DEPARTMENT OF HEALTH AND HUMAN SERVICES

Fiscal Year
2017

Indian Health Service

Justification of Estimates for Appropriations Committees

Indian Health Service
Rockville, MD 20857

January 11, 2016

I am delighted to present the Indian Health (IHS) FY 2017 Congressional Justification. This budget request provides support for priority initiatives of the President and the Secretary 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 2017 budget request.

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

- Renew and strengthen our partnership with Tribes and Urban Indian Health Programs;
- Improve the IHS; and
- Improve the quality of access to care.

The underlying principle for the priorities is to ensure our work remains transparent, accountable, and inclusive.

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

Our FY 2017 budget request represents our efforts to ensure the Agency's valuable programs continue to accomplish greater performance improvements progressing toward the improved health status of American Indian and Alaska Native people.

/Robert G. McSwain/

Robert G. McSwain
Principal Deputy Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2017 Performance Budget Submission to Congress

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE

Approved: /Robert G. McSwain/
Robert G. McSwain

Date: 02/08/2016

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DEPUTY DIRECTOR FOR INTER-GOVERNMENTAL AFFAIRS
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DEPUTY DIRECTOR FOR FIELD OPERATIONS
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DEPUTY DIRECTOR FOR QUALITY HEALTH CARE
Dorothy Dupree

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Geoffrey Roth

(Positions are listed in order of succession to the IHS Principal Deputy Director)

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DIRECTOR
Benjamin Smith
(GAA)

OFFICE OF DIRECT SERVICE AND CONTRACTING TRIBES
DIRECTOR
Chris Buchanan
(GAB)

OFFICE OF URBAN INDIAN HEALTH PROGRAMS
DIRECTOR
Sherriann Moore
(Acting)
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OFFICE OF CLINICAL AND PREVENTIVE SERVICES
DIRECTOR
Alec Thundercloud
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OFFICE OF INFORMATION TECHNOLOGY
DIRECTOR
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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 2.2 million American Indians and Alaska Natives through a network of over 679 hospitals, clinics, and health stations on or near Indian reservations. Facilities are predominantly located in rural primary care settings and are managed by IHS, Tribal, and Urban Indian health programs. The IHS provides a wide range of clinical, public health and community services primarily to members of 566 federally recognized Tribes in 35 states. The IHS has approximately 15,369 employees, including 2,504 nurses, 737 physicians, 462 engineers, 132 sanitarians, 747 pharmacists, and 271 dentists.

United States Government and Indian Nations

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

Indian Health Service and Its Partnership with Tribes

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

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

The IHCIA includes specific authorizations such as improvements for urban Indian health programs, Indian health professions programs, and the authority to collect from Medicare and 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. And, this budget represents the President's annual report to Congress on IHS programs and its achievement of the goals of IHCIA as required by 25 USC Sec. 1671.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
Executive Summary

OVERVIEW OF BUDGET REQUEST

Tribal Recommendations – The IHS FY 2017 budget request identifies the applicable Tribal recommendations and contributes to several HHS principles and themes including: delivery system reform, keeping people healthy and safe, and leaving the department stronger. The FY 2017 Budget Request uses these themes as a framework.

In planning and anticipating the FY 2017 budget needs, the IHS conducted Tribal Budget Consultation meetings where local Indian Health Service, Tribal, and Urban (I/T/U) programs considered and determined funding priorities, hot issues and recommendations for their Areas. The National Tribal Budget Formulation Workgroup then developed national recommendations based on the input from the 12 IHS Areas.

Summary of Request – The discretionary budget request of $5.185 billion in budget authority is an increase of $377.4 million above the FY 2016 Enacted level of $4.808 billion. The request would fully fund pay costs, inflation, and partially fund population growth, and provide increases for priority programs, including a separate appropriations account for Contract Support Costs.

Current Services: +$159 Million
Funding for fixed costs are needed annually to maintain services at the current year level. Otherwise the costs are absorbed by the programs leading to loss of buying power and potentially reducing the level of health care services and access to care. In essence this funding is critical every year for shoring up the base operating budgets of I/T/U health programs because of the budget impact from either no funding or partial funding of fixed costs over many years.

- Pay Costs (Federal and Tribal): $26.0 million
- Non-Medical Inflation: $14.4 million
- Medical Inflation: $75.4 million
- Population Growth: $43.2 million

Program Increases: +$185.4 Million (includes CSC increase)
These increases are above fixed costs so the additional funding can be targeted to specific areas of need across Indian Country where direct and Purchased/Referred Care are provided to approximately 2.2 million American Indian/Alaska Native service population.

- Staffing/Operating Costs for 5 Newly-Constructed Facilities, 37 FTE / 245 Positions: $33 million – funding these facilities allows IHS and Tribes to expand provision of health care in those areas where capacity has been expanded to address critical health care needs.

(Dollars in Thousands)

Project	Location	Open	% Completion	Amount	FTE	Pos
Kayenta Health Center; Replacement IP days: 4,142; OP visits: 102,196	Kayenta, AZ	Mar 2016	100%	$182	1	--
Muskogee Creek Nation Health Center; JV OP visits: 39,844	Eufaula, OK	Aug 2016	100%	$10,743	--	94
Northern California YRTC 32 beds, serve 100 patients (estimate)	Davis, CA	Aug 2017	50%	$3,403	36	--

Project	Location	Open	% Completion	Amount	FTE	Pos
Flandreau Health Center; JV OP visits: 21,158	Flandreau, SD	Oct 2016	100%	$6,279	--	55
Choctaw Nation Regional Medical Ctr; JV OP visits: 50,850	Durant, OK	Aug 2017	50%	$12,375	--	96
TOTAL				**$32,982**	**37**	**245**

IP is Inpatient, and OP is Outpatient
Kayenta Health Center – construction completed; opening is pending receipt/installation of equipment/furniture

Hospitals & Health Clinics

- Health IT: $20 million would fund the improvement of the delivery of healthcare and the security of patient data through enhancement and modernization of the Resource Patient Management System; development, operations, and maintenance of capabilities for the Electronic Health Record; and support of technologies to meet healthcare quality reporting for MACRA and other initiatives. (CJ-61,75)

- Domestic Violence Prevention: $4 million would fund program expansion of the current DVP program and fund approximately 30 additional I/T/U organizations. (CJ-61)

- Quality Consortium: $2 million would fund coordination of quality improvement activities among the 28 IHS Hospitals and Critical Access Hospitals to reduce Hospital Acquired Conditions and Avoidable Readmissions. (CJ-62)

- Tribal Clinic Leases, O&M: $9 million would fund Tribal clinic leases and maintenance costs, specifically where Tribal space is ineligible for IHS Maintenance & Improvements funds. (CJ-62)

Mental Health

- Behavioral Health Integration: $21.4 million would fund continued integration between medical care, behavioral health, and Tribal community organizations to provide the entire spectrum of prevention to impact health outcomes. (CJ-91)

- Zero Suicide: $3.6 million would fund implementation of pilot projects for the Zero Suicide Initiative in I/T/U organizations. (CJ-91)

Alcohol & Substance Abuse

- Generation Indigenous Initiative: $15 million would fund expansion of the Substance Use and Suicide Prevention Program (formerly known as the Methamphetamine and Suicide Prevention Initiative) to focus on hiring additional personnel to improve behavioral health services and prevention programming for AI/AN youth. (CJ-100)

- Pilot Project Youth: $1.8 million would fund the development of a pilot project to fill the gap in services and provide a continuum of care for AI/AN youth after they are discharged and return home from the Youth Regional Treatment Centers located at the local levels. (CJ-99)

Purchased / Referred Care

- CHEF: $1.5 million would provide additional funds for high cost cases. (CJ-106)

Urban Indian Health

- Expand Access: $1.1 million would provide funds for further development and

implementation of a strategic plan for the Urban Indian Health Program through conferring with urban AI/AN in collaboration with the National Academy of Public Administration. This activity will be completed and the strategic plan will be published no later than one year after the date of enactment of the bill.In addition, funds will be utilized to strengthen Urban Indian Organizations operations and improve urban AI/AN access to health care to achieve improved health outcomes. (CJ-134)

Maintenance & Improvement

- BEMAR: $0.5 million would provide additional funds to address the maintenance backlog at existing Federal and Tribal health care facilities. The current backlog is $473 million. (CJ-166)

Health Care Facilities Construction

- Facilities Construction Priority List: $11.4 million would fund construction projects from the Priority List. (CJ-175)

Project	**Purpose**	**Amount**
PIMC NE, Ambulatory Care Center, Salt River, AZ	Completes construction funding	$52.5 million
White River Hospital White River, AZ	Completes design funding and starts construction funding	$15 million
Rapid City Health Center Rapid City, SD	Partially completes construction funding	$27.8 million
Dilkon Alternative Rural Health Center Dilkon, AZ	Begins construction funding	$15 million
Priority List Total		**$110.4 million**
Small Ambulatory Program*	Small Health Clinic funding	$10 million
Staff Quarters**	Priority Staff Quarters funding	$12 million
	TOTAL:	**$132.4 million**

*Small Ambulatory: $10 million would fund 5 to 8 Tribes with grants to construct small ambulatory health clinics.

**Staff Quarters: $12 million would fund the replacement and the addition of new housing quarters in isolated and remote locations for healthcare professionals to enhance recruitment and retention.

Contract Support Costs: +$82 million

(Dollars in Thousands)

FY 2015 Final (Base)	FY 2016 Enacted	FY 2017 Pres. Budget	2017 +/- 2016	%
$662,970	$717,970	$800,000	+$82,030	+11%

Contract Support Costs (CSC) is a separate appropriation account enacted in FY 2016 as an indefinite discretionary budget authority. The proposed increase of $82,030,000 above FY 2016 is an estimate of additional funds needed to ensure the full CSC need is funded for each Tribe. The estimate is generous and will be adjusted to reflect the amount necessary to fund the full CSC need when updated information is available. In FY 2018 and beyond, the Administration proposes to reclassify CSC as a mandatory, three-year appropriation with sufficient increases year over year to fully fund the estimated need for the program, for both the IHS and the Bureau of Indian Affairs which is consistent with tribal consultation. (CJ-162)

Mandatory Proposals – Mental Health Initiatives

- Behavioral Health Professions Expansion Fund: $10 million would support the Indian Health Professions program by expanding the number of behavioral health professionals to provide high quality behavioral health services to AI/AN communities. This investment complements the additional funding proposed for the National Health Service Corps. (CJ-200)

- Tribal Crisis Response Fund: $15 million would provide assistance to prevent reoccurences to Tribes experiencing behavioral health crises including specialized crisis response staffing, technical assistance, and community engagement. (CJ-200)

Budget Impact

(Dollars in Thousands)

Mental Health Initiatives	FY 2015 Final	FY 2016 Enacted	FY 2017 Pres. Budget (Year 1)	FY 2018 (Year 2)	**Total** Outyear Funding
BH Professions Expansion Fund	$0	$0	$10,000	$10,000	$20,000
Tribal Crisis Response Fund	$0	$0	$15,000	$15,000	$30,000

Legislative Proposals

- Special Diabetes Program for Indians – Permanent Authorization
- Tax Exemption for Scholarship & Loan Repayment
- PRC Rates (Medicare-like rates) for Non-Hospitals
- Meet Loan Repayment/Scholarship Service Obligations on a Half-Time Basis
- Extension of FMAP to all Indian Health Programs
- Consistent Definition of "Indian" in the Affordable Care Act

OVERVIEW OF AGENCY PERFORMANCE

The IHS performance measurement and management is structured to reflect our mission: *To raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level*. Many of the IHS performance budget measures are focused on monitoring population health and strategies to assess program trends and management. To increase the frequency of performance reporting and to provide a real time tool for IHS programs to assess performance trends, IHS is building a national performance data mart with web based reports that are as current as the last weekly upload of data submitted to IHS's National Data Warehouse (NDW). The Integrated Data Collection System Data Mart (IDCS DM) will enable full I/T/U participation, consolidate and streamline reporting requirements, produce on-demand results, and reduce the amount of time to access data results. IHS is proposing to report from the IDCS DM in 2018, which includes major changes to FY 2018 outcomes/outputs.

