New Tribes +$171,000 to partially fund 5 new federally recognized Tribes. This level establishes baseline funding for each tribe and recurs in out years. Approximately 4,630 tribal members will gain access to care through this funding.

Direct Operations Headquarters and Area Office – Estimated Distribution: The distribution of funds includes Headquarters operations, 12 Area Offices operations, and Tribal shares as indicated by the table below:

	FY 2013 Final	FY 2014 Enacted	FY 2015 Request
Headquarters (56.5%)	$38,891,028	$39,891,028	$39,959,677
Title I Contracts (non-add)	*2,124,052*	*2,124,052*	*2,192,452*
Title V Compacts (non-add)	*6,371,185*	*6,371,185*	*5,750,941*
Area Offices (12) (43.5%)	28,002,723	28,002,723	28,105,323

Title I Contracts (non-add)	*537,195*	*537,195*	*639,795*
Title V Compacts (non-add)	*8,523,604*	*8,523,604*	*8,789,538*
BA	**$67,893,751**	**$67,893,751**	**$68,065,000**

AREA ALLOCATION – Direct Operations *(dollars in thousands)*

Discretionary SERVICES	**FY 2013 Final**	**FY 2014 Enacted**	**FY 2015 Request**	**FY 2015 +/- FY 2014**
Alaska	4,672	4,672	4,672	0
Albuquerque	1,294	1,294	1,294	0
Bemidji	1,388	1,388	1,388	0
Billings	2,219	2,219	2,219	0
California	1,465	1,465	1,465	0
Great Plains*	$2,422	$2,422	$2,422	$0
Nashville	1,689	1,689	1,860	171
Navajo	3,042	3,042	3,042	0
Oklahoma	3,547	3,547	3,547	0
Phoenix	3,033	3,033	3,033	0
Portland	2,556	2,556	2,556	0
Tucson	675	675	675	0
Headquarters	39,892	39,892	39,892	0
Total, Direct Ops	**$67,894**	**$67,894**	**$68,065**	**$171**

Note: Allocation amounts are estimates.

* The Great Plains Area is the new name for the former Aberdeen Area. The area office name was changed at the request of the Tribes served by the Aberdeen Area Indian Health Service. Notification can be found in the January 10, 2014, issue of the Federal Register, *available at* http://www.gpo.gov/fdsys/pkg/FR-2014-01-10/pdf/2014-00264.pdf.

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

(Dollars in Thousands)

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$5,727	$4,727	$5,727	+$1,000
FTE*	11	11	11	0

*FTE numbers reflect only federal staff and do not include increases in 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 2015 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] The OTSG implements activities to support self-governance in the context of the Agency priorities: renew and strengthen our partnership with Tribes; bring reform to IHS; improve the quality of and access to care for AI/ANs; and make all work accountable, transparent, 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] The IHS Tribal Self-Governance Program has grown dramatically since the initial 14 compacts and funding agreements were signed in 1994. As of January 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 $1.6 billion, over one-third of the total IHS budget appropriation[3], will be transferred to Tribes to support 89 ISDEAA Title V compacts and 114 funding agreements.[4]

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[1] *Available at* http://www.whitehouse.gov/sites/default/files/omb/memoranda/2010/m10-33.pdf.
[2] The Self-Governance budget line only accounts for Title V ISDEAA compacts and funding agreements.
[3] 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. In total, approximately 62% of the IHS budget appropriation is transferred to Tribes and Tribal Organizations through these agreements.
[4] 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

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 authorities; and funding to support 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 applications for Self-Governance Planning and Negotiation Cooperative Agreements.
- Provides resource and technical assistance to Tribes and Tribal organizations for the implementation of Tribal Self-Governance.
- Provides Tribal Self-Governance Trainings 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 IHS Tribal Self-Governance activities and program direction.
- Develops, publishes, and presents information related to the IHS Tribal Self-Governance activities to Tribes, Tribal organizations, state and local governmental agencies, and other interested parties.
- Coordinates Self-Governance Tribal Delegation Meetings for HHS, IHS Headquarters, and Area Senior officials.

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

- Overseeing the negotiation of Tribal Self-Governance compacts and funding agreements with participating Tribes;
- Supporting authorities available to Tribes under the Indian Health Care Improvement Act as amended; and
- Providing support for projects that improve tribally-operated health programs, Government Performance and Results Act reporting, and facility accreditation.

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

- Providing support for projects that assist Tribally-operated health programs to enhance information technology infrastructure to prepare for meaningful use and other federal Agency 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.

Tribe is used to project estimates for Tribes entering into a Title V ISDEAA compact and funding agreement, inclusive of both tribal shares and contract support costs.

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

- Maintaining, troubleshooting, and updating a Title V database containing amendments and payments to Tribes that provides 24/7 access to IHS staff and Tribes. This database 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 Agency 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.

FUNDING HISTORY

Fiscal Year	Amount
2010 Enacted	$6,066,000
2011 Enacted	$6,054,000
2012 Enacted	$6,044,000
2013 Final	$5,727,000
2014 Enacted	$4,727,000

BUDGET REQUEST

The FY 2015 budget request for the Tribal Self-Governance Program of $5,727,000 is an increase of $1,000,000 above the FY 2014 Enacted level.

Base Funding of $4,727,000 – The base funding is necessary to support further implementation of the IHS Tribal Self-Governance program, continue funding for Planning and Negotiation Cooperative Agreements to assist Indian Tribes to 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**.**

The $1,000,000 increase includes funding to restore the Tribal Self-Governance Program to the FY 2013 funding level. This restoration will allow IHS to: support the Inter-Agency Agreement with the U.S. General Services Administration for the purchase of ambulances throughout the IHS; produce print and web resources to educate Tribes, Federal staff, and the public about the IHS Tribal Self-Governance Program; and provide support for projects that improve tribally-operated health programs.

OUTPUTS AND OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
TOHP-1: Percentage of TOHP clinical user population included in GPRA data.	FY 2013: 55.7% Target: 70.3% (Target Not Met)	55.3%	55.3%	0

TOHP-SP: Implement recommendations from Tribes annually to improve the Tribal consultation process.	FY 2013: 4 Target: 3 (Target Exceeded)	3	3	0

GRANT AWARDS

	FY 2013 Final	FY 2014 Enacted	FY 2015 Request
Planning Cooperative Agreements			
Number of Awards	5	5	5
Average Award	$120,000	$120,000	$120,000
Range of Awards	$120,000 - $120,000	$120,000 - $120,000	$120,000 - $120,000
Negotiation Cooperative Agreements			
Number of Awards	5	5	5
Average Award	$48,000	$48,000	$48,000
Range of Awards	$48,000 - $48,000	$48,000 - $48,000	$48,000 - $48,000

AREA ALLOCATION – Self-Governance *(dollars in thousands)*

Discretionary SERVICES	**FY 2013 Final**	**FY 2014 Enacted**	**FY 2015 Request**	**FY 2015 +/- FY 2014**
Headquarters	$5,727	$4,727	$5,727	+$1,000
Total, SELF-GOV	**$5,727**	**$4,727**	**$5,727**	**+$1,000**

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

CONTRACT SUPPORT COSTS

(Dollars in Thousands)

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$447,788	$587,376	$617,205	+$29,829
FTE*	0	0	0	0

*Contract Support Costs funds are not used to support FTE.

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

FY 2015 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 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 2013, approximately $2.49 billion of the IHS appropriations was administered by T/TO, primarily 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 to provide guidance in the administration of CSC. It was developed through extensive consultation and input from Tribes. The IHS continuously reviews the soundness of its CSC allocation policy to assure that CSC provided to T/TO is in accordance with the IHS CSC Policy and does not duplicate other funding provided by IHS. Upon revision in 2007, the policy was established as a permanent Chapter within the IHS Manual.[1]

Since FY 2011, IHS has made significant improvements to the IHS business practices associated with the CSC policy, which include:

- Ensuring a fair and consistent application of the CSC policy, its guidance and its stated procedures;

[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.

- Improved internal Agency understanding of the CSC Policy principles and its application;
- Utilizing key IHS Area Office and Headquarters staff for Tribal data verification, funds certification and allocations; and
- Submission of the 2011 and 2012 CSC Funding Needs Reports to Congress by the Secretary, HHS in FY 2013 and completion of the 2013 CSC Funding Needs Report to Congress.

FUNDING HISTORY

Fiscal Year	Amount
2010 Enacted	$398,490,000
2011 Enacted	$397,693,000
2012 Enacted	$471,437,000
2013 Final	$447,788,000
2014 Enacted	$587,376,000

BUDGET REQUEST

The FY 2015 budget request for Contract Support Costs (CSC) of $617,205,000 is $29,829,000 above the FY 2014 Enacted funding level. The request reflects the estimated amount needed to fully fund CSC associated with this budget request, based on information available as of this budget submission. This budget request responds to the Supreme Court's decision in *Salazar v. Ramah Navajo Chapter*, No. 11-551 (June 18, 2012). Since the number of Tribes assuming new or expanded contracts in FY 2015 is unknown at this time, this request includes an estimated amount. In addition, the actual need for CSC is calculated after the appropriation year and upon receipt of updated information that impacts the calculation of CSC such as updates to provisional rates and corrections will be made as needed. In the explanatory statement of the Consolidated Appropriations Act of 2014, Congress remanded the issue of determining CSC amounts back to the agency and required a work plan to consult with Tribes on a more long term solution. The IHS will provide updated information as it becomes available as a result of this consultation, any decisions on the long term solution requested by Congress, and any updates on the amount of CSC associated with new and expanded contracts or updated information.

AREA ALLOCATION – Contract Support Costs *(dollars in thousands)*

Discretionary SERVICES	**FY 2013 Final**	**FY 2014 Enacted**	**FY 2015 Pres. Request**	**FY 2015 +/- FY 2014**
Alaska	$138,465	$181,628	$190,851	$9,223
Albuquerque	13,012	17,068	17,935	867
Bemidji	27,570	36,164	38,001	1,837
Billings	10,741	14,089	14,805	716
California	43,493	57,051	59,948	2,897
Great Plains*	15,144	19,865	20,874	1,009
Nashville	18,441	24,190	25,418	1,228
Navajo	42,739	56,062	58,909	2,847
Oklahoma	69,711	91,442	96,086	4,644
Phoenix	20,943	27,472	28,867	1,395
Portland	44,511	58,386	61,351	2,965
Tucson	2,108	2,765	2,906	141
Headquarters	910	1,194	1,254	60
Total, CSC	**$447,788**	**$587,376**	**$617,205**	**+$29,829**

Note: These allocation amounts are estimates.

* The Great Plains Area is the new name for the former Aberdeen Area. The area office name was changed at the request of the Tribes served by the Aberdeen Area Indian Health Service. Notification can be found in the January 10, 2014, issue of the Federal Register, *available at* http://www.gpo.gov/fdsys/pkg/FR-2014-01-10/pdf/2014-00264.pdf.

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

PUBLIC AND PRIVATE COLLECTIONS

(dollars in thousands)

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Request	FY 2015 +/- FY 2014
Medicare:				
Federal	$151,417	$153,118	$153,118	$0
Tribal [1]	6,986	6,986	6,986	$0
Tribal [2]	57,244	57,244	57,244	$0
Subtotal:	215,647	217,348	217,348	$0
Medicaid:				
Federal	$573,372	$661,539	$678,826	$17,287
Tribal [1]	22,217	25,305	26,020	$715
Tribal [2]	124,203	141,466	145,464	$3,998
Subtotal:	719,792	828,310	850,310	$22,000
M/M Total:	**935,439**	**1,045,658**	**1,067,658**	**$22,000**
Private Insurance	85,303	90,303	90,303	$0
VA Reimbursement*	$341	$36,000	$39,000	$3,000
TOTAL:	**$1,021,083**	**$1,171,961**	**$1,196,961**	**$25,000**
FTE**	6,009	6,009	6,009	0

[1] Represents CMS tribal collection estimates.
[2] Represents estimates of tribal collections due to direct billing between FY 2002 – FY 2013.
* The FY 2014 President's Budget estimated VA Reimbursements at $52 million for federal and tribal reimbursements. Estimates are revised to $36 million for FY 2014 and $39 million for FY 2015 for federal and tribal reimbursements. The FY 2013 and FY 2014 actual federal collections to date may be an indication that the FY 2014 and FY 2015 collections are overestimated and future year estimates will need to be adjusted accordingly.
** 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

Overview - 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 FY 2013, an estimated $1,021.083 million was collected from third party insurers, of which an estimated $725 million was federal M&M collections and $85.3 million, or 8 percent was from private insurers. In FY 2013, public and private collections made up about 19 percent of the total IHS budget at the program level. The estimates included in the FY 2015 Justification are based on the FY 2014 Budget, current M&M rates available and published in the Federal Register on April 17, 2013 for the 2013 calendar year, and increased Medicaid enrollment estimated related to the Affordable Care Act (ACA).

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 all accreditation standards for its healthcare facilities. Third-party revenue is essential to maintaining facility accreditation and standards of health care through the Joint Commission on Accreditation of Healthcare Organizations or the Accreditation Association for Ambulatory Health Care. Collection funds may be used to maintain the facility certification required by the Centers for Medicare and Medicaid Services (CMS) for participation in the M&M programs. M&M reimbursements continue to be used to support and maintain facility accreditation and improve the delivery and access to health care for American Indian/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. This 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.

During FY 2015, IHS will continue the development of a third-party interface with the Unified Financial Management System and enhanced systems and processes to meet new 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, and electronic claims processing. Priority efforts include the continued development of modifications to third-party billing and accounts receivable software to improve effectiveness and to ensure system integration with its business processes and compliance with M&M regulations. These improvements for IHS operated facilities will be coordinated with concurrent improvements in Purchased/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 care facilities.

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 the ACA Medicaid Expansion and Federal-State Marketplaces with coverage effective January 1, 2014 continues to be a major focus. Increased enrollment and collections will depend, in large part, on IHS' successful partnerships/relationships, state participation in Medicaid expansion, and a willingness of IHS users to enroll in Medicaid in states where the program has been expanded.

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 for direct health care services provided to eligible AI/AN veterans receiving services in IHS facilities. This is a significant step forward in ensuring implementation of Section 405 of the IHCIA. The agreement represents a positive partnership to support improved coordination of care between IHS and the VA and paves the way for future agreements negotiated between VA and tribal health programs. IHS continues to work directly with the VA to implement billing practices to ensure IHS receives proper payment for care provided at IHS facilities to AI/AN veterans. Implementation plans have been developed to bill the VA and collect at all IHS federal sites. Currently, 100 percent of federal sites are billing the VA for services. As of February 2014, the VA has reported 46 tribal programs have implemented signed agreements.

Annually, IHS trains health care facility staff in areas related to coding, third party billing and other aspects of the revenue cycle. In August 2013, the IHS held its 14th Annual Indian Health Partnerships Conference. Two general sessions and 49 breakout sessions were provided to over 500 IHS, Tribal, and Urban Indian organization staff and several hundred people participated via webinar. A large emphasis was placed on the ACA with overview and updates focusing on: implementation, impact on referred care, Medicaid expansion, and enrollment. Other sessions included: ICD-10 implementation, meaningful use requirements, and VA billing. The conference provides frontline staff with the latest information about finance, information technology, Purchased/Referred Care and business office functions.

Claims Processing Improvements - During FY 2015, 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, particularly by utilizing a more robust program to monitor and follow up on outstanding bills. This initiative will maintain current collection efforts. The local Service Units utilize Private Insurance funds collected 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.

FY 2013-2015 Collections Estimates

Medicare and Medicaid (M&M): The anticipated FY 2015 M&M total is $1,067.658 million, an increase of $22 million over the FY 2014 level of $1,045.658 million. The FY 2014 M&M collections total $1,045.658 million and include an increase of $95 million related to increased patient enrollment in Medicaid primarily due to ACA implementation and an increase of $15.219 million associated with the FY 2014 impact of the CY 2013 M&M rate changes. The FY 2014 estimate assumed all states would implement Medicaid under the ACA and FY 2014 actuals will likely be less than the original estimate.

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. 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. Tribal M&M collections estimates reflect information available to IHS. CMS tribal estimates

have not been updated since 1999 and other tribal collection estimates are based on data before tribes started billing and receiving direct payments from CMS. IHS and CMS are developing new methods to update tribal collections estimates with available data, including using facility and provider identified numbers. Since tribes receive direct M&M reimbursement from CMS, any update of tribal estimates will require collaboration with CMS in consultation with the tribes. IHS is committed to working with CMS and consulting with tribes in identifying appropriate methods to update this data.

Medicaid [1] – The FY 2015 estimates total $850.310 million, an increase of $22 million over the FY 2014 revised level of $828.310 million. The FY 2015 increase assumes that IHS will enroll an additional 26,000 enrollees in Medicaid during FY 2015. The anticipated increase in Medicaid enrollment is due to the continued implementation of the ACA in FY 2015. The FY 2015 request assumes that the total Federal and Tribal Medicaid enrollment will increase by about 10 percent over the FY 2013 reported level.

Medicare – The FY 2015 President's Budget estimate of $217.348 million represents the full impact of the CY 2013 rates increases published in the Federal Register on April 17, 2013. The FY 2013 level of $215.647 million has been revised to $217.348 millioin in FY 2014 to include additional collections of $1.701 million which represents the estimated impact of the CY 2013 rates increases in FY 2014.

Private Insurance – For FY 2015, this request proposes a continuation of the FY 2014 estimated level of private insurance collections. The FY 2014 request included an increase of $5 million in private insurance collections related to the implementation of the ACA. The ACA subsidizes the cost of health insurance for AI/ANs with incomes up to 400 percent of the Federal Poverty Level 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. The 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. More reliable AI/AN private insurance data is needed prior to making a significant increase in private insurance revenue.

VA/IHS National Reimbursement Agreement– In FY 2013, the VA reimbursements totaled $0.341 million for IHS federally operated facilities; tribes are not required to report collections totals to IHS. It is estimated that FY 2014 reimbursements will be $36 million and increase to approximately $39 million in FY 2015 for federal and tribal sites. Estimating the true level of FY 2014 and FY 2015 collections is impacted by the actual number of eligible AI/AN Veterans using IHS services as well as success in ensuring sites are prepared to bill for and receive reimbursements. IHS continues to work with the VA in identifying the actual number of AI/ANs with VA benefit 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 81 IHS sites have signed implementation plans and have the ability to bill the VA for Veterans Services.

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[1] The FY 2015 increase of 26,000 new Medicaid enrollees estimated under the ACA (Medicaid expansion) is in addition to the 29,000 new Medicaid enrollees estimated in the FY 2014 budget request. This would increase the number of new Medicaid enrollees to 55,000 or 57% of the FY 2014 OMB estimate of 97,000 new Medicaid enrollees under Medicaid expansion. Since several states, with large American Indian and Alaska Native populations, including Oklahoma, Alaska and South Dakota, have elected not to implement Medicaid expansion, we believe the FY 2015 estimate of 55,000 represents an ambitious goal. IHS plans to monitor FY 2014 progress and do everything possible to implement and maximize Medicaid expansion enrollment in FY 2014 and FY 2015.

The following table shows how third party collections are used:

(dollars in thousands)

Type of Obligation	FY 2013 Final	FY 2014 Enacted	FY 2015 Request
Personnel Benefits & Compensation	$414,420	$417,527	$421,699
Travel & Transportation	4,852	5,935	6,083
Non-Patient Transportation	2,896	3,508	3,589
Comm./Util./Rent	16,870	20,652	21,193
Printing & Reproduction	259	302	308
Other Contractual Services	184,069	226,679	232,754
Supplies	154,403	190,418	195,585
Equipment	11,717	14,576	14,996
Land & Structures	5,726	7,218	7,444
Grants	14,534	17,774	18,225
Insurance / Indemnities	346	371	371
Interest/Dividends	0	0	0
Subtotal	$810,092	$904,960	$922,247
VA Reimbursement	$341	$36,000	$39,000
Tribal Collections (est.)	$210,650	$231,001	$235,714
Total Collections	**$1,021,083**	**$1,171,961**	**$1,196,961**

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

FACILITIES

(Dollars in Thousands)

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$418,570	$451,673	$461,995	+$10,322
FTE*	1,208	1,223	1,248	+25

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

SUMMARY OF THE BUDGET REQUEST

The Indian Health Facilities programs include project, program support, medical equipment, and quarters return activities. Project activities include Maintenance and Improvement (M&I), Sanitation Facilities Construction (SFC), and Health Care Facilities Construction (HCFC). The program support activity is Facilities and Environmental Health Support (FEHS). Equipment and Personnel Quarters collections are also separate activities.

BUDGET AUTHORITY

The FY 2015 budget submission for Facilities of $461.995 million is an increase of +$10.322 million above the FY 2014 Enacted level of $451,673 million. This budget request includes the following changes compared to the FY 2014.

Maintenance & Improvement – The budget request for M&I of $53.614 million is the same as the FY 2014 Enacted level. These funds provide for maintenance, repair, and improvement of health care facilities. Specific objectives and program priorities to address the condition of facilities include:

- Providing routine maintenance and repairs to upkeep facilities at their current conditions;
- Achieving compliance with buildings and grounds accreditation standards of the Joint Commission or other applicable accreditation bodies;
- Providing improvements to facilities for enhanced patient care through larger M&I projects to reduce the Backlog of Essential Maintenance, Alteration and Repair (BEMAR), is estimated at over $465 million for all IHS and reporting Tribal facilities;
- Ensuring that health care facilities meet building codes and standards; and
- Ensuring compliance with executive orders and public laws relative to building requirements, e.g., sustainability, energy conservation, seismic, environmental, handicapped accessibility, and security.

Sanitation Facilities Construction – The budget request for Sanitation Facilities Construction of $79.423 million is the same as the FY 2014 Enacted level. These funds provide for essential water supply, sewage disposal, and solid waste disposal facilities, including:

- 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;
- Projects to serve existing housing; and
- Special projects (e.g., studies, training, or other needs related to sanitation facilities construction) and emergency projects.

Health Care Facilities Construction – The budget request for Health Care Facilities Construction of $85.048 million is the same as the FY 2014 Enacted level. These funds provide funding for continued progress on construction of replacement healthcare facilities in progress. The FY 2015 request will be allocated to the following projects:

- $2.726 million to continue construction of the Gila River Southeast Health Center in Chandler, AZ.
- $46.292 million to begin and complete construction of the Fort Yuma Health Center in Winterhaven, CA.
- $18.869 million to complete construction of the Kayenta Health Center and staff quarters in Kayenta, AZ.
- $17.161 million to complete construction of the Northern California Regional Youth Treatment Center in Davis, CA.

Facilities and Environmental Health Support – The budget request for Facilities and Environmental Health Support of $220.585 million is +$9.534 million above the FY 2014 Enacted level. This total includes funding for staffing and operating costs at new and replacement health care facilities. FEHS funds provide for:

- Personnel who provide facilities and environmental health services and for operating costs associated with provision of those services and activities.

Equipment – The budget request for Equipment of $23.325 million is +$788,000 above the FY 2014 Enacted level. These funds provide for:

- Routine replacement of medical equipment to over 1,500 federally and tribally-operated health care facilities allocated on workload using a standard formula;
- New medical equipment in tribally-constructed health care facilities; and
- TRANSAM, a program under which IHS acquires and distributes surplus Department of Defense medical equipment, and ambulance programs.

COLLECTIONS

Personnel Quarters funds are not discretionary budget authority but are rents collected by IHS and returned to the service unit for Quarters maintenance and operation costs. Quarters are displayed under Program Level Authority:

Quarters – The budget request for Personnel Quarters of $8 million is the same as the FY 2014 Enacted level projection based on FY 2013 collections data. Collected funds are to be used for:

- Operation, management, and general maintenance of quarters, including temporary maintenance personnel services, security guard services, etc.; and
- Repairs to housing units and associated grounds, purchase of materials, supplies, and household appliances/equipment (e.g., stoves, water heaters, furnaces, etc.).

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MAINTENANCE AND IMPROVEMENT

(Dollars in Thousands)

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$50,919	$53,614	$53,614	$0
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 2015 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 IHS and Tribal healthcare facilities which are used to deliver and support healthcare services. M&I funding goes to federal, government-owned buildings and tribally-owned space where healthcare 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 healthcare facilities, to modernize existing healthcare facilities to meet changing healthcare 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 healthcare in direct support of the IHS mission and priorities.

Maintaining reliable and efficient buildings is increasingly challenging as existing healthcare facilities age and additional space is added into the real property inventory. The average age for IHS-owned healthcare facilities is 34 years, whereas the average age, including recapitalization of private-sector hospital plant, is 9 to 10 years.[1] Many IHS and Tribal healthcare facilities are old, operate at or beyond capacity, and are not designed to be utilized efficiently in the context of modern healthcare delivery. As existing healthcare facilities continue to age, they can become less efficient and the operational and maintenance costs increase. The IHS has not had the resources to recapitalize healthcare facilities on a routine basis.

The physical condition of IHS-owned and many tribally-owned healthcare facilities is evaluated through a series of condition surveys. These surveys, together with routine observations by facilities personnel, identify facility, fire-life-safety, and program deficiencies that make up the Backlog of Essential Maintenance, Alteration, and Repair (BEMAR). The BEMAR is a measure of the condition of healthcare facilities and establishes priorities for larger M&I projects. Adequate M&I funding is essential to correct the deficiencies and keep the BEMAR to an

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

acceptable level. The BEMAR for all IHS and reporting Tribal healthcare facilities as of October 1, 2013 is $465 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 healthcare 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 healthcare delivery. Funding allocation is formula based. Under the Budget Request, no funds will be formula allocated as 'project funds' because there is only enough funding for routine maintenance.

- *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 healthcare 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
2010 Enacted	$53,915,000
2011 Enacted	$53,807,000
2012 Enacted	$53,721,000
2013 Final	$50,919,000
2014 Enacted	$53,614,000

BUDGET REQUEST

The FY 2015 budget request for the M&I program is $53,614,000 is the same as the FY 2014 Enacted level. The FY 2015 budget request for Maintenance and Improvement provides:

- Approximately $50.1 million for routine maintenance to sustain the condition of federal and tribal healthcare 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.php?record_id=9807.

- $3 million for environmental compliance projects.
- $500,000 for demolition projects.

IHS and Tribal healthcare administrators will be challenged to meet increasing patient workload space requirements, changes in patient demographics, and infrastructure improvements to support technological and healthcare delivery advancements. The array of benefits achieved through timely investments in healthcare facilities repair and improvement is effective mission attainment, compliance with regulations, improved healthcare facility condition, efficient operations and patient flow, better recruitment of healthcare professionals, and implementation of stakeholder-driven initiatives. Federal and Tribal healthcare administrators may be required to redirect other funding sources (e.g., Medicare/Medicaid, third-party insurance, etc.) normally planned for healthcare services to fund building repairs and improvements in order to continue to meet mission requirements.

IHS and Tribal healthcare administrators will be challenged to fully 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" will be difficult with no increase to the funding level over FY 2014.

OUTPUTS AND OUTCOMES - This program has no Output or Outcomes.

GRANT AWARDS – This program has no grant awards.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
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SANITATION FACILITIES CONSTRUCTION

(Dollars in Thousands)

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$75,431	$79,423	$79,423	$0
FTE*	195	195	195	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; 42 U.S.C. 2004a, Indian Sanitation Facilities Act; 25 U.S.C. 1632, Indian Health Care Improvement Act (IHCIA), as amended 2010

FY 2015 Authorization.....Permanent

Allocation Method ..... Needs-based priority system for construction project allocation to P.L. 86-121Memorandum of Agreements, P.L. 93-638 Self-Determination Contracts and Self-Governance Compacts

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

Sanitation Facilities Construction (SFC) is an integral component of the 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. 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 12.7 percent, or almost 53,200 AI/AN homes, are without access to safe water or adequate wastewater disposal facilities and those individuals who live in those homes are still at an extremely high risk for gastrointestinal disease and respiratory disease at rates similar to developing countries. 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) emergency and special projects (studies, training, or other needs related to sanitation facilities construction); (3) 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; 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 by the facilities. 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, and project funding priorities remain the same, regardless of the delivery methods chosen by a Tribe.
More than 90 percent of all sanitation facilities construction is performed by Indian Tribes or firms.

The Indian Health Care Improvement Act directs 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.[1] 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. As of November 2013, the list of all projects to correct documented sanitation project deficiencies totaled approximately $3.1 billion with those projects considered economically and technically feasible totaling almost $1.72 billion. Typically, projects with exceptionally high capital costs are considered economically infeasible if their cost per home exceeds an established allowable unit cost per home for a particular geographical area. Technical feasibility relates to operability and sustainability of the proposed system.