Consistent with the Government and Performance Results Act of 1993 (GPRA) and the GPRA Modernization Act of 2010 (GPRAMA), IHS continues to report valid and reliable clinical measures and seeks out opportunities to engage leaders in performance improvement to create a culture where data and empirical evidence play a greater role in policy, budget and management decisions. Additionally, IHS's measures support the following HHS performance products: 2014-2018 Strategic Plan goals and objectives, Strategic Reviews and Agency Priority Goals for FY 2015-FY 2016, and the FY 2017 Annual Performance Plan and Report (APP/R). In FY 2017, IHS proposes to report on the five GPRAMA measures to be included in the HHS APP/R: good glycemic control among diabetic patients, childhood immunizations, depression screening among adults eighteen years and older, comprehensive cardiovascular disease (CVD) risk assessment,

and tribal consultation (implementation of tribal recommendations).

Performance Management

IHS monitors and reports national clinical measures annually. As a monitoring tool, clinical measure progress is reported quarterly to all IHS sites. Throughout the year, IHS hosts several webinars focused on clinical measure topics presented by the measure owner. Webinars are also taped and available across the I/T/U health care system.

IHS continues to work towards integrating risk management, performance management and strategic planning efforts. A key strategy for Agency performance management is managing an Agency performance plan. The IHS established an Agency performance plan to accomplish the four Agency priorities as well as a fifth critical program objective to improve quality customer service. The plan, updated annually, cascades performance goals and objectives and performance-related metrics agency wide. Specific measures are cascaded from senior executive performance plans to managers to supervisors and into employee plans, which ensures that performance of all employees relates their job duties to progress on Agency priorities. Agency leadership periodically reviews progress in meeting the Agency performance plan measures and holds regular discussions with senior executives. The connection between performance measures and employee accountability contributes to the Agency leadership decisions on target adjustments or to take corrective actions to address obstacles that could prevent achieving the desired results.

Performance Reporting

Since 2002, IHS has reported population level, electronic performance results for GPRA/GPRAMA clinical measures. IHS' current clinical performance reporting is from the Resource and Patient Management System (RPMS) Clinical Reporting System (CRS). Measure results are electronically calculated on local RPMS servers and aggregated nationally to produce two interim reports and one final report annually. The future of IHS quality reporting is twofold: centralization of national, clinical performance reporting and alignment of clinical measures with national standard measures, where appropriate. To support this effort, IHS is building a national reporting system that will produce aggregated, clinical performance measure results from the new centralized Integrated Data Collection System Data Mart (IDCS DM) housed within IHS' National Data Warehouse (NDW). Measure results will be calculated using any data (RPMS, non-RPMS or Purchased/Referred Care) submitted to the NDW. IHS will generate national results from IDCS DM beginning in FY 2017 for internal tracking and report exclusively from the IDCS DM in FY 2018. In FY 2016, IHS will consult with Tribes and confer with Urban programs on the transition to this new performance reporting system.

Using a new enhanced reporting system provides IHS with the ability to report on performance results for the I/T/U system by allowing Tribes and Urban programs with commercial Electronic Health Records (EHRs) to include their data in national results. This means IHS might be able to increase national performance data collection since performance results will expand to represent data submissions from the I/T/U User Population. IHS results leading up to FY 2018 will include federal sites and tribal sites reporting from RPMS only.

Since the IDCS DM will use all data exported to the NDW including non-RPMS tribal and urban data, budget measures previously reported from CRS will be revised for the following reasons:

- *Updated Data Source*: IHS' clinical performance calculations will be from IDCS DM;
- *User Population Estimates*: The IDCS DM will standardize the use of the User Population estimates as the denominator for the clinical GPRA/GPRAMA measures;
- *Reporting Year*: The GPRA/GPRAMA year of July 1-June 30 will change to match the User Population estimates year of October 1-September 30.

I/T/U users will be able to access secure, web-based reports. Compared to three aggregated CRS reports annually, IDCS DM reports will be as current as the last weekly data refresh in the NDW. This direction aligns with the Affordable Care Act's *National Strategy for Quality Improvement in Health Care* as well as the HHS Measurement Policy Council's (MPC) efforts to align core performance measures. More frequent measure results will inform program decision making and provide opportunities for course correction during the report year.

Discretionary All Purpose Table
Indian Health Service

(Dollars in Thousands)

Program	FY 2015 Final	FY 2016 Enacted	FY 2017 Budget Request	FY 2017 +/- FY 2016
SERVICES				
Hospitals & Health Clinics	1,836,789	1,857,225	1,979,998	122,773
Dental Services	173,982	178,286	186,829	8,543
Mental Health	81,145	82,100	111,143	29,043
Alcohol & Substance Abuse	190,981	205,305	233,286	27,981
Purchased/Referred Care	914,139	914,139	962,331	48,192
Total, Clinical Services	3,197,036	3,237,055	3,473,587	236,532
Public Health Nursing	75,640	76,623	82,040	5,417
Health Education	18,026	18,255	19,545	1,290
Community Health Representatives	58,469	58,906	62,428	3,522
Immunization AK	1,826	1,950	2,062	112
Total, Preventive Health	153,961	155,734	166,075	10,341
Urban Health	43,604	44,741	48,157	3,416
Indian Health Professions	48,342	48,342	49,345	1,003
Tribal Management Grants	2,442	2,442	2,488	46
Direct Operations	68,065	72,338	69,620	-2,718
Self-Governance	5,727	5,735	5,837	102
Total, Other Services	168,180	173,598	175,447	1,849
TOTAL, SERVICES	**3,519,177**	**3,566,387**	**3,815,109**	**248,722**
CONTRACT SUPPORT COSTS[1]	**662,970**	**717,970**	**800,000**	**82,030**
FACILITIES				
Maintenance & Improvement	53,614	73,614	76,981	3,367
Sanitation Facilities Construction	79,423	99,423	103,036	3,613
Health Care Facilities Construction	85,048	105,048	132,377	27,329
Facilities & Environ Health Support	219,612	222,610	233,858	11,248
Equipment	22,537	22,537	23,654	1,117
TOTAL, FACILITIES	460,234	523,232	569,906	46,674
TOTAL, BUDGET AUTHORITY	**4,642,381**	**4,807,589**	**5,185,015**	**377,426**
COLLECTIONS				
Medicare	247,692	248,638	248,638	0
Medicaid	791,201	807,605	807,605	0
Subtotal, M / M	*1,038,893*	*1,056,243*	*1,056,243*	0
Private Insurance	104,272	109,272	109,272	0
VA Reimbursement[2]	7,530	28,062	28,062	0
Total, M / M / PI	*1,150,695*	*1,193,577*	*1,193,577*	0
Quarters	8,000	8,500	8,500	0
TOTAL, COLLECTIONS	**1,158,695**	**1,202,077**	**1,202,077**	**0**
MANDATORY				
Special Diabetes Program for Indians	150,000	150,000	150,000	0
Mental Health Initiatives				
Tribal Crisis Response Fund	0	0	15,000	15,000
Behavioral Health Professions Expansion Fund	0	0	10,000	10,000
TOTAL, MANDATORY	**150,000**	**150,000**	**175,000**	**25,000**
TOTAL, PROGRAM LEVEL	**5,951,076**	**6,159,666**	**6,562,092**	**402,426**

[1]CSC are maintained as discretionary with an indefinite appropropriation in FY 2017. In FY 2018 and beyond, the Administration proposes to reclassify contract support costs as a mandatory three-year appropriation.

[2]FY 2015 displays actual federal collections as reported by the Treasury Department. Please see Public and Private Collections narrative for discussion on the amounts.

INDIAN HEALTH SERVICE
FY 2017 President's Budget
Detail of Changes
(Dollars in Thousands)

Jan 15, 2016

			Current Services							Program Increases																		
			Pay	Inflation			Pop	Current	Staffing		Health	Domestic		Tribal Clinic	Behavioral Health								HCFC		Transfer Funds*		Increases	FY 2017
	FY 2015	FY 2016	Costs	Non-Med	Medical	Inflation	Growth	Services	for New		Info	Violence	Quality	Leases,	Generation	Beh'l Hlth	Zero	Pilot Project					Priority		Accred.	Tribal	& Transfer	President's
Sub IHS Activity	Final	Omnibus	1.6%	2.1%	3.8%	Subtotal	1.8%	Subtotal	Facilities	CHEF	Tech	Prevention	Consortium	O&M	Indigenous	Integration	Suicide	Youth	Urban	CSC	M&I	List	Quarters	Emerg.	Clinics	Subtotal	Budget
SERVICES																												
Hospitals & Health Clinics	1,836,789	1,857,225	16,798	2,423	23,213	25,636	21,261	63,695	20,078	0	20,000	4,000	2,000	9,000	0	0	0	0	0	0	0	0	0	2,000	2000	39,000	**1,979,998**
Dental Services	173,982	178,286	1,858	57	1,999	2,056	1,992	5,906	2,637	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**186,829**
Mental Health	81,145	82,100	816	20	1,048	1,068	928	2,812	1,231	0	0	0	0	0	0	21,400	3,600	0	0	0	0	0	0	0	0	25,000	**111,143**
Alcohol & Substance Abuse	190,981	205,305	1,639	31	3,373	3,404	2,493	7,536	3,645	0	0	0	0	0	15,000		0	1,800	0	0	0	0	0	0	0	16,800	**233,286**
Purchased/Referred Care	914,139	914,139	0	0	37,382	37,382	9,310	46,692	0	1,500	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1,500	**962,331**
Total, Clinical Services	3,197,036	3,237,055	21,111	2,531	67,015	69,546	35,984	126,641	27,591	1,500	20,000	4,000	2,000	9,000	15,000	21,400	3,600	1,800	0	0	0	0	0	2,000	2,000	82,300	**3,473,587**
Public Health Nursing	75,640	76,623	796	27	2,031	2,058	874	3,728	1,689	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**82,040**
Health Education	18,026	18,255	175	2	596	598	210	983	307	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**19,545**
Comm. Health Reps	58,469	58,906	500	1	2,336	2,337	685	3,522	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**62,428**
Immunization AK	1,826	1,950	17	0	74	74	21	112	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**2,062**
Total, Preventive Health	153,961	155,734	1,488	30	5,037	5,067	1,790	8,345	1,996	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**166,075**
Urban Health	43,604	44,741	265	65	1,470	1,535	479	2,279	0	0	0	0	0	0	0	0	0	0	1,137	0	0	0	0	0	0	1,137	**48,157**
Indian Health Professions	48,342	48,342	18	985	0	985	0	1,003	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**49,345**
Tribal Management	2,442	2,442	0	46	0	46	0	46	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**2,488**
Direct Operations	68,065	72,338	641	641	0	641	0	1,282	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(2,000)	(2,000)	(4,000)	**69,620**
Self-Governance	5,727	5,735	20	82	0	82	0	102	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**5,837**
Total, Other Services	168,180	173,598	944	1,819	1,470	3,289	479	4,712	0	0	0	0	0	0	0	0	0	0	1,137	0	0	0	0	(2,000)	(2,000)	(2,863)	**175,447**
Total, Services	3,519,177	3,566,387	23,543	4,380	73,522	77,902	38,253	139,698	29,587	1,500	20,000	4,000	2,000	9,000	15,000	21,400	3,600	1,800	1,137	0	0	0	0	0	0	79,437	**3,815,109**
CONTRACT SUPPORT COSTS																											
Total, Contract Support Costs	662,970	717,970	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	82,030	0	0	0	0	0	82,030	**800,000**
FACILITIES																											
Maintenance & Improvement	53,614	73,614	0	1,872	0	1,872	978	2,850	0	0	0	0	0	0	0	0	0	0	0	0	517	0	0	0	0	517	**76,981**
Sanitation Facilities Constr.	79,423	99,423	0	2,349	0	2,349	1,264	3,613	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**103,036**
Health Care Fac. Constr.	85,048	105,048	0	3,886	0	3,886	0	3,886	0	0	0	0	0	0	0	0	0	0	0	0	0	11,443	12,000	0	0	23,443	**132,377**
Facil. & Envir. Hlth Supp.	219,612	222,610	2,440	1,910	1,012	2,922	2,491	7,853	3,395	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**233,858**
Equipment	22,537	22,537	0	33	825	858	259	1,117	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**23,654**
Total, Facilities	460,234	523,232	2,440	10,050	1,837	11,887	4,992	19,319	3,395	0	0	0	0	0	0	0	0	0	0	0	517	11,443	12,000	0	0	23,960	**569,906**
TOTAL, IHS	4,642,381	4,807,589	25,983	14,430	75,359	89,789	43,245	159,017	32,982	1,500	20,000	4,000	2,000	9,000	15,000	21,400	3,600	1,800	1,137	82,030	517	11,443	12,000	0	0	185,427	**5,185,015**

*FY 2017 amounts for Tribal Clinics Lease, Operations, and Maintenance ($2 million) and Accreditation Emergencies ($2 million) are included in the Hospitals and Health Clinics funding line, as opposed to Direct Operations. The Hospitals and Health Clinics funding line has historically housed funding that supports activities related to Hospitals and Health Clinics, like these two programs.

377,426
7.9%

INDIAN HEALTH SERVICE
STAFFING and OPERATING COSTS FOR NEWLY-CONSTRUCTED HEALTHCARE FACILITIES -- Estimates
FY 2017 BUDGET REQUEST
(Dollars in Thousands)

August 28, 2015

	Kayenta, AZ Kayenta Health Center		Eufaula, OK Muskogee Creek Nation Health Center (JV)		Davis, CA Northern California Youth Treatment Center		Flandreau, SD Flandreau Health Center (JV)		Durant, OK Choctaw Nation Regional Medical Center (JV)				
Opening Date	March 2016		August 2016		August 2017		October 2016		August 2017		**TOTAL**		
Sub Sub Activity	FTE	Amount	Pos	Amount	FTE	Amount	Pos	Amount	Pos	Amount	**FTE**	**Pos**	**AMOUNT**
Hospitals & Health Clinics	1	$182	59	$6,444	0	$0	40	$4,330	73	$9,122	1	172	$20,078
Dental Health	0	$0	12	$1,290	0	$0	4	$402	9	$945	0	25	$2,637
Mental Health	0	$0	7	$731	0	$0	1	$106	4	$394	0	12	$1,231
Alcohol & Substance Abuse	0	$0	3	$307	33	$3,064	1	$102	2	$172	33	6	$3,645
Purchased/Referred Care	0	$0	0	$0	0	$0	0	$0	0	$0	0	0	$0
Total, Clinical Services	1	$182	81	$8,772	33	$3,064	46	$4,940	88	$10,633	34	215	$27,591
Public Health Nursing	0	$0	5	$679	0	$0	4	$557	3	$453	0	12	$1,689
Health Education	0	$0	2	$205	0	$0	1	$102	0	$0	0	3	$307
Comm. Health Representatives	0	$0	0	$0	0	$0	0	$0	0	$0	0	0	$0
Total, Preventive Health	0	$0	7	$884	0	$0	5	$659	3	$453	0	15	$1,996
Total, Services	1	$182	88	$9,656	33	$3,064	51	$5,599	91	$11,086	34	230	$29,587
Facilities Support	0	$0	6	$1,087	3	$339	4	$680	4	$1,102	3	14	$3,208
Environmental Health Support	0	$0	0	$0	0	$0	0	$0	1	$187	0	1	$187
Total, FEHS	0	$0	6	$1,087	3	$339	4	$680	5	$1,289	3	15	$3,395
Total, Facilities	0	$0	6	$1,087	3	$339	4	$680	5	$1,289	3	15	$3,395
Grand Total[1]	**1**	**$182**	**94**	**$10,743**	**36**	**$3,403**	**55**	**$6,279**	**96**	**$12,375**	**37**	**245**	**$32,982**

[1]Includes Utilities

Note: These estimates reflect new facilities anticipated to open in FY 2016

Kayenta - Official opening date is estimated to be March 2016. Construction completed; operation pending receipt/installation of equipment/furniture.

Eufaula - A Joint Venture Agreement with the Tribes was not completed in time to be included in FY 2016 Budget.

Flandreau - A Joint Venture Agreement with the Tribes was not completed in time to be included in FY 2016 Budget.

Workload Projection (Estimates)	Kayenta, AZ	Eufaula, OK	Davis, CA	Flandreau, SD	Durant, OK	**TOTAL**
Inpatient Days	4,142	0	NA	0	0	**4,142**
Outpatient Visits	102,196	39,844	NA	21,158	50,850	**214,048**
User Population (est.)	19,017	4,953	0	2,119	6,169	**32,258**

Capital Invested (est.)						**TOTAL**
Tribes	$0	$34,600	$0	$15,777	$70,305	**$120,682**
Federal Government	$150,000	$0	$17,064	$0	$0	**$167,064**

Statement of Personnel Resources
INDIAN HEALTH SERVICE

	FY 2015 Final	FY 2016 Enacted	FY 2017 Request
Direct:			
Hospitals & Health Clinics	6,094	6,099	6,100
Dental Health	585	585	586
Mental Health	197	197	198
Alcohol & Substance Abuse	191	201	206
Purchased/Referred Care	0	0	0
Total, Clinical Services	7,067	7,082	7,090
Public Health Nursing	202	202	202
Health Education	21	21	21
Community Health Reps	5	5	5
Immunization, AK	0	0	0
Total, Preventive Health	228	228	228
Urban Health	5	5	6
Indian Health Professions	22	22	23
Tribal Management	0	0	0
Direct Operations	261	261	264
Self Governance	13	13	15
Contract Support Costs	0	0	0
Total, SERVICES	7,596	7,611	7,626
Maint. & Improvement	0	0	0
Sanitation Facilities	175	175	175
Hlth Care Facs Construction	0	0	0
Facil. & Envir. Hlth Support	1,088	1,089	1,090
Equipment	0	0	0
Total, FACILITIES	1,263	1,264	1,265
Total, Direct FTE	8,859	8,875	8,891
Reimbursable:			
Buybacks	1,137	1,137	1,137
Medicare	827	827	827
Medicaid	3,699	3,699	3,699
Private Insurance	549	549	549
Quarters	32	32	32
Total, Reimbursable FTE	6,244	6,244	6,244
Trust Funds (Gift)	23	23	23
Health Reform non -add:	0	0	0
TOTAL FTE	**15,126**	**15,142**	**15,158**
Total, Civilian FTE	**13,134**	**13,150**	**13,166**
Total, Military FTE	**1,992**	**1,992**	**1,992**

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

	Federal Health Administration								Tribal Health Administration								
Sub Activity	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 Final
SERVICES																	
Hospitals & Health Clinics	728,990	0	0	0	0	0	0	728,990	1,107,799	0	0	0	0	0	0	1,107,799	1,836,789
Dental Health	67,023	0	0	0	0	0	0	67,023	106,959	0	0	0	0	0	0	106,959	173,982
Mental Health	24,944	0	0	0	0	0	0	24,944	56,201	0	0	0	0	0	0	56,201	81,145
Alcohol & Substance Abuse	19,752	0	0	0	0	0	0	19,752	171,229	0	0	0	0	0	0	171,229	190,981
Purchased/Referred Care	333,698	0	0	0	0	0	0	333,698	580,441	0	0	0	0	0	0	580,441	914,139
Subtotal (CS)	1,174,406	0	0	0	0	0	0	1,174,406	2,022,630	0	0	0	0	0	0	2,022,630	3,197,036
Public Health Nursing	0	0	24,433	0	0	0	0	24,433	0	51,207	0	0	0	0	0	51,207	75,640
Health Education	0	0	2,589	0	0	0	0	2,589	0	15,437	0	0	0	0	0	15,437	18,026
Community Health Repr.	0	0	836	0	0	0	0	836	0	57,633	0	0	0	0	0	57,633	58,469
Immunization AK	0	0	0	0	0	0	0	0	0	1,826	0	0	0	0	0	1,826	1,826
Subtotal (PH)	0	0	27,857	0	0	0	0	27,857	0	126,104	0	0	0	0	0	126,104	153,961
Urban Health Project	0	11,416	0	0	0	0	0	11,416	0	0	32,188	0	0	0	0	32,188	43,604
Indian Health Professions	0	0	0	48,342	0	0	0	48,342	0	0	0	0	0	0	0	0	48,342
Tribal Management	0	0	0	14	0	0	0	14	0	0	0	2,428	0	0	0	2,428	2,442
Direct Operations	0	0	0	0	48,176	0	0	48,176	0	0	0	19,889	0	0	0	19,889	68,065
Self-Governance	0	0	0	0	0	1,459	0	1,459	0	0	0	0	4,268	0	0	4,268	5,727
Contract Support Costs	0	0	0	0	0	0	0	0	0	0	0	0	0	662,970	0	662,970	662,970
Subtotal (OS)	0	11,416	0	48,356	48,176	1,459	0	109,407	0	0	32,188	22,317	4,268	662,970	0	721,743	831,150
Total, Services	1,174,406	11,416	27,857	48,356	48,176	1,459	0	1,311,671	2,022,630	126,104	32,188	22,317	4,268	662,970	0	2,870,476	4,182,147
FACILITIES																	
Maintenance & Improvement	0	0	0	0	0	0	20,285	20,285	0	0	0	0	0	0	33,329	33,329	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	130,314	130,314	0	0	0	0	0	0	89,298	89,298	219,612
Equipment	0	0	0	0	0	0	7,852	7,852	0	0	0	0	0	0	14,685	14,685	22,537
Total, Facilities	0	0	0	0	0	0	268,570	268,570	0	0	0	0	0	0	191,664	191,664	460,234
TOTAL, IHS	1,174,406	11,416	27,857	48,356	48,176	1,459	268,570	1,580,241	2,022,630	126,104	32,188	22,317	4,268	662,970	191,664	3,062,140	4,642,381
% Federal Health Admin.								34.0%									
% Tribal and Urban Health Admin.																	66.0%