As of the end of FY 2013, there were about 250,000 or approximately 60 percent of AI/AN homes in need of some form of sanitation facilities improvements, including 7.4 percent or nearly 30,800 AI/AN homes without potable water. Maximum health benefits will be realized by addressing existing sanitation needs identified in the backlog and by providing sanitation facilities for new homes when they are constructed.

In 2013, IHS provided service to 15,820 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) inventory of all needs in Indian Country. The SDS is an inventory of the sanitation deficiencies of 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. In most years, the SFC program has exceeded all national performance measures, IHS, Departmental and program assessment performance measures.

Beginning in FY 2011, the SFC program has used funds to improve data systems and the collection of AI/AN housing data in an effort to increase transparency, accuracy and accountability of the program. In FY 2014, the SFC program began the transition to use of this data for tracking and reporting on program progress, and that transition will continue in FY 2015.

An efficiency measure based on the average project duration is used in evaluating SFC expertise in advancing project discipline. The goal for SFC projects completed during calendar year (CY) 2011 and the years thereafter is that the average project duration from the execution of the Project Memorandum of Agreement to the Construction Completion date as tracked by the Sanitation Facilities Project Data System shall be 4 years or less.

[1] Title III, Section 302(g) 1 and 2 of P.L.94-437.

Project duration is the average length of time to complete project construction from the time the project is funded and is a measure of actual performance since the project schedule is under a project manager's control. This time frame had been slowly increasing from 2.5 years in 1993 to over 4 years at the end of 2007. Several factors have contributed to this growth in project duration including increased administrative requirements, more involved environmental reviews, increased complexity of designs and decreases in staff resources. Reductions in the length of time a project takes to complete will yield cost savings in both construction inflation costs and project related staffing costs. In 2007, the average length of time to complete a project increased to 4.1 years but with the implementation of a robust project management program the time to complete projects had been reduced to 3.35 years by CY 2011 and in 2012 increased slightly to 3.73. The increase in duration is likely from the long-term impact of the 80 percent budget increase in 2009 from the American Recovery and Reinvestment Act and the resultant increase in the number of projects to manage, but overall the program is still more efficient than in 2007.

FUNDING HISTORY

Fiscal Year	Amount
2010 Enacted	$95,857,000
2011 Enacted	$95,665,000
2012 Enacted	$79,582,000
2013 Final	$75,431,000
2014 Enacted	$79,423,000

BUDGET REQUEST

The FY 2015 budget request for Sanitation Facilities Construction is the same as the FY 2014 Enacted level. The FY 2015 Sanitation Facilities Construction budget will be allocated as follows:

- Up to $48,000,000 of the SFC appropriation in FY 2015 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 $5,000,000 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

- Up to $2,000,000 will be reserved at IHS Headquarters.

  Of this amount, $1,000,000 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 $1,000,000 is for funding special projects. Up to $500,000 will be used in three Areas a year to collect asset inventory data including life cycles, develop as-built drawings and develop rate studies for existing tribal community water supply and waste

water disposal systems to enhance the ability of tribes to establish effective and sustainable operation and maintenance organizations. An amount up to $500,000 will be used for improving data collection systems, providing technical assistance and training for users, as well as for covering the costs of a national automated computer aided drafting contract and to fund a National Tribal Water Center. The National Tribal Water Center will develop teaching materials and techniques for homeowners and communities to improve usage and support in a way that promotes health. The funding stream started in FY 2012 at $250,000 annually and will be funded for five years through FY 2016, in partnership with the Alaska Native Tribal Health Consortium to develop a teaching system that can be used IHS wide.

- The remaining FY 2015 SFC appropriation will be reserved 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 requests. 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.[2]

The IHS appropriated funds are prohibited by law 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 the homes.

OUTPUTS AND OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
(35): Sanitation Improvement: Number of new or like-new and existing AI/AN homes provided with sanitation facilities.	FY 2013: 15,820 Target: 15,000 (Target Exceeded)	16,000	15,500	-500[1]
SFC-E: Track average project duration from the Project Memorandum of Agreement (MOA) execution to construction completion. *(Efficiency)*	Calendar 2012: 3.73 years Target: 4.0 years (Target Exceeded)	4.0 years	4.0 years	0
SFC-3: Percentage of AI/AN homes with sanitation facilities	FY 2013: 87.1% Target: 90% (Target Not Met)	89%	88%	-1%[2]

[1] The unit cost to serve an AI/AN home with sanitation facilities is increasing which has resulted in fewer homes provided with facilities.
[2] The percent of AI/AN homes with sanitation facilities has been declining due to falling infrastructure at the end of its useful life, along with the number of increasing complexity of public water system regulatory requirements necessary to ensure public health protection.

GRANT AWARDS – This program has no grant awards.

[2] "Category A" BIA HIP homes are considered existing homes and will be served out of the funds described in item 1.

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

HEALTH CARE FACILITIES CONSTRUCTION

(Dollars in Thousands)

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$77,238	$85,048	$85,048	$0
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 2015 Authorization.....Permanent

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The IHS Health Care Facilities Construction (HCFC) funds provide optimum availability of functional, modern IHS and tribally operated health care facilities and, where no suitable housing alternative is available, staff housing. The IHS is authorized to construct health care facilities and staff quarters, renovate and construct youth substance abuse treatment centers, 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 and to construct new and replacement dental units.

The construction and modernization of IHS infrastructure through the health care facilities construction program is essential to ensure the IHS commitment to the HHS Services Strategic goal, to strengthen health care. The health care facilities constructed by the IHS ensure access to quality, culturally competent care for one of the poorest and most vulnerable populations in the United States, American Indians and Alaska Natives (AI/AN). The focus of the IHS health service programs provided in these facilities is on prevention and the delivery of comprehensive primary care in a community setting.

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 facility, if any; degree of isolation of the population to be served in the proposed facility; and availability of alternate health care resources. The health facilities projects remaining on the HFCPS, including those partially funded, total approximately $2.1 billion.

The JVCP allows IHS to enter into agreements with Tribes that construct their own health facilities. The funding for the construction of the health facility comes from the Tribe through their own resources, financing or other funding sources; IHS health care facility construction appropriations are not used for construction of facilities in the JVCP. Tribes apply for the JVCP during a competitive process and projects that are approved enter into agreements with IHS. Upon projected completion of construction by the respective Tribe, the IHS agrees to request

Congressional appropriations for additional staffing and operations based on the Tribes' projected dates of completion, fully executed beneficial occupancy, and opening.

FUNDING HISTORY

Fiscal Year	Amount
2010 Enacted	$29,234,000
2011 Enacted	$39,156,000
2012 Enacted	$85,048,000
2013 Final	$77,238,000
2014 Enacted	$85,048,000

BUDGET REQUEST

The FY 2015 budget request for the HCFC program of $85,048,000 is the same as the FY 2014 Enacted level. The HCFC program dollars will be allocated to the following projects:

- Kayenta Health Center, Kayenta, AZ to complete construction of the health care facility and staff quarters,
- Northern California Regional Youth Treatment Center, Davis, CA to complete construction of the treatment center,
- Fort Yuma Health Center, Winterhaven, CA to begin and complete construction; and
- Gila River Southeast Health Center, Chandler, AZ to continue construction.

Kayenta Health Center, Kayenta, AZ $18,869,000

The proposed new Kayenta replacement health center will provide space to support a modern and adequately staffed health care delivery program. The current facility was built in 1959 and in 1990 remodeled and expanded for total of 26,300 square feet. The proposed center has been planned for a projected user population of 19,253, generating approximately 54,000 primary care provider visits and 107,000 outpatient visits annually. This facility will ensure availability of the medical services needed to maintain and promote the health status and overall quality of life for the residents of the service area. The health care programs and services provided at this facility include a level III emergency and urgent care unit with the support of the Tribal emergency medical services; a 10-bed short stay nursing unit that provides sub-acute care; and a three-bed low-risk birthing center, which will allow this health center to function as an IHS alternative rural hospital. Additionally, this health center will have comprehensive ambulatory care, ancillary services, preventive community health services, behavioral health services, service unit administration, and facility support services. The existing facility will be disposed of in accordance with established regulations and procedures after the replacement health center is operational. The FY 2015 funds will complete construction on the facility, the equipment procurement, and the construction of the 129 new staff housing units.

Northern California Youth Regional Treatment Center, Davis, CA $17,161,000

These funds will be used for site preparation and to begin and complete the construction of a 3,948 gross square meter (GSM) Youth Regional Treatment Center (YRTC). The design for this facility is being completed in conjunction with the Southern California YRTC design and the only costs will be to adapt the facility to the northern site. The proposed new YRTC will be located approximately 10 miles west of Sacramento, in Davis, California. The new facility will have 32 beds for routine general residential treatment, 6 beds for a close observation unit for youth who require crisis intervention, and five family suites. This facility will provide treatment of eligible AI/AN youth, ages 12 to 17, with substance abuse and/or co-occurring mental health and

substance use disorder. Treatment includes a highly structured, culturally appropriate, therapeutic program based on an individual achievement level system.

Fort Yuma Health Center, Winterhaven, CA, $46,292,000
These funds will be used to begin and complete construction of the replacement Fort Yuma Health Center, which received design funding in 2008. The current facility was initially built in 1860 with multiple renovations. The total is now 21,700 square feet. The proposed 7,088 gross square meter (GSM) outpatient health center will serve a projected user population of 4,442 generating 18,000 primary care provider visits and 36,000 outpatient visits annually. The replacement outpatient health center will provide a full range of ambulatory care services including dental, podiatry, physical therapy, telemedicine, wellness, community health, contract health care, tribal health programs, and administration services.

Gila River Southeast Health Center, Chandler, AZ $2,726,000
These funds will be used to continue construction of the Gila River Southeast Health Center which received design funding in 2005 and initial construction funds in 2009. The proposed new Southeast Ambulatory Care Center will consist of 12,962 gross square meter (GSM) 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, 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 will improve access to medical care as well as improve the collaboration and partnership between the Gila River Health Care Corporation and the Indian Health Service. The new facility will provide an expanded outpatient department, community health department, and a full array of ancillary and support services. The balance required in the following years to complete this project totals $63.684 million.

As noted on page 2, the Opportunity, Growth, and Security Initiative proposes an additional $200 million for HCFC to build new facilities on the healthcare priority list.

OUTPUTS AND OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
36 Health Care Facility Construction: Number of health care facilities construction projects completed.	FY 2013: 2* Target: 2 (Target Met)	1	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.	Set Baseline	NA	1	+1

* The health care facilities completed in FY 2013 are Nome, Alaska (tribal) and Barrow, Alaska (Federal)
** The health care facilities scheduled to be completed in FY 2015 are Kayenta, Arizona and Southern California YRTC

GRANTS AWARDS -- Program has no grants awards.

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

FACILITIES AND ENVIRONMENTAL HEALTH SUPPORT

(Dollars in Thousands)

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$193,578	$211,051	$220,585	+$9,534
Facilities Support	*$111,735*	*$124,096*	*$131,010*	*+$6,914*
Environmental Health Support	*$66,522*	*$70,902*	*$73,449*	*+$2,547*
Office of Environmental Health Engineering Support	*$15,321*	*$16,053*	*$16,126*	*+$73*
FTE*	1,013	1,028	1,053	+25
Facilities Support	*384*	*396*	*415*	*+19*
Environmental Health Support	*561*	*564*	*570*	*+6*
Office of Environmental Health Engineering Support	*68*	*68*	*68*	*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 2015 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 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 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 Facilities and Environmental Health Support 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.

One way the FEHS programs have demonstrated their commitment to collaborating with other agencies is through participation in the United National Millennium Development goal of reducing the number of AI/AN homes lacking access to safe drinking water and basic sanitation by 50 percent by 2015. In 2007, the Infrastructure Task Force (ITF) was created to work towards this goal. The ITF combines resources from all participating agencies to fund needed projects to provide water infrastructure, wastewater infrastructure, and solid waste management services to tribal communities. Additionally, the ITF leverages their ability to provide technical assistance and operator training opportunities to the tribes to assist the tribes in providing or sustaining improved access to safe drinking water and basic sanitation for their people. Most recently, on April 9, 2013 the Indian Health Service, the Environmental Protection Agency, the Department of Interior, the Department of Agriculture, and the Department of Housing and Urban Development updated their Memorandum of Understanding, renewing their commitment to meet the goals established in 2002.

In addition to staffing costs, funding under this activity includes utilities and certain non-medical supplies and personal property, and biomedical equipment repair.

FUNDING HISTORY

Fiscal Year	Amount
2010 Enacted	$193,087,000
2011 Enacted	$192,701,000
2012 Enacted	$199,413,000
2013 Final	$193,578,000
2014 Enacted	$211,051,000

BUDGET REQUEST

The FY 2015 budget request for Facilities and Environmental Health Support of $220,585,000 is an increase of $9,534,000 above the FY 2014 Enacted level. This increase will provide:

Base Funding of $211,051,000 – the recurring base funding for Facilities Support, Environmental Health Support, and for the Office of Environmental Health and Engineering support. All are described in greater detail below.

The +$9,534,000 increase includes funding for:

- Medical Inflation +$973,000 to cover inflationary costs of providing health care services. This activity supports direct health care services by supporting the maintenance and

operations of the health facilities and the environmental health services required inside of them.

- Additional Staffing and Operating Costs for Newly-Constructed Healthcare Facilities +$8,494,000 – There are 3 new and expanded healthcare facilities and 1 youth treatment facility that are planned to open in FY 2015. These facilities reflect the 56 additional staffing needs that IHS has determined as its minimum potential request for FY 2015. One of the 4 facilities is a Joint Venture Construction Program (JVCP) project where the Tribe is fulfilling its responsibility under the JVCP agreement to fund the construction and equipment for the healthcare facility. IHS' responsibility is to request the funds for the additional staff and to operate the healthcare facility. Increases in Facilities and Environmental Health Support funding are required for additional staffing since it is recurring funding to the facility in subsequent years.

(Dollars in Thousands)

Additional Staff for New Healthcare Facility –Request for FY 2015	Amount	Additional Positions to be Funded
San Carlos Health Center, AZ	$3,598	25
Southern California Youth Treatment Center, CA	$312	2
Choctaw Alternative Rural Healthcare Center (JV), MS	$931	5
Kayenta Alternative Healthcare Center, AZ	$3,653	24
Grand Total:	**$8,494**	**56**

- New Tribes +$67,000 - To support five newly, restored or reaffirmed federally recognized tribes. This level establishes baseline funding for each tribe and recurs in out years. Approximately 4,630 tribal members will gain access to care through this funding.