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

	Federal Health Administration								Tribal Health Administration								
Sub Activity	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 2016 Enacted
SERVICES																	
Hospitals & Health Clinics	734,039	0	0	0	0	0	0	734,039	1,123,186	0	0	0	0	0	0	1,123,186	1,857,225
Dental Health	69,101	0	0	0	0	0	0	69,101	109,185	0	0	0	0	0	0	109,185	178,286
Mental Health	25,188	0	0	0	0	0	0	25,188	56,912	0	0	0	0	0	0	56,912	82,100
Alcohol & Substance Abuse	21,204	0	0	0	0	0	0	21,204	184,101	0	0	0	0	0	0	184,101	205,305
Purchased/Referred Care	333,697	0	0	0	0	0	0	333,697	580,442	0	0	0	0	0	0	580,442	914,139
Subtotal (CS)	1,183,230	0	0	0	0	0	0	1,183,230	2,053,825	0	0	0	0	0	0	2,053,825	3,237,055
Public Health Nursing	0	0	24,715	0	0	0	0	24,715	0	51,908	0	0	0	0	0	51,908	76,623
Health Education	0	0	2,622	0	0	0	0	2,622	0	15,633	0	0	0	0	0	15,633	18,255
Community Health Repr.	0	0	842	0	0	0	0	842	0	58,064	0	0	0	0	0	58,064	58,906
Immunization AK	0	0	0	0	0	0	0	0	0	1,950	0	0	0	0	0	1,950	1,950
Subtotal (PH)	0	0	28,179	0	0	0	0	28,179	0	127,555	0	0	0	0	0	127,555	155,734
Urban Health Project	0	11,570	0	0	0	0	0	11,570	0	0	33,171	0	0	0	0	33,171	44,741
Indian Health Professions	0	0	0	48,342	0	0	0	48,342	0	0	0	0	0	0	0	0	48,342
Tribal Management	0	0	0	14	0	0	0	14	0	0	0	2,428	0	0	0	2,428	2,442
Direct Operations	0	0	0	0	52,328	0	0	52,328	0	0	0	20,010	0	0	0	20,010	72,338
Self-Governance	0	0	0	0	0	1,467	0	1,467	0	0	0	0	4,268	0	0	4,268	5,735
Subtotal (OS)	0	11,570	0	48,356	52,328	1,467	0	113,721	0	0	33,171	22,438	4,268	0	0	59,877	173,598
Total, Services	1,183,230	11,570	28,179	48,356	52,328	1,467	0	1,325,130	2,053,825	127,555	33,171	22,438	4,268	0	0	2,241,257	3,566,387
CONTRACT SUPPORT COSTS	0	0	0	0	0	0	0	0	0	0	0	0	0	717,970	0	717,970	717,970
FACILITIES																	
Maintenance & Improvement	0	0	0	0	0	0	27,852	27,852	0	0	0	0	0	0	45,762	45,762	73,614
Sanitation Facilities Constr.	0	0	0	0	0	0	34,798	34,798	0	0	0	0	0	0	64,625	64,625	99,423
Health Care Facs. Constr.	0	0	0	0	0	0	27,000	27,000	0	0	0	0	0	0	78,048	78,048	105,048
Facs. & Env. Health Sup	0	0	0	0	0	0	131,339	131,339	0	0	0	0	0	0	91,271	91,271	222,610
Equipment	0	0	0	0	0	0	7,852	7,852	0	0	0	0	0	0	14,685	14,685	22,537
Total, Facilities	0	0	0	0	0	0	228,842	228,842	0	0	0	0	0	0	294,390	294,390	523,232
TOTAL, IHS	1,183,230	11,570	28,179	48,356	52,328	1,467	228,842	1,553,971	2,053,825	127,555	33,171	22,438	4,268	717,970	294,390	3,253,617	4,807,589
% Federal Health Admin.								32.3%									
% Tribal and Urban Health Admin.																	67.7%

FY 2017 Crosswalk
Budget Authority
Estimated Distribution
(Dollars in Thousands)

	Federal Health Administration								Tribal Health Administration								
Sub Activity	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 2017 PB
SERVICES																	
Hospitals & Health Clinics	770,817	0	0	0	0	0	0	770,817	1,209,181	0	0	0	0	0	0	1,209,181	1,979,998
Dental Health	70,788	0	0	0	0	0	0	70,788	116,041	0	0	0	0	0	0	116,041	186,829
Mental Health	34,504	0	0	0	0	0	0	34,504	76,639	0	0	0	0	0	0	76,639	111,143
Alcohol & Substance Abuse	24,006	0	0	0	0	0	0	24,006	209,280	0	0	0	0	0	0	209,280	233,286
Purchased/Referred Care	348,857	0	0	0	0	0	0	348,857	613,474	0	0	0	0	0	0	613,474	962,331
Subtotal (CS)	1,248,971	0	0	0	0	0	0	1,248,971	2,224,616	0	0	0	0	0	0	2,224,616	3,473,587
Public Health Nursing	0	0	25,811	0	0	0	0	25,811	0	56,229	0	0	0	0	0	56,229	82,040
Health Education	0	0	2,783	0	0	0	0	2,783	0	16,762	0	0	0	0	0	16,762	19,545
Community Health Repr.	0	0	887	0	0	0	0	887	0	61,541	0	0	0	0	0	61,541	62,428
Immunization AK	0	0	0	0	0	0	0	0	0	2,062	0	0	0	0	0	2,062	2,062
Subtotal (PH)	0	0	29,481	0	0	0	0	29,481	0	136,594	0	0	0	0	0	136,594	166,075
Urban Health Project	0	12,412	0	0	0	0	0	12,412	0	0	35,745	0	0	0	0	35,745	48,157
Indian Health Professions	0	0	0	49,345	0	0	0	49,345	0	0	0	0	0	0	0	0	49,345
Tribal Management	0	0	0	14	0	0	0	14	0	0	0	2,474	0	0	0	2,474	2,488
Direct Operations	0	0	0	0	49,249	0	0	49,249	0	0	0	20,371	0	0	0	20,371	69,620
Self-Governance	0	0	0	0	0	1,522	0	1,522	0	0	0	0	4,315	0	0	4,315	5,837
Subtotal (OS)	0	12,412	0	49,359	49,249	1,522	0	112,543	0	0	35,745	22,844	4,315	0	0	62,904	175,447
Total, Services	1,248,971	12,412	29,481	49,359	49,249	1,522	0	1,390,995	2,224,616	136,594	35,745	22,844	4,315	0	0	2,424,114	3,815,109
CONTRACT SUPPORT COSTS	0	0	0	0	0	0	0	0	0	0	0	0	0	800,000	0	800,000	800,000
FACILITIES																	
Maintenance & Improvement	0	0	0	0	0	0	28,756	28,756	0	0	0	0	0	0	48,225	48,225	76,981
Sanitation Facilities Constr.	0	0	0	0	0	0	36,063	36,063	0	0	0	0	0	0	66,973	66,973	103,036
Health Care Facs. Constr.	0	0	0	0	0	0	69,831	69,831	0	0	0	0	0	0	62,546	62,546	132,377
Facs. & Env. Health Sup	0	0	0	0	0	0	134,500	134,500	0	0	0	0	0	0	99,358	99,358	233,858
Equipment	0	0	0	0	0	0	8,151	8,151	0	0	0	0	0	0	15,503	15,503	23,654
Total, Facilities	0	0	0	0	0	0	277,301	277,301	0	0	0	0	0	0	292,605	292,605	569,906
TOTAL, IHS	1,248,971	12,412	29,481	49,359	49,249	1,522	277,301	1,668,296	2,224,616	136,594	35,745	22,844	4,315	800,000	292,605	3,516,719	5,185,015
% Federal Health Admin.								32.2%									
% Tribal and Urban Health Admin.																	67.8%

INDIAN HEALTH SERVICE

Indian Health Services

For expenses necessary to carry out the Act of August 5, 1954 (68 Stat. 674), the Indian Self-Determination and Education Assistance Act, the Indian Health Care Improvement Act, and titles II and III of the Public Health Service Act with respect to the Indian Health Service, **[**$3,566,387,000**]** *$3,815,109,000*, together with payments received during the fiscal year pursuant to 42 U.S.C. 238(b) and 238b, for services furnished by the Indian Health Service: *Provided*, That funds made available to tribes and tribal organizations through contracts, grant agreements, or any other agreements or compacts authorized by the Indian Self-Determination and Education Assistance Act of 1975 (25 U.S.C. 450), shall be deemed to be obligated at the time of the grant or contract award and thereafter shall remain available to the tribe or tribal organization without fiscal year limitation: *Provided further*, That, **[**$914,139,000**]** *$962,331,000* for Purchased/Referred Care, including **[**$51,500,000**]** $*53,000,000* 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, of the funds provided, **[**$2,000,000**]** *$11,000,000* shall **[**be used**]** *remain available until expended* to supplement funds available for operational costs at tribal clinics operated under an Indian Self-Determination and Education Assistance Act compact or contract where health care is delivered in space acquired through a full service lease, which is not eligible for maintenance and improvement and equipment funds from the Indian Health Service **[**and $2,000,000 shall be for accreditation emergencies**]**: *Provided further*, That the amounts collected by the Federal Government as authorized by sections 104 and 108 of the Indian Health Care Improvement Act (25 U.S.C. 1613a and 1616a) during the preceding fiscal year for breach of contracts shall be deposited to the Fund authorized by section 108A of the Act (25 U.S.C. 1616a-1) and shall remain available until expended and, notwithstanding section 108A(c) of the Act (25 U.S.C. 1616a-1(c)), funds shall be available to make new awards under the loan repayment and scholarship programs under sections 104 and 108 of the Act (25 U.S.C. 1613a and 1616a): *Provided further*, That, notwithstanding any other provision of law, the amounts made available within this account for the **[**methamphetamine and suicide prevention and treatment initiative**]** *Substance Abuse and Suicide Prevention Program*, for the **[**domestic violence prevention initiative**]** *Domestic Violence Prevention Program, for the Zero Suicide Initiative, for aftercare pilots at Youth Regional Treatment Centers*, to improve collections from public and private insurance at Indian Health Service and tribally operated facilities[1], and for accreditation emergencies 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, 2016.)*

Contract Support Costs

For payments to tribes and tribal organizations for contract support costs associated with Indian Self-Determination and Education Assistance Act agreements with the Indian Health Service for fiscal year **[**2016**]** *2017*, such sums as may be necessary: *Provided*, That amounts obligated but not expended by a tribe or tribal organization for contract support costs for such agreements for the current fiscal year shall be applied to contract support costs otherwise due for such agreements for subsequent fiscal years: *Provided further*, That, notwithstanding any other provision of law, no amounts made available under this heading shall be available for transfer to another budget account. *(Department of the Interior, Environment, and Related Agencies Appropriations Act, 2016.)*

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, **[**$523,232,000**]** *$569,906,000*, to remain available until expended: *Provided*, That, notwithstanding any other provision of law, funds appropriated for the planning, design, construction, renovation or expansion of health facilities for the benefit of an Indian tribe or tribes may be used to purchase land on which such facilities will be located: *Provided further*, That not to exceed $500,000 may be used by the Indian Health Service to purchase TRANSAM equipment from the Department of Defense for distribution to the Indian Health Service and tribal facilities: *Provided further*, That none of the funds appropriated to the Indian Health Service may be used for sanitation facilities construction for new homes funded with grants by the housing programs of the United States Department of Housing and Urban Development: *Provided further*, That not to exceed $2,700,000 from this account and the "Indian Health Services" account may be used by the Indian Health Service to obtain ambulances for the Indian Health Service and tribal facilities in conjunction with an existing interagency agreement between the Indian Health Service and the General Services Administration: *Provided further*, That not to exceed $500,000 may be placed in a Demolition Fund, to remain available until expended, and be used by the Indian Health Service for the demolition of Federal buildings. *(Department of the Interior, Environment, and Related Agencies Appropriations Act, 2016.)*

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: *Provided further*, That funds

appropriated to the Indian Health Service in this Act, except those used for administrative and program direction purposes, shall not be subject to limitations directed at curtailing Federal travel and transportation: *Provided further*, That none of the funds made available to the Indian Health Service in this Act shall be used for any assessments or charges by the Department of Health and Human Services unless identified in the budget justification and provided in this Act, or **[**approved by**]** *notified to* the House and Senate Committees on Appropriations through the reprogramming process: *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 : *Provided further*, That the Indian Health Service shall develop a strategic plan for the Urban Indian Health program in consultation with urban Indians and the National Academy of Public Administration, and shall publish such plan not later than one year after the date of enactment of this Act**]**[2]. *(Department of the Interior, Environment, and Related Agencies Appropriations Act, 2016.)*

General Provisions

Contract Support Costs, Fiscal Year 2017 Limitation

SEC. 406. Amounts provided by this Act for fiscal year [2016] *2017* under the headings ''Department of Health and Human Services, Indian Health Service, Contract Support Costs'' and ''Department of the Interior, Bureau of Indian Affairs and Bureau of Indian Education, Contract Support Costs'' are the only amounts available for contract support costs arising out of self-determination or self-governance contracts, grants, compacts, or annual funding agreements for fiscal year [2016] *2017* with the Bureau of Indian Affairs or the Indian Health Service: *Provided*, That such amounts provided by this Act are not available for payment of claims for contract support costs for prior years, or for repayments of payments for settlements or judgments awarding contract support costs for prior years[3].

Language Analysis

Language Provision	Explanation
SERVICES PROVISIONS	
[1]*Provided further*, That, notwithstanding any other provision of law, the amounts made available within this account for *the Substance Abuse and Suicide Prevention Program, for the Domestic Violence Prevention Program, the Zero Suicide Initiative, for aftercare pilots at Youth Regional Treatment Centers,* to improve collections from public and private insurance at Indian Health Service and tribally operated facilities, and for accreditation emergencies shall be allocated at the discretion of the Director of the Indian Health Service and shall remain available until expended:	Methamphetamine language is changed to better reflect broader use of the funds, and new language is included for Zero Suicide and aftercare.

ADMINISTRATIVE PROVISIONS	
[: *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: *Provided further,* That the Indian Health Service shall develop a strategic plan for the Urban Indian Health program in consultation with urban Indians and the National Academy of Public Administration, and shall publish such plan not later than one year after the date of enactment of this Act**]**	Language is struck to maximize operational flexibility, and funds are no longer needed for a plan for the Urban Indian Health program.
GENERAL PROVISIONS	
[3]SEC. 406. Amounts provided by this Act for fiscal year [2016] *2017* under the headings ''Department of Health and Human Services, Indian Health Service, *Contract Support Costs''* and ''Department of the Interior, Bureau of Indian Affairs and Bureau of Indian Education, Contract Support Costs'' are the only amounts available for contract support costs arising out of self-determination or self-governance contracts, grants, compacts, or annual funding agreements for fiscal year [2016] 2017 with the Bureau of Indian Affairs or the Indian Health Service: *Provided,* That such amounts provided by this Act are not available for payment of claims for contract support costs for prior years, or for repayments of payments for settlements or judgments awarding contract support costs for prior years[3].	Added to ensure that the FY 2017 appropriation for Contract Support Costs will not be used to pay prior year contract support costs claims or to repay the Judgment Fund for payments on prior year claims.

INDIAN HEALTH SERVICE
Amounts Available for Obligations

SERVICES

	FY 2015	FY 2016	FY 2017
General Fund Discretionary Appropriation:			
Appropriation (Interior)	$3,519,177,000	$3,566,387,000	$3,815,109,000
Across-the-board reductions (Interior)	$0	$0	$0
Subtotal, Appropriation (Interior)	$3,519,177,000	$3,566,387,000	$3,815,109,000
Mandatory Appropriation:			
Appropriation	$150,000,000	$150,000,000	$175,000,000
Offsetting Collections:			
Federal sources	($243,000,000)	($271,000,000)	($271,000,000)
Non-federal sources	($1,130,000,000)	($1,151,000,000)	($1,151,000,000)
Subtotal, Offsetting Collections	($1,373,000,000)	($1,422,000,000)	($1,422,000,000)
Unobligated Balances:			
Discretionary, Start of Year	$668,000,000	$740,000,000	$968,000,000
Mandatory, Start of Year	$72,000,000	$228,000,000	--
End of Year	$740,000,000	$968,000,000	$1,196,000,000
Total Obligations, Services	$2,296,177,000	$2,294,387,000	$2,340,109,000

INDIAN HEALTH SERVICE
Amounts Available for Obligations

FACILITIES

	FY 2015	FY 2016	FY 2017
General Fund Discretionary Appropriation:			
Appropriation (Interior)	$460,234,000	$523,232,000	$569,906,000
Across-the-board reductions (Interior)	$0	$0	$0
Subtotal, Appropriation (Interior)	$460,234,000	$523,232,000	$569,906,000
Offsetting Collections:			
Federal sources	$0	($55,000,000)	($56,000,000)
Subtotal, Offsetting Collections	$0	($55,000,000)	($56,000,000)
Unobligated Balances:			
Discretionary, Start of Year	$171,000,000	$236,000,000	$290,000,000
End of Year	$236,000,000	$290,000,000	$345,000,000
Total Obligations, Facilities	$395,234,000	$414,232,000	$458,906,000

INDIAN HEALTH SERVICE
Amounts Available for Obligations

CONTRACT SUPPORT COSTS

	FY 2015	FY 2016	FY 2017
General Fund Discretionary Appropriation:			
Appropriation (Interior)	$662,970,000	$717,970,000	$800,000,000
Across-the-board reductions (Interior)	$0	$0	$0
Subtotal, Appropriation (Interior)	$662,970,000	$717,970,000	$800,000,000
Total Obligations, CSC	$662,970,000	$717,970,000	$800,000,000

INDIAN HEALTH SERVICE

SERVICES

Summary of Changes

FY 2016 Enacted	$3,566,387,000
Total estimated budget authority	3,566,387,000
Less Obligations	(3,566,387,000)
FY 2017 Estimate	3,815,109,000
Less Obligations	(3,815,109,000)
Net Change	248,722,000
Less Obligations	(248,722,000)

		FY 2016 Enacted Base		Change from Base	
		FTE	BA	FTE/Pos	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2016 CO Pay Raise (3months)	--	n/a	--	346,000
2	FY 2017 Pay Raise CO (9months)	--	n/a	--	949,000
3	Annualization of FY 2016 CS Pay Raise (3months)	--	n/a	--	1,956,000
4	FY 2017 Pay Raise CS (9months)	--	n/a	--	5,569,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	14,723,000
7	Increased Cost of Travel	--	44,026,000	--	1,517,000
8	Increased Cost of Transportation & Things	--	5,935,000	--	121,000
9	Increased Cost of Printing	--	142,000	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	26,307,000	--	496,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	520,637,000	--	19,238,000
12	Increased Cost of Supplies	--	102,536,000	--	3,806,000
13	Increased Cost of Medical or other Equipment	--	12,430,000	--	253,000
14	Increased Cost of Land & Structure	--	5,000	--	2,000
15	Increased Cost of Grants	--	2,092,725,000	--	52,451,000
16	Increased Cost of Insurance / Indemnities	--	27,143,000	--	20,000
17	Increased Cost of Interest / Dividends	--	33,000	--	1,000
18	Population Growth	--	n/a	--	65,168,000
	Subtotal, Built-In	--	2,831,919,000	--	166,616,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	264	29,587,000
C. Program Increases		--	0	--	83,437,000
	TOTAL INCREASES	--	2,831,919,000	264	279,640,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(26,918,000)
B. Program Decreases		--	0	--	(4,000,000)
	TOTAL DECREASES	--	0	--	(30,918,000)
NET CHANGE		--	**$2,831,919,000**	**264**	**$248,722,000**

INDIAN HEALTH SERVICE
CLINICAL Services
Summary of Changes

FY 2016 Enacted	$3,237,055,000
Total estimated budget authority	3,237,055,000
Less Obligations	(3,237,055,000)
FY 2017 Estimate	3,473,587,000
Less Obligations	(3,473,587,000)
Net Change	236,532,000
Less Obligations	(236,532,000)

		FY 2016 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2014 CO Pay Raise (3months)	--	n/a	--	314,000
2	FY 2015 Pay Raise CO (9months)	--	n/a	--	855,000
3	Annualization of FY 2014 CS Pay Raise (3months)	--	n/a	--	1,764,000
4	FY 2015 Pay Raise CS (9months)	--	n/a	--	5,012,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	13,166,000
7	Increased Cost of Travel	--	40,400,000	--	1,488,000
8	Increased Cost of Transportation & Things	--	4,693,000	--	95,000
9	Increased Cost of Printing	--	87,000	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	25,096,000	--	482,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	484,552,000	--	18,804,000
12	Increased Cost of Supplies	--	96,400,000	--	3,670,000
13	Increased Cost of Medical or other Equipment	--	10,027,000	--	220,000
14	Increased Cost of Land & Structure	--	5,000	--	2,000
15	Increased Cost of Grants	--	1,891,261,000	--	44,770,000
16	Increased Cost of Insurance / Indemnities	--	24,449,000	--	17,000
17	Increased Cost of Interest / Dividends	--	33,000	--	1,000
18	Population Growth	--	n/a	--	61,449,000
	Subtotal, Built-In	--	2,577,003,000	--	152,109,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	249	27,591,000
C. Program Increases		--	0	--	82,300,000
	TOTAL INCREASES	--	2,577,003,000	249	262,000,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(25,468,000)
	TOTAL DECREASES	--	0	--	(25,468,000)
NET CHANGE		--	**$2,577,003,000**	**249**	**$236,532,000**

INDIAN HEALTH SERVICE
Hospitals & Health Clinics
Summary of Changes

FY 2016 Enacted	$1,857,225,000
Total estimated budget authority	1,857,225,000
Less Obligations	(1,857,225,000)
FY 2017 Estimate	1,979,998,000
Less Obligations	(1,979,998,000)
Net Change	122,773,000
Less Obligations	(122,773,000)

		FY 2016 Enacted Base		Change from Base	
		FTE	BA	FTE/Pos	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2016 CO Pay Raise (3months)	--	n/a	--	261,000
2	FY 2017 Pay Raise CO (9months)	--	n/a	--	699,000
3	Annualization of FY 2016 CS Pay Raise (3months)	--	n/a	--	1,483,000
4	FY 2017 Pay Raise CS (9months)	--	n/a	--	4,199,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	10,156,000
7	Increased Cost of Travel	--	3,501,000	--	59,000
8	Increased Cost of Transportation & Things	--	4,245,000	--	84,000
9	Increased Cost of Printing	--	79,000	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	24,400,000	--	470,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	132,404,000	--	4,965,000
12	Increased Cost of Supplies	--	76,615,000	--	2,944,000
13	Increased Cost of Medical or other Equipment	--	7,676,000	--	185,000
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	1,028,678,000	--	16,924,000
16	Increased Cost of Insurance / Indemnities	--	21,895,000	--	5,000
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	34,854,000
	Subtotal, Built-In	--	1,299,493,000	--	77,288,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	173	20,078,000
C. H&HC - Health IT		--	0	--	20,000,000
D. Domestic Violence		--	0	--	4,000,000
E. Quality Consortium		--	0	--	2,000,000
F. Tribal Clinic Leases, Operation and Maintenance		--	0	--	9,000,000
G. Accreditation Emergencies & Tribal Clinics (Transfer from Direct Ops)		--	0	--	4,000,000
	TOTAL INCREASES	--	1,299,493,000	173	136,366,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(13,593,000)
	TOTAL DECREASES	--	0	--	(13,593,000)
NET CHANGE		--	**$1,299,493,000**	**173**	**$122,773,000**