The Facilities and Environmental Health Support provides for programs and activities described in this section.

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 964,000 square meters of facilities (buildings and structures) and 743 hectares 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 34 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 components 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 2013, total utility costs have increased 59 percent from $15.5 million to $24.6 million and total utility costs per Gross Square Meter (GSM) increased 68 percent from $25/GSM to $42/GSM. 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 2,149,000 British Thermal Units per Square Meter (BTU/SM) in 2003 to 1,959,000 BTU/SM in 2013, which is an 8.8 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. Treatment of injuries costs an estimated $350 million per year in direct health care costs to IHS, Tribes, and contract care facilities. 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-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 AND OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
Injury Intervention: Occupant Protection Use (Output)	CY 2013: The Tribal Injury Prevention Cooperative	Increase the national Tribal Injury Prevention	Expand the implementation of the effective strategies	

[1] Title III, Section 302(g) 1 and 2 of P.L. 94-437.
[2] P.L. 103-399.

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
	Agreement Programs (TIPCAP) reported preliminary seatbelt use percents that were used to develop one national preliminary seatbelt use percent of 71%. This is an improvement of 16% above the 2011 baseline Target: Areas will report preliminary seatbelt use percentages so one national seatbelt use percent could be developed (Target Met)	Cooperative Agreement Programs (TIPCAP) seatbelt use percent by 5 percent, as compared to the 2011 national TIPCAP seatbelt use percent.	identified by the Tribal Injury Prevention Cooperative Agreement Program (TIPCAP) coordinators to additional tribal communities to increase seatbelt usage.	
Environmental Surveillance: Identification and control of environmental health risk factors (Output)	CY 2013: Areas reported preliminary food risk factor deficiency percentages that were used to develop one national food risk factor deficiency percent of 3.6%. This is a reduction of 19% from the 2011 baseline measure. Target: Areas will implement comprehensive interventions targeted at improving the national food risk factor deficiency	Reduce the national risk factor deficiency percentage by 2% , as compared to the 2011 baseline measure	Expand the implementation of the effective strategies identified in the targeted food service operations to additional food service operations to reduce food risk factors.	

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
	measure. (Target Met)			

GRANT AWARDS

In 2013, 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.

	FY 2012 Enacted	FY 2013 Continuing Resolution	FY 2014 Request
Number of Awards	Part Ia 16 Part Ib 17 Part II 7	Part Ia 16 Part Ib 17 Part II 0	Part Ia 16 (est.) Part Ib 17 (est.) Part II 0
Average Award	Part Ia $65,000 Part Ib $80,000 Part II $10,000	Part Ia $61,750 Part Ib $76,000	Part Ia $65,000 (est.) Part Ib $80,000 (est.)
Range of Awards	Part Ia $65,000 Part Ib $$80,000 Part II $10,000	Part Ia $61,750 Part Ib $76,000	Part Ia $65,000 (est.) Part Ib $80,000 (est.)

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 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 were 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 the Health Care Facilities Construction Program. 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 use of resources to improve access to quality healthcare services.

OUTPUTS AND OUTCOMES – This program has no outputs and outcomes.

GRANT AWARDS – This program has no additional grant awards.

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

EQUIPMENT

(Dollars in Thousands)

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$21,404	$22,537	$23,325	+$788
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 2015 Authorization.....Permanent

Allocation Method.....Direct Federal, P.L. 93-638 Self Determination contracts and Self-Governance compacts for replacement medical equipment that is formula based; Equipment funds for tribally-constructed healthcare facilities are competitively allocated; and TRANSAM and 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 IHS and tribal healthcare 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 healthcare providers using modern and effective medical equipment to assure the best possible health outcomes. The IHS and tribal health programs manage approximately 90,000 biomedical devices consisting of laboratory, x-ray, patient monitoring, pharmacy, and other biomedical, diagnostic, and patient equipment valued at approximately $500 million. With today's medical devices having an average life expectancy of approximately six years, medical equipment replacement is a continual process and it is 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 healthcare facilities, TRANSAM and ambulance programs, and new and replacement equipment:

- Tribally-Constructed Healthcare Facilities – The IHS provides medical equipment funds to support the initial purchase of equipment for tribally-constructed healthcare facilities. $5 million is set aside annually for competitive awards to Tribes and Tribal organizations that construct new or expand healthcare facilities space using non-IHS funding sources. As a result, approximately 500,000 patients will be treated with updated 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 sets aside $500,000 for Ambulances and $500,000 for TRANSAM annually.[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 are allocated to IHS and tribal healthcare facilities to 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
2010 Enacted	$22,664,000
2011 Enacted	$22,618,000
2012 Enacted	$22,582,000
2013 Final	$21,404,000
2014 Enacted	$22,537,000

BUDGET REQUEST

The FY 2015 budget request for Equipment of $23,325,000 is an increase of +$788,000 above the FY 2014 Enacted level.

Base Funding $23,325,000

- Approximately $17.3 million for new and routine replacement medical equipment to over 1,500 federally and tribally-operated healthcare facilities.
- Approximately $5 million for new medical equipment in tribally-constructed healthcare facilities.
- Approximately $500,000 for the TRANSAM and $500,000 for ambulance programs.

The +$788,000 increase includes funding for:

- Medical Inflation +$788,000 – to cover inflationary costs of providing health care services. The medical equipment directly affects the ability to deliver health care and quality thus incorporates inflationary costs.

IHS and tribal healthcare facilities 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 medical equipment technologies, telemedicine, and Electronic Health Records have a profound impact on the quality of healthcare. Equipment funds are used to address the most pressing medical equipment needs while incorporating new medical equipment advances.

The program anticipates some challenges to procure new and replacement medical equipment. The request funds the program without adjustments for population growth and it does not fully address the need to replace old equipment with upgraded technologies. There continues to be a need to replace outdated equipment with upgraded technologies to meet current medical and

[1] The IHS Facilities appropriation limits total expenditures to up to $500,000 for equipment purchased through the TRANSAM Program and up to $2.7 million for purchasing ambulances.

diagnostic requirements. Modern medical equipment enhances the ability to effectively and efficiently diagnose and treat patients. Also, ongoing support costs for operating, testing, and maintaining medical equipment continue to rise. As a result, the program expects delays in the procurement of new and replacement medical equipment and postponement of fielding new technologies that are necessary to provide quality health care.

OUTPUTS AND OUTCOMES - This program has no Output or Outcomes.

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 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$8,000	$8,000	$8,000	$0
FTE	0	0	0	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.

Authorizing Legislation..... Public Law 98-473, Sec. 320 as amended
FY 2015 Authorization.....Permanent
Allocation Method.....Federal Direct

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

Staff quarters operation, maintenance, and improvement costs are funded with Quarters Return (QR) funds. QR funds are collected from tenants of quarters residing in IHS owned quarters. These funds will be used for the operation, management, and general maintenance of quarters, including 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
2010 Enacted	$6,288,000
2011 Enacted	$6,288,000
2012 Enacted	$7,500,000
2013 Final	$8,000,000
2014 Enacted	$8,000,000

BUDGET REQUEST

The FY 2015 budget request of collections for Personnel Quarters of $8,000,000 is the same as the 2014 Enacted level. Rental rates are established in accordance with OMB Circular A-45 and adjusted annually based on the national Consumer Price Index.

OUTPUTS AND OUTCOMES - This program has no Output or Outcomes.

GRANT AWARDS – This program has no grant awards.

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

SPECIAL DIABETES PROGRAM FOR INDIANS

(Dollars in Thousands)

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$147,000	$147,000	$150,000	+$3,000
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 and the American Taxpayer Relief Act of 2012 (P.L. 112-240) to extend funding through FY 2014. The program authorization is set to expire after FY 2014.

FY 2015 Authorization..... Expires FY 2014

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 17th year, the SDPI operates with a budget of $150 million per year that is currently authorized through FY 2014. 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 a public health effort 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 in 23 different IHS and Tribal sites, and 364 local SDPI Community-directed grants and sub-grants, and 68 Diabetes Prevention (DP) and Healthy Heart (HH) Initiatives in 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/ANs have the highest age-adjusted rate of diagnosed diabetes (16.1 percent) among all racial and ethnic groups in the United States – roughly twice the rate of the general population (8.3 percent). In some AI/AN communities more than half of adults aged 18 and older have diagnosed diabetes, with prevalence rates reaching as high as 60 percent. The disease increasingly affects AI/AN youth, threatening the health, well-being, and quality of life of future generations.

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 collaborations and 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 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 had to make choices about how to best use their local SDPI funding to address the primary, secondary and tertiary prevention of diabetes and its complications in AI/AN communities.

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. Community-directed Programs

The Community-directed component 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 Community-directed programs is unique in that its diabetes treatment and prevention needs and priorities are defined locally. Based on these local needs and priorities the SDPI Community Directed Diabetes Program implements 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 grant application process used throughout AI/AN communities. Grant programs are required to document the use of at least one Diabetes Best Practice[1], 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:

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

Diabetes treatment and prevention services available to AI/AN individuals	Access in 1997	Access in 2010	Percentage increase
Diabetes clinics	31%	71%	+40%
Diabetes clinical teams	30%	94%	+64%
Diabetes patient registries	34%	94%	+60%
Nutrition services for adults	39%	89%	+50%
Access to registered dieticians	37%	77%	+40%
Culturally tailored diabetes education programs	36%	99%	+63%
Access to physical activity specialists	8%	74%	+66%
Adult weight management programs	19%	76%	+57%

Clinical Diabetes Outcomes During SDPI

At the same time that access to these diabetes services increased, key outcome measures for AI/AN people with diabetes showed improvement or maintenance at or near national targets. These results have been sustained throughout the SDPI era. 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 2013, nearing the A1C goal for most patients of less than 7 percent.
- *Improving Blood Lipid Levels*
  Average LDL cholesterol (i.e., "bad" cholesterol) declined percent from 118 mg/dL in 1998 to 94.7 mg/dL in 2013, surpassing the goal of less than 100 mg/dL.

2. 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 Program and the Healthy Heart Project. Sixty-six Demonstration Project grants were funded that served 110 tribal communities from FY 2004 through FY 2009. From FY 2010 through FY 2014, 68 grants were awarded as Diabetes Prevention and Healthy Heart Initiatives.

Diabetes Prevention (DP) Demonstration Program

The Diabetes Prevention Program 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 achieved rates of diabetes incidence in high risk AI/AN people similar to the the one achieved in the NIH DPP lifestyle intervention group. Reductions in diabetes incidence have significant implications for preserving health and reducing health care costs.

Healthy Heart (HH) Demonstration Project

The 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 HH Project achieved significant reductions in cardiovascular disease risk factors among AI/ANs with diabetes.

Transition to 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 Diabetes Prevention and Healthy Heart Initiative activities.

DP and HH grantees must adhere to a strict intervention protocol and data reporting requirements. 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 use it to improve their 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. Technical assistance, provider networks, clinical monitoring, and grant evaluation activities at the Headquarters and Area office levels have also been strengthened.

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 2013 Diabetes Audit included a review of 105,626 patient charts at 330 I/T/U health facilities. This 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 in multiple online and webinar formats. DDTP receives evaluations on all trainings and uses them to guide future sessions. DDTP also calculates the cost savings of internet-based vs. in-person trainings.

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. 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 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. These 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

FUNDING HISTORY

Fiscal Year	Amount
2010 Enacted	$150,000,000
2011 Omnibus	$150,000,000
2012 Enacted	$150,000,000
2013 Final	$147,000,000
2014 Enacted	$147,000,000

BUDGET

The FY 2015 budget request includes a legislative proposal to extend the SDPI reauthorization for three years through FY 2017 at $150,000,000, per year. The SDPI Budget for FY 2004 through FY 2012 was $150,000,000 annually. In FY 2013 and FY 2014, the 2 percent mandatory sequestration reduced the budget to $147,000,000. 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 the limited 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**

In FY 2013, unobligated administrative funding was used to help lessen the impact of sequestration on SDPI grant programs.

In FY 2014, final decisions on the IHS operating plan are in progress.

Budget request includes a legislative proposal to reauthorize the SDPI at $150,000,000 for three years.

The distribution of FY 2015 SDPI funding will be based on tribal consultation and final agency decision; the activities will be continued or modified appropriately.

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 from FY 2011 to FY 2014 and will contribute to improved performance on outcome measures in subsequent years.

Outputs and Outcomes

Measure	**Year and Most Recent / Target for Recent Result (Summary of Result)**	**FY 2014 Target**	**FY 2015 Target**	**FY 2015 +/- FY 2014**
2: American Indian and Alaska Native patients with diagnosed diabetes achieve	FY 2013: 55% / 48.3% Target: Baseline (Target Met)	55% / 48.3%	47.7%	-0.6%

Measure	Year and Most Recent / Target for Recent Result (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
Good Glycemic Control (A1c less than 8.0) IHS-All[1]				
2: Tribally Operated Health Programs	FY 2013: 50.9% Target: Baseline (Target Met)	50.9%	50.3%	-0.6%
3: **Diabetes: Blood Pressure Control**: Proportion of patients with diagnosed diabetes that have achieved blood pressure control (<140/90). IHS-Al[1]	FY 2013: 68% / 64.6% Target: Baseline (Target Met)	68% / 64.6%	63.8%	-0.8%
3: Tribally Operated Health Programs	FY 2013: 63.5% Target: Baseline (Target Met)	63.5%	62.7%	-0.8%
4: **Diabetes: Dyslipidemia Assessment:** Proportion of patients with diagnosed diabetes assessed for Dyslipidemia (LDL cholesterol). IHS-All[1]	FY 2013: 78% / 72.7% Target: 68.0% (Target Exceeded)	78% / 73.9%	71.8%	–2.1%
4: Tribally Operated Health Programs	FY 2013: 71.8% Target: 66.9% (Target Exceeded)	73.1%	70.9%	-2.2%

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

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 Diabetes Prevention and Healthy Heart Initiative grant programs have begun the dissemination of what was learned during the DP and HH Demonstration Projects.