INDIAN HEALTH SERVICE
Dental Health
Summary of Changes

FY 2016 Enacted	$178,286,000
Total estimated budget authority	178,286,000
Less Obligations	(178,286,000)
FY 2017 Estimate	186,829,000
Less Obligations	(186,829,000)
Net Change	8,543,000
Less Obligations	(8,543,000)

		FY 2016 Enacted Base		Change from Base	
		FTE	BA	Pos	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2016 CO Pay Raise (3months)	--	n/a	--	45,000
2	FY 2017 Pay Raise CO (9months)	--	n/a	--	129,000
3	Annualization of FY 2016 CS Pay Raise (3months)	--	n/a	--	160,000
4	FY 2017 Pay Raise CS (9months)	--	n/a	--	458,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	1,066,000
7	Increased Cost of Travel	--	429,000	--	7,000
8	Increased Cost of Transportation & Things	--	206,000	--	2,000
9	Increased Cost of Printing	--	1,000	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	379,000	--	5,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	7,834,000	--	210,000
12	Increased Cost of Supplies	--	6,283,000	--	249,000
13	Increased Cost of Medical or other Equipment	--	999,000	--	20,000
14	Increased Cost of Land & Structure	--	0	--	2,000
15	Increased Cost of Grants	--	100,552,000	--	1,561,000
16	Increased Cost of Insurance / Indemnities	--	3,000	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	3,266,000
	Subtotal, Built-In	--	116,686,000	--	7,180,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	25	2,637,000
	TOTAL INCREASES	--	116,686,000	25	9,817,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(1,274,000)
	TOTAL DECREASES	--	0	--	(1,274,000)
NET CHANGE		--	**$116,686,000**	**25**	**$8,543,000**

INDIAN HEALTH SERVICE
Mental Health
Summary of Changes

FY 2016 Enacted	$82,100,000
Total estimated budget authority	82,100,000
Less Obligations	(82,100,000)
FY 2017 Estimate	111,143,000
Less Obligations	(111,143,000)
Net Change	29,043,000
Less Obligations	(29,043,000)

		FY 2016 Enacted Base		Change from Base	
		FTE	BA	Pos	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2016 CO Pay Raise (3months)	--	n/a	--	4,000
2	FY 2017 Pay Raise CO (9months)	--	n/a	--	13,000
3	Annualization of FY 2016 CS Pay Raise (3months)	--	n/a	--	70,000
4	FY 2017 Pay Raise CS (9months)	--	n/a	--	199,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	530,000
7	Increased Cost of Travel	--	246,000	--	5,000
8	Increased Cost of Transportation & Things	--	138,000	--	6,000
9	Increased Cost of Printing	--	1,000	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	47,000	--	4,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	3,707,000	--	158,000
12	Increased Cost of Supplies	--	923,000	--	70,000
13	Increased Cost of Medical or other Equipment	--	167,000	--	1,000
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	51,940,000	--	824,000
16	Increased Cost of Insurance / Indemnities	--	1,306,000	--	0
17	Increased Cost of Interest / Dividends	--		--	0
18	Population Growth	--	n/a	--	1,521,000
	Subtotal, Built-In	--	58,475,000	--	3,405,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	12	1,231,000
C. Behavorial Health Integration		--	0	--	21,400,000
D. Zero Suicide		--	0	--	3,600,000
	TOTAL INCREASES	--	58,475,000	12	29,636,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(593,000)
	TOTAL DECREASES	--	0	--	(593,000)
NET CHANGE		--	**$58,475,000**	**12**	**$29,043,000**

INDIAN HEALTH SERVICE
Alcohol and Substance Abuse
Summary of Changes

FY 2016 Enacted	$205,305,000
Total estimated budget authority	205,305,000
Less Obligations	(205,305,000)
FY 2017 Estimate	233,286,000
Less Obligations	(233,286,000)
Net Change	27,981,000
Less Obligations	(27,981,000)

		FY 2016 Enacted Base		Change from Base	
		FTE	BA	FTE/Pos	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2016 CO Pay Raise (3months)	--	n/a	--	4,000
2	FY 2017 Pay Raise CO (9months)	--	n/a	--	14,000
3	Annualization of FY 2016 CS Pay Raise (3months)	--	n/a	--	51,000
4	FY 2017 Pay Raise CS (9months)	--	n/a	--	156,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	1,414,000
7	Increased Cost of Travel	--	254,000	--	4,000
8	Increased Cost of Transportation & Things	--	104,000	--	3,000
9	Increased Cost of Printing	--	6,000	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	270,000	--	3,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	11,605,000	--	357,000
12	Increased Cost of Supplies	--	2,328,000	--	46,000
13	Increased Cost of Medical or other Equipment	--	1,155,000	--	7,000
14	Increased Cost of Land & Structure	--	2,000	--	0
15	Increased Cost of Grants	--	171,631,000	--	2,983,000
16	Increased Cost of Insurance / Indemnities	--	855,000	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	4,087,000
	Subtotal, Built-In	--	188,210,000	--	9,129,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	39	3,645,000
C. Generation Indigenous		--	0	--	15,000,000
D. Pilot Project Youth		--	0	--	1,800,000
	TOTAL INCREASES	--	188,210,000	39	29,574,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(1,593,000)
	TOTAL DECREASES	--	0	--	(1,593,000)
NET CHANGE		--	**$188,210,000**	**39**	**$27,981,000**

INDIAN HEALTH SERVICE
Purchased/Referred Care
Summary of Changes

FY 2016 Enacted	$914,139,000
Total estimated budget authority	914,139,000
Less Obligations	(914,139,000)
FY 2017 Estimate	962,331,000
Less Obligations	(962,331,000)
Net Change	48,192,000
Less Obligations	(48,192,000)

		FY 2016 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2016 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2017 Pay Raise CO (9months)	--	n/a	--	0
3	Annualization of FY 2016 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2017 Pay Raise CS (9months)	--	n/a	--	0
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	0
7	Increased Cost of Travel	--	35,970,000	--	1,413,000
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	--	329,002,000	--	13,114,000
12	Increased Cost of Supplies	--	10,251,000	--	361,000
13	Increased Cost of Medical or other Equipment	--	30,000	--	7,000
14	Increased Cost of Land & Structure	--	3,000	--	0
15	Increased Cost of Grants	--	538,460,000	--	22,478,000
16	Increased Cost of Insurance / Indemnities	--	390,000	--	12,000
17	Increased Cost of Interest / Dividends	--	33,000	--	1,000
18	Population Growth	--	n/a	--	17,721,000
	Subtotal, Built-In	--	914,139,000	--	55,107,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	--	0
C. CHEF Increase		--	0	--	1,500,000
	TOTAL INCREASES	--	914,139,000	--	56,607,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(8,415,000)
	TOTAL DECREASES	--	0	--	(8,415,000)
NET CHANGE		--	**$914,139,000**	--	**$48,192,000**

INDIAN HEALTH SERVICE
PREVENTIVE Health
Summary of Changes

FY 2016 Enacted	$155,734,000
Total estimated budget authority	155,734,000
Less Obligations	(155,734,000)
FY 2017 Estimate	166,075,000
Less Obligations	(166,075,000)
Net Change	10,341,000
Less Obligations	(10,341,000)

		FY 2016 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2016 CO Pay Raise (3months)	--	n/a	--	18,000
2	FY 2017 Pay Raise CO (9months)	--	n/a	--	53,000
3	Annualization of FY 2016 CS Pay Raise (3months)	--	n/a	--	71,000
4	FY 2017 Pay Raise CS (9months)	--	n/a	--	208,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	1,138,000
7	Increased Cost of Travel	--	158,000	--	4,000
8	Increased Cost of Transportation & Things	--	819,000	--	21,000
9	Increased Cost of Printing	--	10,000	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	35,000	--	5,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	2,885,000	--	97,000
12	Increased Cost of Supplies	--	3,517,000	--	119,000
13	Increased Cost of Medical or other Equipment	--	403,000	--	21,000
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	118,515,000	--	4,800,000
16	Increased Cost of Insurance / Indemnities	--	2,359,000	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	2,934,000
	Subtotal, Built-In	--	128,701,000	--	9,489,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	15	1,996,000
	TOTAL INCREASES	--	128,701,000	15	11,485,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(1,144,000)
	TOTAL DECREASES	--	0	--	(1,144,000)
NET CHANGE		--	**$128,701,000**	**15**	**$10,341,000**

INDIAN HEALTH SERVICE
Public Health Nursing
Summary of Changes

FY 2016 Enacted	$76,623,000
Total estimated budget authority	76,623,000
Less Obligations	(76,623,000)
FY 2017 Estimate	82,040,000
Less Obligations	(82,040,000)
Net Change	5,417,000
Less Obligations	(5,417,000)

		FY 2016 Enacted Base		Change from Base	
		FTE	BA	Pos	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2016 CO Pay Raise (3months)	--	n/a	--	17,000
2	FY 2017 Pay Raise CO (9months)	--	n/a	--	48,000
3	Annualization of FY 2016 CS Pay Raise (3months)	--	n/a	--	61,000
4	FY 2017 Pay Raise CS (9months)	--	n/a	--	176,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	494,000
7	Increased Cost of Travel	--	101,000	--	2,000
8	Increased Cost of Transportation & Things	--	799,000	--	20,000
9	Increased Cost of Printing	--	2,000	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	31,000	--	5,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	1,910,000	--	70,000
12	Increased Cost of Supplies	--	2,571,000	--	103,000
13	Increased Cost of Medical or other Equipment	--	276,000	--	17,000
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	45,676,000	--	1,841,000
16	Increased Cost of Insurance / Indemnities	--	1,944,000	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	1,432,000
	Subtotal, Built-In	--	53,310,000	--	4,286,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	12	1,689,000
	TOTAL INCREASES	--	53,310,000	12	5,975,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(558,000)
	TOTAL DECREASES	--	0	--	(558,000)
NET CHANGE		--	**$53,310,000**	**12**	**$5,417,000**

INDIAN HEALTH SERVICE
Health Education
Summary of Changes

FY 2016 Enacted	$18,255,000
Total estimated budget authority	18,255,000
Less Obligations	(18,255,000)
FY 2017 Estimate	19,545,000
Less Obligations	(19,545,000)
Net Change	1,290,000
Less Obligations	(1,290,000)

		FY 2016 Enacted Base		Change from Base	
		FTE	BA	Pos	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2016 CO Pay Raise (3months)	--	n/a	--	1,000
2	FY 2017 Pay Raise CO (9months)	--	n/a	--	4,000
3	Annualization of FY 2016 CS Pay Raise (3months)	--	n/a	--	9,000
4	FY 2017 Pay Raise CS (9months)	--	n/a	--	27,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	134,000
7	Increased Cost of Travel	--	45,000	--	1,000
8	Increased Cost of Transportation & Things	--	20,000	--	1,000
9	Increased Cost of Printing	--	7,000	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	4,000	--	0
11	Increased Cost of Health Care Provided under Contracts & Grants	--	538,000	--	13,000
12	Increased Cost of Supplies	--	704,000	--	16,000
13	Increased Cost of Medical or other Equipment	--	96,000	--	4,000
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	13,679,000	--	563,000
16	Increased Cost of Insurance / Indemnities	--	415,000	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	344,000
	Subtotal, Built-In	--	15,508,000	--	1,117,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	3	307,000
	TOTAL INCREASES	--	15,508,000	3	1,424,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(134,000)
	TOTAL DECREASES	--	0	--	(134,000)
NET CHANGE		--	**$15,508,000**	**3**	**$1,290,000**

INDIAN HEALTH SERVICE
Community Health Representatives
Summary of Changes

FY 2016 Enacted	$58,906,000
Total estimated budget authority	58,906,000
Less Obligations	(58,906,000)
FY 2017 Estimate	62,428,000
Less Obligations	(62,428,000)
Net Change	3,522,000
Less Obligations	(3,522,000)

		FY 2016 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2016 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2017 Pay Raise CO (9months)	--	n/a	--	1,000
3	Annualization of FY 2016 CS Pay Raise (3months)	--	n/a	--	1,000
4	FY 2017 Pay Raise CS (9months)	--	n/a	--	5,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	493,000
7	Increased Cost of Travel	--	12,000	--	1,000
8	Increased Cost of Transportation & Things	--	0	--	0
9	Increased Cost of Printing	--	1,000	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	0	--	0
11	Increased Cost of Health Care Provided under Contracts & Grants	--	437,000	--	14,000
12	Increased Cost of Supplies	--	242,000	--	0
13	Increased Cost of Medical or other Equipment	--	31,000	--	0
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	57,210,000	--	2,322,000
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	1,123,000
	Subtotal, Built-In	--	57,933,000	--	3,960,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	--	0
	TOTAL INCREASES	--	57,933,000	--	3,960,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(438,000)
	TOTAL DECREASES	--	0	--	(438,000)
NET CHANGE		--	**$57,933,000**	--	**$3,522,000**

INDIAN HEALTH SERVICE
Immunization AK
Summary of Changes

FY 2016 Enacted	$1,950,000
Total estimated budget authority	1,950,000
Less Obligations	(1,950,000)
FY 2017 Estimate	2,062,000
Less Obligations	(2,062,000)
Net Change	112,000
Less Obligations	(112,000)

		FY 2016 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2016 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2017 Pay Raise CO (9months)	--	n/a	--	0
3	Annualization of FY 2016 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2017 Pay Raise CS (9months)	--	n/a	--	0
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	17,000
7	Increased Cost of Travel	--	0	--	0
8	Increased Cost of Transportation & Things	--	0	--	0
9	Increased Cost of Printing	--	0	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	0	--	0
11	Increased Cost of Health Care Provided under Contracts & Grants	--	0	--	0
12	Increased Cost of Supplies	--	0	--	0
13	Increased Cost of Medical or other Equipment	--	0	--	0
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	1,950,000	--	74,000
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	--	1,950,000	--	126,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	--	0
	TOTAL INCREASES	--	1,950,000	--	126,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(14,000)
	TOTAL DECREASES	--	0	--	(14,000)
NET CHANGE		--	**$1,950,000**	--	**$112,000**

INDIAN HEALTH SERVICE
OTHER Services
Summary of Changes

FY 2016 Enacted	$173,598,000
Total estimated budget authority	173,598,000
Less Obligations	(173,598,000)
FY 2017 Estimate	175,447,000
Less Obligations	(175,447,000)
Net Change	1,849,000
Less Obligations	(1,849,000)

		FY 2016 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2016 CO Pay Raise (3months)	--	n/a	--	14,000
2	FY 2017 Pay Raise CO (9months)	--	n/a	--	41,000
3	Annualization of FY 2016 CS Pay Raise (3months)	--	n/a	--	121,000
4	FY 2017 Pay Raise CS (9months)	--	n/a	--	349,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	419,000
7	Increased Cost of Travel	--	3,468,000	--	25,000
8	Increased Cost of Transportation & Things	--	423,000	--	5,000
9	Increased Cost of Printing	--	45,000	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	1,176,000	--	9,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	33,200,000	--	337,000
12	Increased Cost of Supplies	--	2,619,000	--	17,000
13	Increased Cost of Medical or other Equipment	--	2,000,000	--	12,000
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	82,949,000	--	2,881,000
16	Increased Cost of Insurance / Indemnities	--	335,000	--	3,000
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	785,000
	Subtotal, Built-In	--	126,215,000	--	5,018,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	--	0
C. Program Increase		--	0	--	1,137,000
	TOTAL INCREASES	--	126,215,000	--	6,155,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(306,000)
B. Program Decreases		--	0	--	(4,000,000)
	TOTAL DECREASES	--	0	--	(4,306,000)
NET CHANGE		--	**$126,215,000**	--	**$1,849,000**

INDIAN HEALTH SERVICE
Urban Indian Health
Summary of Changes

FY 2016 Enacted	$44,741,000
Total estimated budget authority	44,741,000
Less Obligations	(44,741,000)
FY 2017 Estimate	48,157,000
Less Obligations	(48,157,000)
Net Change	3,416,000
Less Obligations	(3,416,000)

		FY 2016 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2016 CO Pay Raise (3months)	--	n/a	--	1,000
2	FY 2017 Pay Raise CO (9months)	--	n/a	--	3,000
3	Annualization of FY 2016 CS Pay Raise (3months)	--	n/a	--	4,000
4	FY 2017 Pay Raise CS (9months)	--	n/a	--	13,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	244,000
7	Increased Cost of Travel	--	69,000	--	2,000
8	Increased Cost of Transportation & Things	--	11,000	--	0
9	Increased Cost of Printing	--	0	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	25,000	--	1,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	10,865,000	--	180,000
12	Increased Cost of Supplies	--	418,000	--	6,000
13	Increased Cost of Medical or other Equipment	--	141,000	--	2,000
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	31,237,000	--	1,344,000
16	Increased Cost of Insurance / Indemnities	--	8,000	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	785,000
	Subtotal, Built-In	--	42,774,000	--	2,585,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	--	0
C. Urban Expansion		--	0	--	1,137,000
	TOTAL INCREASES	--	42,774,000	--	3,722,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(306,000)
	TOTAL DECREASES	--	0	--	(306,000)
NET CHANGE		--	**$42,774,000**	--	**$3,416,000**

INDIAN HEALTH SERVICE
Indian Health Professions
Summary of Changes

FY 2016 Enacted	$48,342,000
Total estimated budget authority	48,342,000
Less Obligations	(48,342,000)
FY 2017 Estimate	49,345,000
Less Obligations	(49,345,000)
Net Change	1,003,000
Less Obligations	(1,003,000)

		FY 2016 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2016 CO Pay Raise (3months)	--	n/a	--	1,000
2	FY 2017 Pay Raise CO (9months)	--	n/a	--	3,000
3	Annualization of FY 2016 CS Pay Raise (3months)	--	n/a	--	3,000
4	FY 2017 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	--	35,000	--	0
8	Increased Cost of Transportation & Things	--	0	--	1,000
9	Increased Cost of Printing	--	0	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	1,000	--	0
11	Increased Cost of Health Care Provided under Contracts & Grants	--	710,000	--	53,000
12	Increased Cost of Supplies	--	7,000	--	0
13	Increased Cost of Medical or other Equipment	--	2,000	--	0
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	45,580,000	--	931,000
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	--	46,335,000	--	1,003,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	--	0
	TOTAL INCREASES	--	46,335,000	--	1,003,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	0
	TOTAL DECREASES	--	0	--	0
NET CHANGE		--	**$46,335,000**	--	**$1,003,000**

INDIAN HEALTH SERVICE
Tribal Management
Summary of Changes

FY 2016 Enacted	$2,442,000
Total estimated budget authority	2,442,000
Less Obligations	(2,442,000)
FY 2017 Estimate	2,488,000
Less Obligations	(2,488,000)
Net Change	46,000
Less Obligations	(46,000)

		FY 2016 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2016 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2017 Pay Raise CO (9months)	--	n/a	--	0
3	Annualization of FY 2016 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2017 Pay Raise CS (9months)	--	n/a	--	0
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	0
7	Increased Cost of Travel	--	0	--	0
8	Increased Cost of Transportation & Things	--	0	--	0
9	Increased Cost of Printing	--	0	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	0	--	0
11	Increased Cost of Health Care Provided under Contracts & Grants	--	10,000	--	0
12	Increased Cost of Supplies	--	0	--	0
13	Increased Cost of Medical or other Equipment	--	0	--	0
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	2,432,000	--	46,000
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	--	2,442,000	--	46,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	--	0
	TOTAL INCREASES	--	2,442,000	--	46,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	0
	TOTAL DECREASES	--	0	--	0
NET CHANGE		--	**$2,442,000**	--	**$46,000**

INDIAN HEALTH SERVICE
Direct Operations
Summary of Changes

FY 2016 Enacted	$72,338,000
Total estimated budget authority	72,338,000
Less Obligations	(72,338,000)
FY 2017 Estimate	69,620,000
Less Obligations	(69,620,000)
Net Change	(2,718,000)
Less Obligations	2,718,000

		FY 2016 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2016 CO Pay Raise (3months)	--	n/a	--	12,000
2	FY 2017 Pay Raise CO (9months)	--	n/a	--	35,000
3	Annualization of FY 2016 CS Pay Raise (3months)	--	n/a	--	109,000
4	FY 2017 Pay Raise CS (9months)	--	n/a	--	310,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	175,000
7	Increased Cost of Travel	--	3,237,000	--	21,000
8	Increased Cost of Transportation & Things	--	410,000	--	4,000
9	Increased Cost of Printing	--	45,000	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	1,143,000	--	8,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	20,959,000	--	103,000
12	Increased Cost of Supplies	--	2,182,000	--	11,000
13	Increased Cost of Medical or other Equipment	--	1,851,000	--	10,000
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	581,000	--	481,000
16	Increased Cost of Insurance / Indemnities	--	327,000	--	3,000
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	0
	Subtotal, Built-In	--	30,735,000	--	1,282,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	--	0
	TOTAL INCREASES	--	30,735,000	--	1,282,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	0
B. Accreditation Emergencies & Tribal Clinics (Transfer to H&HC)		--	0	--	(4,000,000)
	TOTAL DECREASES	--	0	--	0
NET CHANGE		--	**$30,735,000**	--	**($2,718,000)**

INDIAN HEALTH SERVICE
Self-Governance
Summary of Changes

FY 2016 Enacted	$5,735,000
Total estimated budget authority	5,735,000
Less Obligations	(5,735,000)
FY 2017 Estimate	5,837,000
Less Obligations	(5,837,000)
Net Change	102,000
Less Obligations	(102,000)

		FY 2016 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2016 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2017 Pay Raise CO (9months)	--	n/a	--	0
3	Annualization of FY 2016 CS Pay Raise (3months)	--	n/a	--	5,000
4	FY 2017 Pay Raise CS (9months)	--	n/a	--	15,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	0
7	Increased Cost of Travel	--	127,000	--	2,000
8	Increased Cost of Transportation & Things	--	2,000	--	0
9	Increased Cost of Printing	--	0	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	7,000	--	0
11	Increased Cost of Health Care Provided under Contracts & Grants	--	656,000	--	1,000
12	Increased Cost of Supplies	--	12,000	--	0
13	Increased Cost of Medical or other Equipment	--	6,000	--	0
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	3,119,000	--	79,000
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	--	3,929,000	--	102,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	--	0
	TOTAL INCREASES	--	3,929,000	--	102,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	0
	TOTAL DECREASES	--	0	--	0
NET CHANGE		--	**$3,929,000**	--	**$102,000**