Size of Awards

CFDA No. 93.443 / SDPI Community-directed Grant Programs			
(whole dollars)	FY 2013 Enacted	FY 2014 Enacted	FY 2015 Request
Number of Awards	364 (includes sub-grants)	364 (includes sub-grants)	364* (includes sub-grants)
Average Award	$304,764	$304,764	$304,764
Range of Awards	$12,549 - $6,483,988	$12,549 - $6,483,988	$12,549 - $6,483,988
Total Awards	$111,239,967	$111,239,967**	$111,239,967

*Exact number of grants awarded in FY 2015 may be different if a competitive application process is used.
** Exact amount of awards under review given sequestration impact

CFDA No. 93.443 / SDPI Diabetes Prevention / Healthy Heart Initiative Grants			
(whole dollars)	FY 2013 Enacted	FY 2014 Enacted	FY2015 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

* Exact amount of awards under review given sequestration impact

FY 2013 Mandatory State/Formula Grants

CFDA No. 93.442 / Special Diabetes Program for Indians Community-Directed Grant Programs by State and FY 2013 Annual Financial Assistance Awards						
State	State Name	Total # Grant Programs	FY 2013 Final	FY 2014 Enacted	FY 2015 Request*	Difference +/- 2013
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	26,011,038	26,011,038	26,011,038	0
CA	California	41	8,670,593	8,670,593	8,670,593	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	6,598,176	6,598,176	6,598,176	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	17,400,264	17,400,264	17,400,264	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	5,059,349	5,059,349	5,059,349	0
TN	Tennessee	2	79,915	79,915	79,915	0
TX	Texas	4	575,946	575,946	575,946	0
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

CFDA No. 93.442 / Special Diabetes Program for Indians Community-Directed Grant Programs by State and FY 2013 Annual Financial Assistance Awards						
State	State Name	Total # Grant Programs	FY 2013 Final	FY 2014 Enacted	FY 2015 Request*	Difference +/- 2013
Funds Pending Distribution**			**1,138,509**	**1,138,509**	**1,138,509**	**0**
	TOTAL	**364** * (IHS, Tribal & Urban grants and sub-grantees)	**$111,239,967**	**$111,239,967**	**$111,239,967**	**$0**
	Indian Tribes	**282 primary grants and sub-grants**	**$91,697,309**			
	Total States	**#35 states**	**$111,239,697**			

* Specific grant amounts subject to changes due to outcome of the competitive application process.
**Funds pending distribution in FY 2013 due to late applications or review submissions. .
***For FY 2013, 364 grants and sub-grants received financial assistance awards compared to 384 SDPI grants that ever received funding.
Exact amount of FY 2014 awards under review given sequestration impact

CFDA No. 93.442 / Special Diabetes Program for Indians Diabetes Prevention (DP) and Healthy Heart (HH) Initiative Grants by State and FY 2012 Annual Financial Assistance Awards						
	State	Total # DP and HH Initiatives	Total FY 2013 Final	FY 2014 Enacted	FY 2015 Request*	Difference +/- 2013
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 Dakota	8	2,667,100	2,667,100	2,667,100	0
UT	Utah	1	397,000	397,000	397,000	0
WA	Washington	5	1,694,200	1,694,200	1,694,200	0

CFDA No. 93.442 / Special Diabetes Program for Indians Diabetes Prevention (DP) and Healthy Heart (HH) Initiative Grants by State and FY 2012 Annual Financial Assistance Awards						
	State	Total # DP and HH Initiatives	Total FY 2013 Final	FY 2014 Enacted	FY 2015 Request*	Difference +/- 2013
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 competitive application process. Exact amount of FY 2014 awards under review given sequestration impact.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Drug Control Budget
FY 2015

RESOURCE SUMMARY			
	Budget Authority (in Millions)		
	FY 2013 Final	FY 2014 Enacted	FY 2015 Request Level
Drug Resources by Function			
Prevention	17.832	18.501	18.501
Treatment	73.798	77.887	77.887
Construction	0.000	15.500	17.161
Total Drug Resources by Function	**$91.630**	**$111.888**	**$113.549**
Drug Resources by Decision Unit			
Alcohol and Substance Abuse	87.228	91.984	91.984
Urban Indian Health Program	4.403	4.492	4.492
Facilities Construction	0.000	15.500	17.161
Total Drug Resources by Decision Unit	**$91.631**	**$111.976**	**$113.637**
Drug Resources Personnel Summary			
Total FTEs (direct only)	171	171	171
Drug Resources as a Percent of Budget			
Agency Budget	$ 5,306.589	$ 5,761.476	$5,989.138
Drug Resources Percentage	1.73%	1.94%	1.90%

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 constructing both the Southern and Northern California Youth Regional Treatment Centers, respectively.

BUDGET
In FY 2015, IHS requests $113.5 million for its drug control activities, an increase of $1.6 million above the FY 2014 Enacted level. The FY 2015 request includes an increase due to construction costs for the Northern California Youth Regional Treatment Center.

Alcohol and Substance Abuse
Total FY 2015 Request: $193.8 million
The FY 2015 budget request for the Alcohol and Substance Abuse program is the same level as the FY 2014 President's Budget. The FY 2015 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.

Urban Indian Health Program – Alcohol and Substance Abuse Title V Grants
Total FY 2015 Request: $41.4 million
The FY 2015 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 2015, 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 2012 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 2015, 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.

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 sequelae 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 recently 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, include participation with existing state PDMP programs. IHS has worked with ONDCP, the Bureau of Justice Assistance, and numerous state PDMPs to participate in development of best practice recommendations as well as 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.

PERFORMANCE

Introduction

This section on the FY 2013 performance of the drug control portion of the IHS Alcohol and Substance Abuse Program is based on Agency Government Performance and Results Act (GPRA) documents. IHS has added two program measures to report on the effectiveness of IHS programs that focus on drug abuse. IHS is also in the process of developing a measure for prescription drug abuse. The IHS Alcohol and Substance Abuse Program provides anti-drug abuse activities to raise community awareness and target high-risk groups in addition to educating staff on issues and skills related to substance abuse.

The measures reported in the table provide targets and results from both Tribally-Operated Health Programs and Federally-Administered Health Programs. Currently, Tribally-Operated Health Programs have 16 measures, including alcohol- and health-related performance indicators.

IHS Alcohol and Substance Abuse Program		
Selected Measures of Performance	FY 2013 Target	FY 2013 Achieved
Alcohol-use screening among appropriate female patients	61.7%	65.7%
Accreditation rate for Youth Regional Treatment Centers*	100%	90%
Report on number of Emergency Department patients who receive Substance Use Disorder (SUD) intervention	41,319	44,325
Report on #SUD services in primary care clinics	113,567	102,456

* In operation 18 months or more.

Discussion

Heavy drinking during pregnancy can cause significant birth defects, including Fetal Alcohol Syndrome (FAS). Known as the leading and most preventable cause of mental retardation, 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.

The accreditation measure for Youth Regional Treatment Centers 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% accreditation performance measure was not met in FY 2013 as a result of the ongoing difficulties experienced by one Tribally-Operated YRTC that is continuing to experience challenges with completing CARF accreditation. The YRTC hoped to obtain accreditation in 2013; however due to internal delays, the YRTC has established a revised action plan with a tentative CARF site visit for April-May 2014.

The FY 2013 performance measure was also impacted when a tribally operated YRTC closed its doors as of July 31, 2013. With this closure, the total number of operating YRTC facilities is now ten; therefore, accreditation of the nine out of the ten YRTCs results in a FY 2013 actual of 90%.

The IHS provides several training opportunities annually on alcohol and substance abuse issues for its providers. In 2013 and in partnership with the University of New Mexico, the Tele-Behavioral Health Center for Excellence (TBHCE) conducted webinar training for over 2,400 participants on current and pressing behavioral health issues through a series of webinars, including a concentrated focus on substance use disorders through a concentrated weekly Pain and Addiction Series and Addiction Mini-Series. Topics included: Opioid Dependence, Buprenorphine, Medication Management: Opioid Based, Screening for Opiate Addictions, Methadone I and II.

The TBHCE is also evaluating models of care delivery, access to care, and sustainability. A toolkit was developed for sites to prepare the infrastructure to have tele-behavioral health services. Critical video infrastructure components were purchased and installed. Intra-Agency agreements were established with IHS Billings, Great Plains and Nashville Areas. TBHCE sites for direct clinical services are Spirit Lake, Great Plains Area; Fort Peck (Wolf Point clinic and Poplar clinics) and Fort Belknap, Billings Area; Elko, Phoenix Area; Acoma-Canoncito-Laguna, New Sunrise Regional Treatment Center, To’hajiilee clinic, Mescalero, Albuquerque Indian Health Center, and the Santa Clara clinic, Albuquerque Area; and Catawba, Nashville Area.

FY 2015 BUDGET SUBMISSION
INDIAN HEALTH SERVICE
OBJECT CLASSIFICATION
(Dollars in Thousands)

Object Class	FY 2014 Enacted	FY 2015 Pres. Budget	FY 15 +/- FY 2014
DIRECT OBLIGATIONS			
Personnel Compensation:			
Full-Time Permanent(11.0)……	452,372	463,925	11,553
Other than Full-Time Permanent(11.3)……	22,430	23,075	645
Other Personnel Comp.(11.5)……	53,012	54,190	1,178
Military Personnel Comp (11.7)……	97,815	100,397	2,582
Special Personal Services Payments (11.8)……	204	205	1
Subtotal, Personnel Compensation...……	625,833	641,792	15,959
Civilian Personnel Benefits(12.1)…….	160,881	164,917	4,036
Military Personnel Benefits (12.2)	41,363	42,418	1,055
Benefits to Former Personnel(13.0)…….	13,129	13,173	44
Subtotal, Pay Costs…….	**841,206**	**862,300**	**21,094**
Travel(21.0)……	43,133	44,720	1,587
Transportation of Things(22.0)……	9,846	10,157	311
Rental Payments to GSA(23.1)…….	8,795	9,130	335
Rental Payments to Others(23.2)……..	1,344	1,391	47
Communications, Utilities and Miscellaneous Charges(23.3……	26,753	27,739	986
Printing and Reproduction(24.0)……..	348	351	3
Other Contractual Services:			
Advisory and Assistance Services(25.1)…….	10,727	10,560	(167)
Other Services(25.2)……	165,520	171,203	5,683
Purchases from Govt. Accts.(25.3)……	52,905	54,661	1,756
Operation and Maintenance of Facilities(25.4)…..	18,888	19,047	159
Research and Development Contracts(25.5)…….	5	6	1
Medical Care(25.6)……	451,540	502,307	50,767
Operation and Maintenance of Equipment(25.7)…	18,973	19,606	633
Subsistence and Support of Persons(25.8)…….	3,164	3,225	61
Subtotal, Other Contractual Current.....……	**721,722**	**780,615**	**58,893**
Supplies and Materials(26.0)……	109,642	115,833	6,191
Equipment (31.0)……	16,948	17,682	734
Land & Structures (32.0)……	81,755	80,810	(945)
Investments & Loans (33.0)……	0	0	0
Grants, Subsidies, & Contributions (41.0)……	2,572,372	2,682,783	110,411
Insurance Claims & Indemnities (42.0)……	619	633	14
Interest & Dividends (43.0)……	32	33	1
Subtotal Non-Pay Costs.....……	**3,593,309**	**3,771,877**	**178,568**
Total, Direct Obligations…….	**4,434,515**	**4,634,177**	**199,662**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
Salaries and Expenses
(Budget Authority - Dollars in Thousands)

Object Class	FY 2014 Enacted	FY 2015 Pres. Budget	Increase or Decrease
Personnel Compensation:			
Full-Time Permanent (11.0)	452,372	463,925	11,553
Other than Full-Time Permanent (11.3)	22,430	23,075	645
Other Personnel Comp. (11.5)	53,012	54,190	1,178
Military Personnel Comp. (11.7)	97,815	100,397	2,582
Special Personnel Services Payments (11.8)	204	205	1
Subtotal, Personnel Compensation	625,833	641,792	15,959
Civilian Personnel Benefits (12.1)	160,881	164,917	4,036
Military Personnel Benefits (12.2)	41,363	42,418	1,055
Benefits to Former Personnel (13.0)	13,129	13,173	44
Total, Pay Costs	**841,206**	**862,300**	**21,094**
Travel (21.0)	43,133	44,720	1,587
Transportation of Things (22.0)	9,846	10,157	311
Rental Payments to Others (23.2)	1,344	1,391	47
Communications, Utilities & Misc. Charges (23.3)	26,753	27,739	986
Printing and Reproduction (24.0)	348	351	3
Other Contractual Services:			
Advisory and Assistance Services (25.1)	10,727	10,560	(167)
Other Services (25.2)	165,520	171,203	5,683
Purchases from Govt. Accts. (25.3)	52,905	54,661	1,756
Operation and Maintenance of Facilities (25.4)	18,888	19,047	159
Operation and Maintenance of Equipment (25.7)	18,973	19,606	633
Subsistance and Support of Persons (25.8)	3,164	3,225	61
Subtotal, Other Contractual	270,177	278,302	8,125
Supplies and Materials (26.0)	109,642	115,833	6,191
Total, Non-Pay Costs	**461,243**	**478,493**	**17,250**
Total Salaries & Expenses	1,302,449	1,340,793	38,344
Direct FTE	9,578	9,728	150

INDIAN HEALTH SERVICE
Detail of Full-Time Equivalents (FTE)

	FY 2013 Final	FY 2014 Enacted	FY 2015 Request
Headquarters			
Sub-Total, Headquarters	433	452	470
Area Offices			
Aberdeen Area Office	2,213	2,242	2,262
Alaska Area Office	479	485	490
Albuquerque Area Office	961	974	982
Bemidji Area Office	546	553	558
Billings Area Office	931	943	951
California Area Office	95	96	96
Nashville Area Office	191	193	195
Navajo Area Office	4,151	4,209	4,246
Oklahoma City Area Office	1,700	1,722	1,737
Phoenix Area Office	2,656	2,691	2,714
Portland Area Office	538	545	550
Tucson Area Office	476	482	486
Sub-Total, Area Offices	14,937	15,135	15,267
Trust Funds (Gift)	23	23	23
TOTAL FTES	15,393	15,610	15,760

Average GS Grade

2011.....	8.1
2012.....	8.1
2013.....	8.1

INDIAN HEALTH SERVICE

DETAIL OF PERMANENT POSITIONS

(Dollars in Thousands)

	FY 2013 Final	FY 2014 Enacted	FY 2015 Pres. Budget
Total - ES's.....	19	19	19
Total - ES Salaries.....	$3,139	$3,139	$3,139
GS/GM-15.....	433	441	446
GS/GM-14.....	414	421	427
GS/GM-13.....	434	442	447
GS-12.....	990	1,007	1,020
GS-11.....	1,302	1,325	1,341
GS-10.....	583	593	601
GS-9.....	1,377	1,401	1,419
GS-8.....	341	347	351
GS-7.....	1,135	1,155	1,169
GS-6.....	1,411	1,436	1,454
GS-5.....	2,238	2,277	2,306
GS-4.....	1,084	1,103	1,117
GS-3.....	195	198	201
GS-2.....	35	36	36
Subtotal.....	11,972	12,180	12,335
Total - GS Salaries.....	$636,543	$649,967	$666,202
Director Grade CO-06.....	440	442	441
Senior Grade CO-05.....	562	564	563
Full Grade CO-04.....	610	613	611
Senior Assistant Grade CO-03.....	396	398	397
Assistant Grade CO-02.....	67	67	67
Junior Grade CO-01.....	8	8	8
Subtotal.....	2,083	2,092	2,087
Total - CO Salaries	$136,051	$139,178	$142,815
Ungraded.....	1,296	1,296	1,296
Total - Ungraded Salaries	$47,912	$48,922	$50,144
Trust Funds (Gift)	23	23	23
Average ES level.....	ES-02	ES-02	
Average ES salary.....	$174	$174	
Average GS grade.....	8.1	8.1	
Average GS salary.....	$53	$53	

Physicians' Comparability Allowance (PCA)
Indian Health Service
Table 1

		PY 2013 (Actual)	CY 2014 (Estimates)	BY 2015* (Estimates)
1) Number of Physicians Receiving PCAs		41	41	41
2) Number of Physicians with One-Year PCA Agreements		4	4	4
3) Number of Physicians with Multi-Year PCA Agreements		37	37	37
4) Average Annual PCA Physician Pay (without PCA payment)		$141,224	$141,224	$141,224
5) Average Annual PCA Payment		$23,927	$23,927	$23,927
6) Number of Physicians Receiving PCAs by Category (non-add)	Category I Clinical Position	38	38	38
	Category II Research Position			
	Category III Occupational Health			
	Category IV-A Disability Evaluation			
	Category IV-B Health and Medical Admin.	3	3	3

*FY 2015 data will be approved during the FY 2016 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) - $30,000. Factors used were board certification, multi-year agreement, categorical allowance, and mission specific 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.

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.

***Information previously provided in August 2013 was incorrect because of an error in reporting. Information provided within this document is confirmed as correct by IHS Human Resources 1/6/14.**

Summary of Reimbursements, Assessments, and Purchases
FY 2015 Estimates

CJ FY 2015

		Object Class								FY 2012	FY 2013	FY 2014	FY 2015
		11.1 & 12.1	21.0	22.0	23.2 & 23.3	24.0	25.3	26.0	31.0	Actual	Actual	Estimate	Estimate
Type of Funding	**Reimbursement for Services Purchased within HHS**												
SSF	Service & Supply Fund				98,330		104,657,950			15,936,000	24,166,950	23,722,000	23,778,000
SSF	HHS Consolidated Acquisition System (HCAS) Operations and Maintenance						14,117,370			2,651,922	2,711,448	2,717,000	2,719,000
SSF	Unified Financial Management System (UFMS) Operations and Maintenance						31,482,430			4,728,868	6,013,562	7,420,000	7,424,000
SSF	UFMS Assessment and Upgrade (Under JFA as of FY 10)						0			0	0	0	0
	Subtotal SSF	0	0	0	98,330	0	150,257,750	0	0	23,316,790	32,891,960	33,859,000	33,921,000
OS TAP	Audit Resolution						472,101			27,513	33,543	62,000	329,000
OS TAP	Web Communications						12,783,119				2,339,000	4,086,000	4,086,000
OS TAP	Governance-Program MGMT & Systems Enhancements(new in FY14)						1,106,000			0	0	1,106,000	1,106,000
OS TAP	Strategic Sourcing Program (SSP)						347,738			64,000	81,000	69,000	69,000
OS TAP	Web Crawler						30,000			6,000	6,000	6,000	6,000
OS TAP	Telecommunications Management/WITS						438,579			216,459	222,121	0	0
OS TAP	Telecommunications Services						174,470			42,240	132,231	0	0
OS TAP	HHS University						32,448			32,448	0	0	0
OS TAP	Small Business Center						884,282			176,000	179,000	179,000	181,000
OS TAP	Tracking Accountability Government Grants System (TAGGS)						1,049,810			194,000	256,000	237,000	241,000
OS TAP	Enterprise Architecture Program-new in FY 2013-Included in the Departmental IT Mgmt line item in FY 2014 & 2015-per SSF in 07/13						247,302			0	247,302	0	0
OS TAP	Networx						656,091			321,000	335,091	0	0
OS TAP	Departmental Contract Information System (DCIS)						2,119,523			439,000	458,000	458,000	474,000
OS TAP	Acquisition Integration Modernization (AIM)						1,207,000			259,000	227,000	227,000	235,000
OS TAP	High Performing Organizations and Competitive Sourcing Reporting (HPO & CSM)						143,842			49,000	42,800	0	0
OS TAP	Commissioned Corps Force Management (CCFM)						23,804,865			327,972	7,499,965	7,948,000	7,601,000
OS TAP	Human Resource Services						5,764,077			1,328,584	1,816,143	0	0
OS TAP	HHS NET						1,341,832			398,684	301,949	0	0
OS TAP	HSPD-12						6,567,057			2,241,882	2,081,486	0	0
OS TAP	OGC Claims						1,460,242			353,591	350,000	235,000	235,000
OS TAP	EEO Investigations (new for non-psc in FY11)						792,343			432,885	0	0	0
OS TAP	EEO Services (new for non-psc in FY11)						6,000			6,000	0	0	0
	Subtotal Non-PSC	0	0	0	0	0	61,428,723	0	0	6,916,258	16,608,629	14,613,000	14,563,000
JFA	UFMS Assessment and Upgrade (under JFA as of FY 10)						1,543,043			1,105,000	1,105,000	1,105,000	1,105,000
JFA	Office of General Counsel	535,860	43,144	16		697	384,309	1,196	18,633	1,248,000	1,338,648	1,338,648	1,338,648
JFA	OGC Departmental Ethics Program						333,000			320,000	320,000	320,000	340,000
JFA	OGC Ethics Program - 2-OMS-13-0007									0	201,560	201,560	201,560
JFA *	Legislatively Mandated Initiatives and Emerging Technologies (formerly part of HHS Enterprise) (LMIE)						1,438,025			1,217,736	624,164	535,136	562,866
JFA	Regional Health Administrators						308,010			308,010	308,010	308,010	308,010
JFA	Motor Vehicle Management Information System						8,000			8,400	0	0	0
JFA	National Institute of Health - Health Services Research Library						868,216			860,424	940,921	940,921	940,921
JFA	Office of Global Health Affairs						13,404			13,404	13,404	13,404	13,404
JFA *	CFO Financial Statement Audit						535,000			555,000	537,700	583,000	600,500
JFA	Media Monitoring and Analysis						59,322			61,695	65,125	71,946	74,823
	Subtotal JFA Assessments	535,860	43,144	16	0	697	5,490,329	1,196	18,633	5,697,669	5,454,532	5,417,625	5,485,732
	Government-wide Administrative Functions												
JFA	Tri-Council (CFOC, CIOC, PEC)						120,795			60,897	0	0	0
JFA *	Government-wide E-Gov Initiatives (formerly part of HHS Enterprise)						2,303,384			351,886	881,835	363,820	363,820
JFA	Federal Employment Services (USAJOBS)						371,013			76,269	74,513	74,513	74,513
JFA	President's Council on Study of Bioethics						114,000			22,800	22,800	22,800	22,800
	Subtotal, GAF	0	0	0	0	0	2,909,192	0	0	511,852	979,148	461,133	461,133
	Grand Total	535,860	43,144	16	98,330	697	220,085,994	1,196	18,633	36,442,569	55,934,269	54,350,758	54,430,865

* New

Object Class Description:
11.1 & 12.1 -- Salaries & Benefits
21.0 -- Travel
22.0 -- Transportation of Things
23.2. & 23.3-- Rental Payments, Communications, Utilities
24.0 -- Printing & Reproduction
25.3 -- Purchases of goods and servics from Gov't Accounts
26.0 -- Supplies & Materials
31.0 -- Equipment

Department of Health & Human Services
Indian Health Service
Number of Service Units and Facilities
Operated by IHS and Tribes, October 1, 2013

Type of Facility	TOTAL	IHS Total	TRIBAL Total	Title I [a]	Title V [b]	Other [c]
Service Units	**168**	61	107			
Hospitals	**45**	28	17	2	15	0
Ambulatory	**587**	**98**	489	145	337	7
Health Centers	310	61	249	95	154	0
School Health Centers	9	3	6	3	3	0
Health Stations	104	34	70	39	30	1
Alaska Village Clinics	164	0	164	8	150	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

Indian Health Service
Summary of Inpatient Admissions and Outpatient Visits
Federal and Tribal
FY 2012 Data

Direct Care Admissions

	IHS	Tribal	TOTAL
TOTAL	**20,707**	**25,200**	**45,907**
Alaska		13,016	13,016
Albuquerque	1,284		1,284
Bemidji	454		454
Billings	993		993
California			*
Great Plains**	3,452		3,452
Nashville		1,080	1,080
Navajo	8,625	5,076	13,701
Oklahoma	1,252	6,005	7,257
Phoenix	4,229	23	4,252
Portland			*
Tucson	418		418

* No direct inpatient facilities in FY 2012
** The Great Plains Area is the new name for the former Aberdeen Area. The area office name was changed at the request of the Tribes served by the Aberdeen Area Indian Health Service. Notification can be found in the January 10, 2014, issue of the Federal Register, *available at* http://www.gpo.gov/fdsys/pkg/FR-2014-01-10/pdf/2014-00264.pdf.

Direct Care Outpatient Visits

	IHS	Tribal	TOTAL
TOTAL	**5,023,569**	**7,825,417**	**12,848,986**
Alaska	*	1,641,769	1,641,769
Albuquerque	474,413	104,290	578,703
Bemidji	241,830	681,065	922,895
Billings	485,752	123,003	608,755
California	*	521,751	521,751
Great Plains**	910,651	109,819	1,020,470
Nashville	11,999	458,656	470,655
Navajo	990,521	703,859	1,694,380
Oklahoma	613,530	2,339,471	2,953,001
Phoenix	844,444	512,066	1,356,510
Portland	292,464	574,164	866,628
Tucson	157,965	55,504	213,469

* No IHS facilities in FY 2012
** The Great Plains Area is the new name for the former Aberdeen Area. The area office name was changed at the request of the Tribes served by the Aberdeen Area Indian Health Service. Notification can be found in the January 10, 2014, issue of the Federal Register, *available at* http://www.gpo.gov/fdsys/pkg/FR-2014-01-10/pdf/2014-00264.pdf.

INDIAN HEALTH SERVICE
Immunization Expenditures

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Estimate	FY 2014 Estimate	FY 2015 Estimate	Increase or Decrease
Infants, <2 yrs	$12,903,354	$12,903,354	$13,329,165	$21,922,093	$18,793,408	-$3,128,685
Adolescents, 13-17 years				$12,412,350	$11,704,995	-$707,355
HPV vaccine, Female 19-26 years	$9,088,511	$9,088,511	$9,388,432	$6,001,292	$7,389,130	+$1,387,838
HPV Vaccine, Males 19-21 yrs				$5,889,641	$6,799,171	+$909,530
Tdap, 19+ yrs				$6,508,229	$6,977,397	+$469,168
Hepatitis B for diabetics, 19-64 yrs				$5,752,971	$4,595,452	-$1,157,519
Influenza, 19+ yrs			$3,210,800	$25,969,076	$29,225,712	+$3,256,636;
Zoster vaccine, 60 yrs				$494,463	$36,189	-$458,274 2015 Limited to 60 years - Provision of Affordable Care Act
Pneumococcal, 65+ yrs	$1,786,625	$1,786,625		$392,934	$432,156	+$39,222
Monitoring	$106,914	$106,914	$110,442	$114,528	$118,078	+$3550 3.1% increase over FY2014
TOTAL	$23,885,404	$23,885,404	$26,038,839	$85,457,577	$86,071,688	+$614,111

1/ The immunization estimates do not include the Hepatitis B and Haemophilus Immunization program (Alaska) budget line item

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 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 2015 estimated costs. In prior years, costs were only included for adults 65+ yrs and for influenza vaccine. The assumptions for these calculations are included in the table below.

Costs for monitoring of immunization coverage were also included, and represent 3.1 percent increase over the FY 2014 estimate.

- FY 2011 Estimated Costs = FY 2010 CR
- 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

For 2015, $85, 953,609 is estimated for vaccine costs, and $118,078 for immunization monitoring costs, for a total of $86,071,688 estimated for all immunization expenditures. This represents an $614,111 increase over FY 2014 due to an increase in population.

Calculations for the costs included as part of the 2015 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	43,243	80%	NA	34,594	$0.00	$21.73	25	$543.25	$18,793,408
Adolescents, 13-17 years	134,664	80%	NA	107,731	$0.00	$21.73	5	$108.65	$11,704,995
HPV Females, 19-26	122,044	60%	50%	21,968	$90.39	$21.73	3	$336.36	$7,389,130
HPV Males, 19-21 yrs	41,253	60%	28%	20,214	$90.39	$21.73	3	$336.36	$6,799,171
Tdap, 19+ yrs	1,051,890	80%	74%	147,265	$25.65	$21.73	1	$47.38	$6,977,397
Hepatitis B for diabetics, 19-64 yrs	76,799	60%	21%	32,256	$25.76	$21.73	3	$142.47	$4,595,452
Influenza, 19+ yrs	1,051,890	80%	34%	841,512	$13.00	$21.73	1	$34.73	$29,225,712
Zoster, 60 yrs	13,264	30%	39%	265	$114.69	$21.73	1	$136.42	$36,189
Pneumococcal, 65+ yrs	124,297	90%	75%	19,888	$26.15	$21.73	1	$47.88	$432,156
Vaccine Costs									$85,953,609
Monitoring									$118,078
Total Vaccine Costs									$86,071,688

*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.

Indian Health Service
Overview of Evidence and Innovation Strategies

BACKGROUND

The Office of Management and Budget (OMB) noted in Memorandum M-13-17, "Next Steps in the Evidence and Innovation Agenda that agencies should work with their OMB contacts to agree on a format within their 2015 Budget submissions that: (1) explains agency progress in using evidence and (2) present their plans to build new knowledge of what works and is cost-effective.

OMB will evaluate agency submissions for the Budget based partly on their use of evidence in shaping resource allocations and their plans to build evidence to improve performance moving forward. The commitment to evidence and evaluation should be reflected throughout agencies' budget submissions. M-13-17 laid out specific ways that agencies can use evidence and evaluation.

The Memorandum identifies five focus areas for action: (1) harnessing data to improve agency results, (2) high-quality, low-cost evaluations and rapid, iterative experimentation, (3) using innovative outcome-focused grant designs, (4) strengthening agency capacity to use evidence; and (5) other agency specific needs, for any strategies that do not fall within the previous categories. See Appendix A of M-13-17 for examples within each focus area.

Following is a summary of IHS progress in using evidence and potential plans to build new knowledge of what works and is cost-effective.

A. **Highlights of Current Activities:**

The Indian Health Service (IHS) currently uses the following activities to improve performance.

1. Harnessing existing data to improve agency results

- The quarterly dashboard of twenty four GPRA measures and targets is widely shared with clinical and administrative staffs to problem solve issues and improve results.
- The Improving Patient Care (IPC) program was launched in 2006 to enable greater access to and improved quality of care. An evaluation of the IPC program is planned that will assess the impact of IPC on access and clinical quality indicators, including patient satisfaction. Dissemination of best practices will be part of the evaluation dissemination plan. Challenges include the hiring of a full-time evaluator to conduct the evaluation.
- The IHS Resource and Patient Management System (RPMS), which is the IHS health information system and certified electronic health record (EHR), incorporates evidence-based clinical decision support to clinicians providing patient care services across the country. The IHS leverages software developed by the Veterans Administration called Clinical Reminders, and has developed reminder logic to provide decision support across a broad range of clinical domains. The national team develops reminders based on published clinical evidence and validated by IHS subject matter experts. Those facilities that have studied the impact of Clinical Reminders implementation have shown significant improvements in screening rates and other targeted metrics. Reminders have been used effectively to improve performance on GPRA and meaningful use measures.
- Clinical Reminders are but one example of how IHS incorporates evidence-based practice into electronic support for clinical care. Other examples include regularly

updated clinical guidance for HIV/AIDS treatment in the RPMS HIV Management System, accurate forecasting for childhood immunizations in the RPMS Immunization Tracking System, "Best Practice Prompts" that are part of the RPMS iCare population health application, anticipatory guidance for parents in the RPMS Well Child Module, and drug-drug interaction order checks in the RPMS Pharmacy applications.

- The IHS has been a data-driven agency for decades. The agency leverages the wealth of clinical and administrative data in RPMS to evaluate performance and outcomes. GPRA clinical performance measures have been calculated exclusively from RPMS, without manual chart audits, for more than ten years. GPRA clinical performance measures are routinely updated as standards of care change. The IHS Improving Patient Care initiative uses RPMS to assess the success of that program in establishing the patient-centered medical home. For meaningful use (MU), all MU performance and clinical quality measures can be calculated from RPMS, and for Stage 2 MU these measure results will be electronically submitted to CMS.
- The IHS National Patient Information Reporting System (NPIRS) aggregates data from RPMS systems across the country, purchased and referred care fiscal intermediary data, and data from commercial health information systems serving Tribal organizations, to provide a system-wide perspective on service population and workload. The IHS is in the midst of a project to utilize the "big data" capabilities of the NPIRS to engage in analytics at an enterprise level, including the calculation of national GPRA measures and other appropriate metrics of organizational performance. We also plan to work closely with the OMB and HHS to adopt more national standard performance measures, such as those published by the National Quality Forum, to enable benchmarking of IHS quality performance against the health care industry nationwide.

2. <u>High-quality, low-cost evaluations that piggy-back on existing programs and data sets</u>

- The Division of Oral Health (DOH) conducted an evaluation of the Oral Health Program in 2010 and also oversees an ongoing annual surveillance of oral health. DOH convened an expert review committee assessment of the Alaska Dental Health Aide Therapist Initiative. Recently DOH also began an assessment of the dental support centers project. At present, 6 of 8 support centers have undergone comprehensive, on-site evaluations. 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 insure the timely response of program data to field programs.
- Using the quarterly GPRA Dashboard, specific lagging measures are targeted for a national webinar to discuss measure performance as well as provide ideas and allow for brainstorming to improve measure performance. The dental GPRA objectives were recently revised to more closely align with Healthy People 2020 objectives. This allows us to assess our performance with respect to these objectives relative to the national norms.

3. <u>Use of innovative outcome-focused grant designs</u>

- The Division of Planning, Evaluation, and Research is conducting an evaluation of the Native American Research Centers for Health (NARCH) grant program administered jointly by IHS and the National Institutes of Health. The evaluation will provide a wide range of quantitative and qualitative analyses that will help improve the administration and performance of the program.

- The IHS Division of Diabetes Treatment and Prevention (DDTP) conducts a number of evaluation processes:
  - Special Diabetes Program for Indians (SDPI) Community-directed grant program: grantees must select a diabetes Best Practice to direct their work, including development of their work plan and reporting on their progress in required reports. Also, they must report data on the Required Key Measures associated with their chosen Best Practice. Grantees receive training on how to collect, evaluate, and improve their data collection and use it to improve their outcome results.
  - SDPI Diabetes Prevention (DP) and Healthy Heart (HH) Initiatives: DP and HH grantees must adhere to a strict intervention protocol and data reporting requirements. 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 use it to improve their outcome results.
  - Diabetes Care and Outcomes Audit: all SDPI grantee sites must submit data to the annual Audit, which assesses a number of factors associated with the provision of quality diabetes clinical care. Audit results are then given back to the individual sites to help them improve their diabetes care and education efforts. Audit results are also calculated for IHS Areas as well as nationally. Grantees receive training on how to collect, evaluate, and improve their Audit data collection and use it to improve their outcome results.
  - DDTP provides diabetes training in multiple online and webinar formats. DDTP receives evaluations on all trainings and uses them to guide future sessions. DDTP also calculates the cost savings of internet-based vs. in-person trainings.

4. <u>Strengthen agency capacity to use evidence</u>

- The yearly performance plans and ratings currently include selected GPRA outcomes in the performance plans of senior leadership, cascaded to all areas.

5. <u>Other evaluation activities</u>

IHS will address findings and recommendations from the following program evaluations in process or recently completed:

- Preventive Behavioral Health Screening Study conducted jointly with Assistant Secretary for Planning and Evaluation and the Office of Public Health, Division of Planning, Evaluation and Research to improve behavioral health screening practice and success;
- Office of Environmental Health contract to determine improvements in dental space and staffing for Health Systems Planning;
- Division of Sanitation Facilities Construction conducted an Employee Survey to assess the impact of strategic planning efforts;
- Post Occupancy Evaluation onsite study of use of recently completed heath facilities to determine effective planning and operation.

The Methamphetamine and Suicide Prevention Initiative (MSPI) and Domestic Violence Prevention Initiative (DVPI) are nationally-coordinated demonstration programs that focus on targeted methamphetamine, suicide, domestic violence, and sexual assault prevention and intervention resources in American Indian and Alaska Native communities. The funding is

used to support the use and development of innovative practice-based and evidence-based interventions.

- In the last year of the demonstration phase, national program evaluation is a central component to both the MSPI and DVPI.
- The completion of the national evaluation for MSPI and DVPI is underway and will be used to identify successful practice-based and evidenced interventions that can be replicated across the Indian health system.
- The MSPI and DVPI support the implementation of culturally appropriate prevention and treatment approaches related to methamphetamine addiction, suicide, domestic violence, and sexual assault.

B. **Proposed Activities:**

The IHS proposes to expand evidence and innovation strategies by supporting the interoperability of electronic health records and health information exchange and by enhancing evaluation capacity.

1. Harnessing existing data to improve agency results

The Health Information Exchange will expand the electronic exchange of health information providers and systems to improve clinical decision-making, better patient engagement and patient safety. Elements include standardization of terminology, health information exchange and Enterprise Quality Analytics to calculate clinical outcomes from National Data Warehouse.

2. High-quality, low-cost evaluations that piggy-back on existing programs and data sets

The Office of Public Health Support Division of Program Statistics (DPS) and the Office of Information Technology National Data Warehouse (NDW) National Patient Information Registry System (NPIRS) Team will collaborate with the Veteran's Administration (VA) to identify American Indian and Alaska Native veterans in their respective databases so that a matched patient data set can be developed.

3. Use of innovative outcome-focused grant designs

The MSPI program recently revised its data collection tool for IHS, Tribal, and Urban (I/T/U) projects. The revised data collection instrument collects a rich and wide range of data informed by knowledge gained through process measures and vastly improved in terms of outcome measurement. A new Data Mart was also developed that eliminated the need for contract services to perform data collection and analytics.

4. Strengthen agency capacity to use evidence

The Division of Planning, Evaluation, and Research is planning to provide increased data analytics and evaluation support for clinical programs. Plans include the hiring of 1 full-time performance analysts and 1 full-time evaluator. Division staff is also being trained in the latest performance improvement and management principles to help guide IHS into a data-driven management decision-making environment. In addition, local evaluation efforts - critical to performance improvement - has been slowly improving over the past few years but would continue to benefit greatly from additional resources and technical support from IHS HQ.

5. Other evaluation activities

The Division of Planning, Evaluation and Research plans to develop increased evaluation capacity, subject to funding support. Critical partnerships have been forged within the Office of Public Health Support, with the Division of Epidemiology and Disease Prevention and the Division of Program Statistics, to leverage resources in an effort to increase access to data sources, conduct data analytics, evaluation planning and implementation, and outcome reporting to drive management decision-making.

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 has been reauthorized since 1997 and under current law, the American Taxpayer Relief Act of 2012, P.L. 112-240, Section 625(b), authorizes the SDPI at $150 million through September 30, 2014.

Rationale: Reauthorization of the SDPI beyond FY 2014 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 four SDPI Reports to Congress in FY 2000, 2004, 2007, and 2011 have demonstrated that significant positive changes and outcomes have occurred as a result of the diabetes prevention and treatment activities implemented with SDPI funding. Key clinical outcome measures have improved for all IHS, Tribal and urban programs since the program's inception:

- Improved blood sugar control: the average blood sugar level (as measured by the A1C test) decreased from 9 percent in 1996 to 8. 11 percent in 2013, nearing the A1C goal for most patients of less than 7 percent.
- Improved blood lipid levels: average LDL cholesterol in IHS patients with diabetes decreased 20 percent from 1998 to 2013.
- Improved kidney function:
  - Between 2000 and 2011, the incidence of new cases of kidney failure leading to dialysis decreased 43 percent among the entire adult AI/AN diabetic population.

The **Community-directed Grant Programs** have implemented diabetes prevention and treatment activities that are culturally appropriate and community-driven and that are based on best practices in diabetes treatment and prevention. 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 2014. In FY 2015 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 have 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 2015 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 2015.

IHS-2015\02

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: Provide 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.[1]

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 Title 25 of 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

[1] This proposal applies exclusively to two IHS programs described in the Indian Health Care Improvement Act (Public Law 94-437): the Indian Health Service Health Professions Scholarship Program (Section 104), and IHS Health Professions Loan Repayment Program (Section 108). The tax treatment of all other IHS programs would be unchanged.

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 liability 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	$2,091,600
Total	$7,803,493

Budget impact is the estimated amount that would be withheld from IHS Health Professions Scholarship and Loan Repayment and forwarded to the Internal Revenue Service, based on FY 2012 award levels.

Effective Date: Upon enactment.

IHS-2015
Fiscal Year 2015 DHHS Legislative Proposal
Indian Health Service

Medicare-like Rate Payment for Non-ITU Physician and Other Health Care Professional Services Associated with Either Outpatient or Inpatient Care Provided at Non-ITU Facilities

MLR for Nonhospital and Physician/Non-physician Services to permit IHS, Tribes, tribal Organizations, or IHS-funded programs operated by Urban Indian organization to pay Medicare rates for outpatient services funded through PRC program. Since 2007, IHS's PRC program has had the authority to pay MLR for referred in-patient services furnished by Medicare-participating hospitals. This proposal expands these rates 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 increase the care they are able to provide through the PRC program.

INDIAN HEALTH SERVICE
FY 2015 CONGRESSIONAL JUSTIFICATION
Significant Items

Joint Explanatory Statement

Dental Health – The agreement includes funding for the early childhood caries initiative. The Service is encouraged to work with the Bureau of Indian Education (BUE) and to consult with Tribes about increasing preventive dental care for children by bringing dentists and hygienists into BIE schools. The Service should continue to make significant strides towards completion of electronic dental records. The Service is encouraged to explore establishing a centralized credentialing system to address workforce needs similar to those of the Departments of Defense and Veterans Affairs, to consider a pilot program for the credentialing of dentists, and to propose funding for fiscal year 2015. (p. 46)

Action taken or to be taken

Early Childhood Caries and BIE Preventive Services
The IHS is in the midst of the final year of the 5-year IHS Early Childhood Caries Collaborative (ECC), aimed at preventing early childhood caries through increased preventive services in the 0-5 year-old age group. 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.

Electronic Dental Record (EDR)
The IHS continues to make significant strides in the implementation of electronic dental records. A new contract was awarded to Science Applications International Corporation on May 20, 2013 to continue the deployment of the Dentrix Enterprise for the IHS. An IHS EDR Project update is provided below:

- 230 RPMS EDR implementations (Original implementation schedule)
- 146 RPMS EDR Fully implemented (as of February 7, 2014)
- 84 RPMS sites remain to be implemented (as of February 7, 2014)
- Remaining 84 RPMS sites will 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 February 7, 2014)
- After 7 RPMS sites currently in progress complete EDR implementation, 66.5 percent (153 of 230 sites) of original implementation schedule will be fully implemented

Centralized Credentialing
The IHS in the past has not established an IHS-wide centralized credentialing program due to constraints in program dollars and human resources as well as the lack of identified advantages to do so.

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 and volunteers appears small compared to the cost to establish and maintain. IHS will review this issue with its new Hospital Consortium that is focused on making our accreditation-related training and systems more consistent. Making credentialing processes and policies more consistent is the current goal, and we will add to that discussion exploration of the option of centralized credentialing programs.

Coordinated health care far American Indian and Alaska Native veterans - The Department of Veterans Affairs (VA) and the Indian Health Service have developed mechanisms to implement and monitor their memorandum of understanding (MOU) regarding the provision of health care to Native American veterans. However, the Government Accountability Office (GAO) reported that the performance metrics developed to assess the MOU's implementation could limit the ability of VA and Service managers to gauge progress and make decisions relating to the expansion or modification of their programs and activities. Both agencies are encouraged to implement the recommendations contained in the GAO report to the extent possible and provide the Committees with an update by March 1, 2014.

Action Taken or to be Taken

Performance Metrics Developed to Assess the MOU's implementation

The VA and IHS are in the process of conducting a workplace assessment with the assistance of The VHA National Center for Organization Development (NCOD) to acquire a better understanding of organizational dynamics. Part of the workplace assessment will include the development of an action plan to improve organizational effectiveness and employee satisfaction. Part of this strategy will be to assess if existing performance measures accurately capture workgroup activities and if these activities are outcome oriented. The assessment is scheduled to run to the middle of April 2014.

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 Number (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 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 1992, 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, approximately $2.5 billion of the Agency's appropriation is under Tribal health administration through Title I contracts and Title V compacts. The IHS and Tribes have entered into 225 Title I contracts and annual funding agreements. Under Title V, IHS is party to 84 compacts and 109 funding agreements; through which $1.6 billion or 38% 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 control 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 IHS. With the increase of ambulatory medical facilities, Tribes continue to expand their provision of health care.

Self-Determination Implementation: Contract Support Cost (CSC) Funding –The 1975 Indian Self-Determination and Education Assistance Act (ISDEAA), Pub. L. No. 93-638, gave Indian Tribes the authority to contract with the Federal government to operate programs serving their Tribal members and other 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 Act was further amended; the 1988 amendments identified Contract Support Costs (CSC) and provided that CSC be added to the program amount. CSC are defined as reasonable costs for activities that Tribes and Tribal Organizations 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.

The demand for CSC funding has increased because of the new and expanded programs, services, functions, or activities assumed by Tribes and Tribal organizations under both Titles I and V of the ISDEAA. Tribes and Tribal organizations use this funding to increase their Tribal capacity to professionally manage ISDEAA agreements and the corresponding services in their communities.

In its June 18, 2012 ruling in Salazar v. Ramah Navajo Chapter, the United States Supreme Court held that "not to exceed" language in past appropriations was not sufficient to limit CSC. The

Court identified legislative remedies, ranging from amending the authorizing statute, to changing payments for CSC, to enacting line-item appropriations for each contract, to appropriating full funding for CSC. The Consolidated Appropriations Act of 2014 included in its explanatory statement direction to both the Bureau of Indian Affairs and the IHS to develop a work plan to consult with Tribes on a long term solution. The Administration looks forward to working with Tribes and Congress to develop a balanced long-term CSC management plan.

Indian Health Service
Self-Governance Funded Compacts FY 2013
(Dollars in Thousands)

Compacts by State	IHS Services	IHS Facilities	Contract Support Costs Direct	Contract Support Costs Indirect	Total
Alabama	**3,835**	**219**	**125**	**649**	**4,828**
Poarch Band of Creek Indians	3,835	219	125	649	4,828
Alaska	**434,911**	**32,607**	**34,259**	**101,880**	**603,657**
Alaska Native Tribal Health Consortium	103,837	18,504	9,536	11,835	143,712
Aleutian Pribilof Islands Association, Inc.	3,234	733	333	1,216	5,516
Arctic Slope Native Association	9,786	380	1,185	2,965	14,316
Bristol Bay Area Health Corporation	21,307	882	1,944	7,454	31,587
Chickaloon Native Village	54	1	9	7	71
Chugachmiut	3,487	56	178	1,498	5,219
Copper River Native Association	2,433	29	203	541	3,206
Council of Athabascan Tribal Governments	1,741	97	60	855	2,753
Eastern Aleutian Tribes, Inc.	3,001	22	147	1,240	4,410
Kenalitze Indian Tribe	2,139	11	194	358	2,702
Ketchikan Indian Community	5,314	124	847	2,677	8,962
Knik Traditional Council	66	1	9	11	87
Kodiak Area Native Association	6,983	84	374	1,582	9,023
Maniilaq Association	26,425	883	2,324	11,331	40,963
Metlakatla Indian Community	5,965	898	392	851	8,106
Mount Sanford Tribal Consortium	758	1	67	189	1,015
Native Village of Eklutna	172	2	5	19	198
Native Village of Eyak	737	19	73	154	983
Norton Sound Health Corporation	33,841	2,276	1,722	4,631	42,470
Seldovia Village Tribe	1,728	34	62	467	2,291
Southcentral Foundation	77,978	2,675	4,980	19,618	105,251
SouthEast Alaska Regional Health Corporation	37,655	1,286	2,982	8,188	50,111
Tanana Chiefs Conference	41,320	1,596	1,872	7,000	51,788
Yakutat Tlingit Tribe	304	2	25	77	408
Yukon-Kuskokwim Health Corporation	44,646	2,011	4,736	17,116	68,509
Arizona	**99,241**	**8,968**	**3,907**	**20,788**	**132,904**
Gila River Indian Community	35,964	4,441	1,453	6,486	48,344
Tuba City Health Regional Care Corporation	40,664	3,436	1,780	9,512	55,392
Winslow Indian Health Care Center, Inc.	22,613	1,091	674	4,790	29,168
California	**61,897**	**2,706**	**2,272**	**19,242**	**86,117**
Chapa-De Indian Health Program, Inc.	4,077	8	98	963	5,146
Consolidated Tribal Health Project, Inc.	3,792	208	86	1,617	5,703
Feather River Tribal Health, Inc.	5,867	207	136	917	7,127
Hoopa Valley Tribe	5,041	304	218	1,285	6,848
Indian Health Council, Inc.	8,127	379	232	2,929	11,667
Karuk Tribe of California	2,955	237	78	1,099	4,369
Northern Valley Indian Health, Inc.	3,936	553	96	832	5,417
Redding Rancheria	6,339	208	476	2,665	9,688
Riverside-San Bernardino County Indian Health, Inc.	20,141	446	721	6,352	27,660
Susanville Indian Rancheria	1,622	156	131	583	2,492
Connecticut	**2,358**	**30**	**162**	**218**	**2,768**
Mohegan Tribe of Indians of Connecticut	2,358	30	162	218	2,768
Florida	**7,580**	**436**	**211**	**1,207**	**9,434**
Seminole Tribe of Florida	7,580	436	211	1,207	9,434
Kansas	**2,480**	**98**	**6**	**231**	**2,815**
Prairie Band of Potawatomi Nation	2,480	98	6	231	2,815
Idaho	**15,079**	**878**	**1,604**	**3,951**	**21,512**
Coeur D'Alene Tribe	5,938	261	1,182	2,588	9,969
Kootenai Tribe of Idaho	761	32	64	78	935
Nez Perce Tribe	8,380	585	358	1,285	10,608
Louisana	**1,355**	**89**	**100**	**126**	**1,670**
Chitimacha Tribe of Louisana	1,355	89	100	126	1,670
Maine	**3,138**	**150**	**136**	**665**	**4,089**
Penobscot Indian Nation	3,138	150	136	665	4,089
Massachusetts	**687**	**58**	**176**	**206**	**1,127**
Wampanoag Tribe of Gay Head	687	58	176	206	1,127
Michigan	**24,687**	**1,042**	**1,478**	**2,576**	**29,783**
Grand Traverse Band of Ottawa and Chippewa Indians	2,784	176	187	428	3,575
Keweenaw Bay Indian Community	3,282	262	452	586	4,582
Little River Band of Ottawa Indians	1,978	60	204	332	2,574
Sault Ste. Marie Tribe of Chippewa Indians	16,643	544	635	1,230	19,052
Minnesota	**19,718**	**1,110**	**2,070**	**1,735**	**24,633**
Bois Forte Band of Chippewa Indians	2,531	236	67	587	3,421
Fond du Lac Band of Lake Superior Chippewa	11,300	552	1,013	616	13,481
Mille Lacs Band of Ojibwe	4,196	273	975	267	5,711
Shakopee Mdewakanton Sioux Community	1,691	49	15	265	2,020
Mississippi	**16,969**	**919**	**1,030**	**1,485**	**20,403**
Mississippi Band of Choctaw Indians	16,969	919	1,030	1,485	20,403

Indian Health Service
Self-Governance Funded Compacts FY 2013
(Dollars in Thousands)

Compacts by State	IHS Services	IHS Facilities	Contract Support Costs Direct	Contract Support Costs Indirect	Total
Montana	**20,525**	**1,332**	**1,605**	**4,061**	**27,523**
Chippewa Cree Tribe of the Rocky Boy's Reservation	9,659	699	915	2,053	13,326
Confederated Salish and Kootenai Tribes of Flathead	10,866	633	690	2,008	14,197
Nevada	**18,977**	**873**	**1,223**	**3,932**	**25,005**
Duck Valley Shoshone-Paiute Tribe	6,522	428	638	1,821	9,409
Duckwater Shoshone Tribe	1,134	29	158	611	1,932
Ely Shoshone Tribe	1,251	21	52	286	1,610
Las Vegas Paiute Tribe	3,167	70	98	346	3,681
Washoe Tribe of Nevada and California	5,018	185	195	554	5,952
Yerington Paiute Tribe of Nevada	1,885	140	82	314	2,421
New Mexico	**15,638**	**645**	**1,020**	**1,491**	**18,794**
Pueblo of Jemez	9,286	190	800	1,132	11,408
Pueblo of Sandia	1,987	101	30	227	2,345
Taos Pueblo	4,365	354	190	132	5,041
New York	**7,676**	**410**	**291**	**591**	**8,968**
St. Regis Mohawk Tribe	7,676	410	291	591	8,968
North Carolina	**20,129**	**1,390**	**828**	**4,248**	**26,595**
Eastern Band of Cherokee Indians	20,129	1,390	828	4,248	26,595
Oklahoma	**350,031**	**32,776**	**22,205**	**44,685**	**449,697**
Absentee Shawnee Tribe of Oklahoma	14,844	1,166	1,637	1,650	19,297
Cherokee Nation	117,771	10,461	4,357	11,718	144,307
Chickasaw Nation	78,511	11,559	7,669	11,827	109,566
Choctaw Nation of Oklahoma	56,974	6,412	5,290	9,651	78,327
Citizen Potawatomi Nation	13,276	882	1,499	3,134	18,791
Kaw Nation	1,362	93	175	282	1,912
Kickapoo Tribe of Oklahoma	7,538	97	135	1,102	8,872
Modoc Tribe of Oklahoma	50	62	4	31	147
Muscogee (Creek) Nation	40,067	1,749	1,002	3,326	46,144
Northeastern Tribal Health System	6,933	52	127	794	7,906
Ponca Tribe of Oklahoma	3,655	52	139	372	4,218
Sac and Fox Nation	7,210	65	138	467	7,880
Wyandotte Nation	1,840	126	33	331	2,330
Oregon	**23,245**	**1,132**	**2,178**	**7,638**	**34,193**
Confederated Tribes of Coos, Lower Umpqua and Siuslaw Indians of Oregon	1,553	58	250	511	2,372
Confederated Tribes of Grand Ronde	6,076	257	465	2,475	9,273
Confederated Tribes of Siletz Indians of Oregon	7,285	309	637	1,833	10,064
Confederated Tribes of the Umatilla Reservation	6,422	423	628	1,942	9,415
Coquille Indian Tribe	1,909	85	198	877	3,069
Utah	**7,324**	**142**	**1,527**	**1,431**	**10,424**
Utah Navajo Health System, Inc.	7,324	142	1,527	1,431	10,424
Washington	**51,799**	**3,469**	**2,350**	**11,449**	**69,067**
Cowlitz Indian Tribe	3,037	114	21	421	3,593
Jamestown S'Klallam Indian Tribe	1,213	54	78	284	1,629
Kalispel Tribe of Indians	997	159	18	79	1,253
Lower Elwha Klallam Tribe	1,778	141	93	309	2,321
Lummi Indian Nation	7,496	621	222	1,895	10,234
Makah Indian Tribe	3,696	400	252	873	5,221
Muckleshoot Indian Tribe	6,766	260	168	-	7,194
Nisqually Indian Tribe	2,186	93	100	556	2,935
Port Gamble S'Klallam Tribe	2,419	134	122	655	3,330
Quinault Indian Nation	5,265	453	187	1,609	7,514
Shoalwater Bay Indian Tribe	1,751	54	251	729	2,785
Skokomish Indian Tribe	1,953	84	100	500	2,637
Squaxin Island Indian Tribe	2,614	187	176	910	3,887
Suquamish Tribe	1,545	74	132	657	2,408
Swinomish Indian Tribal Community	2,111	142	146	667	3,066
Tulalip Tribes of Washington	6,972	499	284	1,305	9,060
Wisconsin	**23,247**	**975**	**1,261**	**1,401**	**26,884**
Forest County Potawatomi Community	2,188	108	587	320	3,203
Oneida Tribe of Indians of Wisconsin	17,852	648	268	664	19,432
Stockbridge-Munsee Community	3,207	219	406	417	4,249
Grand Total	**1,232,526**	**92,454**	**82,024**	**235,886**	**1,642,890**

Indian Health Service
FY 2013 Self-Governance Funding Agreements
By Area

(Dollars in Thousands)

Area	Program Tribal Shares	Area Tribal Shares	Headquarters Tribal Shares	Contract Support Costs (Direct)	Contract Support Costs (Indirect)	Total
Alaska	443,888	13,314	10,316	34,259	101,880	**603,657**
Albuquerque	13,313	2,240	730	1,020	1,491	**18,794**
Bemidji	65,899	2,788	2,092	4,809	5,712	**81,300**
Billings	18,948	1,919	990	1,605	4,061	**27,523**
California	58,349	3,498	2,756	2,272	19,242	**86,117**
Nashville	59,829	5,680	1,919	3,059	9,395	**79,882**
Navajo	69,288	3,276	2,706	3,981	15,733	**94,984**
Oklahoma	362,426	10,818	12,141	22,211	44,916	**452,512**
Phoenix	57,060	1,584	1,611	2,676	10,418	**73,349**
Portland	86,255	6,003	3,344	6,132	23,038	**124,772**
Total, IHS	**1,235,255**	**51,120**	**38,605**	**82,024**	**235,886**	**1,642,890**