INDIAN HEALTH SERVICE
Contract Support Costs
Summary of Changes

FY 2016 Enacted	$717,970,000
Total estimated budget authority	717,970,000
Less Obligations	(717,970,000)
FY 2017 Estimate	800,000,000
Less Obligations	(800,000,000)
Net Change	82,030,000
Less Obligations	(82,030,000)

		FY 2016 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2016 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2017 Pay Raise CO (9months)	--	n/a	--	0
3	Annualization of FY 2016 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2017 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	--	717,970,000	--	82,030,000
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	--	717,970,000	--	82,030,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	--	0
C. Contract Support Costs		--	0	--	0
	TOTAL INCREASES	--	717,970,000	--	82,030,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	0
	TOTAL DECREASES	--	0	--	0
NET CHANGE		--	**$717,970,000**	--	**$82,030,000**

INDIAN HEALTH SERVICE

FACILITIES

Summary of Changes

FY 2016 Enacted	$523,232,000
Total budget authority	523,232,000
Less Obligations	(523,232,000)
FY 2017 Estimate	569,906,000
Less Obligations	(569,906,000)
Net Change	46,674,000
Less Obligations	(46,674,000)

		FY 2016 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2016 CO Pay Raise (3months)	--	n/a	--	109,000
2	FY 2017 Pay Raise CO (9months)	--	n/a	--	314,000
3	Annualization of FY 2016 CS Pay Raise (3months)	--	n/a	--	229,000
4	FY 2017 Pay Raise CS (9months)	--	n/a	--	661,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	1,127,000
7	Increased Cost of Travel	--	2,826,000	--	41,000
8	Increased Cost of Transportation & Things	--	3,354,000	--	81,000
9	Increased Cost of Printing	--	56,000	--	1,000
10	Increased Cost of Rents, Communications, & Utilities	--	16,696,000	--	355,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	122,478,000	--	3,293,000
12	Increased Cost of Supplies	--	6,731,000	--	137,000
13	Increased Cost of Medical or other Equipment	--	23,182,000	--	333,000
14	Increased Cost of Land & Structure	--	89,099,000	--	3,934,000
15	Increased Cost of Grants	--	161,362,000	--	3,711,000
16	Increased Cost of Insurance / Indemnities	--	2,000	--	1,000
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Increased Cost of Service & Supply Fund	--	0	--	0
19	Population Growth	--	n/a	--	8,184,000
	Subtotal, Built-In	--	425,786,000	--	22,511,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	17	3,395,000
C. Program Increases		--	0	--	23,960,000
	TOTAL INCREASES	--	425,786,000		49,866,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(3,192,000)
	TOTAL DECREASES	--	0	--	(3,192,000)
NET CHANGE		**--**	**$425,786,000**	**17**	**$46,674,000**

INDIAN HEALTH SERVICE
Maintenance & Improvement
Summary of Changes

FY 2016 Enacted	$73,614,000
Total budget authority	73,614,000
Less Obligations	(73,614,000)
FY 2017 Estimate	76,981,000
Less Obligations	(76,981,000)
Net Change	3,367,000
Less Obligations	(3,367,000)

		FY 2016 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2016 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2017 Pay Raise CO (9months)	--	n/a	--	0
3	Annualization of FY 2016 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2017 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	--	37,000	--	1,000
8	Increased Cost of Transportation & Things	--	19,000	--	1,000
9	Increased Cost of Printing	--	1,000	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	9,000	--	4,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	35,076,000	--	1,110,000
12	Increased Cost of Supplies	--	3,224,000	--	65,000
13	Increased Cost of Medical or other Equipment	--	332,000	--	6,000
14	Increased Cost of Land & Structure	--	2,940,000	--	76,000
15	Increased Cost of Grants	--	31,976,000	--	609,000
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Increased Cost of Service & Supply Fund	--	0	--	0
19	Population Growth	--	0	--	1,604,000
	Subtotal, Built-In	--	73,614,000	--	3,476,000
B.	Maintenance & Improvement Increase	--	0	--	517,000
	TOTAL INCREASES	--	73,614,000	--	3,993,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(626,000)
	TOTAL DECREASES	--	0	--	(626,000)
NET CHANGE		--	**$73,614,000**	--	**$3,367,000**

INDIAN HEALTH SERVICE
Sanitation Facilities Construction
Summary of Changes

FY 2016 Enacted	$99,423,000
Total budget authority	99,423,000
Less Obligations	(99,423,000)
FY 2017 Estimate	103,036,000
Less Obligations	(103,036,000)
Net Change	3,613,000
Less Obligations	(3,613,000)

		FY 2016 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2016 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2017 Pay Raise CO (9months)	--	n/a	--	0
3	Annualization of FY 2016 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2017 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	--	65,000	--	1,000
8	Increased Cost of Transportation & Things	--	633,000	--	12,000
9	Increased Cost of Printing	--	0	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	140,000	--	1,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	72,405,000	--	1,881,000
12	Increased Cost of Supplies	--	247,000	--	6,000
13	Increased Cost of Medical or other Equipment	--	52,000	--	1,000
14	Increased Cost of Land & Structure	--	544,000	--	1,000
15	Increased Cost of Grants	--	21,380,000	--	446,000
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	--	2,072,000
	Subtotal, Built-In	--	95,466,000	--	4,421,000
B. Sanitation Increase		--	0	--	0
	TOTAL INCREASES	--	95,466,000	--	4,421,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(808,000)
	TOTAL DECREASES	--	0	--	(808,000)
NET CHANGE		--	**$95,466,000**	--	**$3,613,000**

INDIAN HEALTH SERVICE
Health Care Facilities Construction
Summary of Changes

FY 2016 Enacted	$105,048,000
Total budget authority	105,048,000
Less Obligations	(105,048,000)
FY 2017 Estimate	132,377,000
Less Obligations	(132,377,000)
Net Change	27,329,000
Less Obligations	(27,329,000)

		FY 2016 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2016 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2017 Pay Raise CO (9months)	--	n/a	--	0
3	Annualization of FY 2016 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2017 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	--	167,000	--	4,000
12	Increased Cost of Supplies	--	0	--	0
13	Increased Cost of Medical or other Equipment	--	14,256,000	--	0
14	Increased Cost of Land & Structure	--	84,720,000	--	3,856,000
15	Increased Cost of Grants	--	5,905,000	--	26,000
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	--	105,048,000	--	3,886,000
B. HCFC Increase		--	0	--	23,443,000
	TOTAL INCREASES	--	105,048,000	--	27,329,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	0
	TOTAL DECREASES	--	0	--	0
NET CHANGE		--	**$105,048,000**	--	**$27,329,000**

INDIAN HEALTH SERVICE
Facilities & Environmental Health Support
Summary of Changes

FY 2016 Enacted	$222,610,000
Total budget authority	222,610,000
Less Obligations	(222,610,000)
FY 2017 Estimate	233,858,000
Less Obligations	(233,858,000)
Net Change	11,248,000
Less Obligations	(11,248,000)

		FY 2016 Enacted Base		Change from Base	
		FTE	BA	FTE/Pos	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2016 CO Pay Raise (3months)	--	n/a	--	109,000
2	FY 2017 Pay Raise CO (9months)	--	n/a	--	314,000
3	Annualization of FY 2016 CS Pay Raise (3months)	--	n/a	--	229,000
4	FY 2017 Pay Raise CS (9months)	--	n/a	--	661,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	1,127,000
7	Increased Cost of Travel	--	2,719,000	--	39,000
8	Increased Cost of Transportation & Things	--	2,574,000	--	64,000
9	Increased Cost of Printing	--	55,000	--	1,000
10	Increased Cost of Rents, Communications, & Utilities	--	16,459,000	--	347,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	13,726,000	--	274,000
12	Increased Cost of Supplies	--	3,133,000	--	64,000
13	Increased Cost of Medical or other Equipment	--	2,407,000	--	55,000
14	Increased Cost of Land & Structure	--	893,000	--	1,000
15	Increased Cost of Grants	--	87,153,000	--	2,076,000
16	Increased Cost of Insurance / Indemnities	--	2,000	--	1,000
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Increased Cost of Service & Supply Fund	--	0	--	0
19	Population Growth	--	n/a	--	4,084,000
	Subtotal, Built-In	--	129,121,000	--	9,446,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	17	3,395,000
	TOTAL INCREASES	--	129,121,000	--	12,841,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(1,593,000)
	TOTAL DECREASES	--	0	--	(1,593,000)
NET CHANGE		**--**	**$129,121,000**	**17**	**$11,248,000**

INDIAN HEALTH SERVICE
Equipment
Summary of Changes

FY 2016 Enacted	$22,537,000
Total budget authority	22,537,000
Less Obligations	(22,537,000)
FY 2017 Estimate	23,654,000
Less Obligations	(23,654,000)
Net Change	1,117,000
Less Obligations	(1,117,000)

		FY 2016 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2016 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2017 Pay Raise CO (9months)	--	n/a	--	0
3	Annualization of FY 2016 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2017 Pay Raise CS (9months)	--	n/a	--	0
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	0
7	Increased Cost of Travel	--	5,000	--	0
8	Increased Cost of Transportation & Things	--	128,000	--	4,000
9	Increased Cost of Printing	--	0	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	88,000	--	3,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	1,104,000	--	24,000
12	Increased Cost of Supplies	--	127,000	--	2,000
13	Increased Cost of Medical or other Equipment	--	6,135,000	--	271,000
14	Increased Cost of Land & Structure	--	2,000	--	0
15	Increased Cost of Grants	--	14,948,000	--	554,000
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Increased Cost of Service & Supply Fund	--	0	--	0
19	Population Growth	--	0	--	424,000
	Subtotal, Built-In	--	22,537,000	--	1,282,000
	TOTAL INCREASES	--	22,537,000	--	1,282,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(165,000)
	TOTAL DECREASES	--	0	--	(165,000)
NET CHANGE		--	**$22,537,000**	--	**$1,117,000**

INDIAN HEALTH SERVICE
Budget Authority by Activity

(Dollars in Thousands)

	2015 Final		2016 Enacted		2017 President's Budget	
	FTE	Amount	FTE	Amount	FTE	Amount
SERVICES:						
Hospitals & Health Clinics	6,094	$1,836,789	6,099	$1,857,225	6,100	$1,979,998
Dental Services	585	173,982	585	178,286	586	186,829
Mental Health	197	81,145	197	82,100	198	111,143
Alcohol & Substance Abuse	191	190,981	201	205,305	206	233,286
Contract Health Services	0	914,139	0	914,139	0	962,331
Total, Clinical Services	7,067	3,197,036	7,082	3,237,055	7,090	3,473,587
Public Health Nursing	202	75,640	202	76,623	202	82,040
Health Education	21	18,026	21	18,255	21	19,545
Comm. Health Reps.	5	58,469	5	58,906	5	62,428
Immunization AK	0	1,826	0	1,950	0	2,062
Total, Preventive Health	228	153,961	228	155,734	228	166,075
Urban Health	5	43,604	5	44,741	6	48,157
Indian Health Professions	22	48,342	22	48,342	23	49,345
Tribal Management	0	2,442	0	2,442	0	2,488
Direct Operations	261	68,065	261	72,338	264	69,620
Self-Governance	13	5,727	13	5,735	15	5,837
Total, Other services	301	168,180	301	173,598	308	175,447
Total, Services	7,596	3,519,177	7,611	3,566,387	7,626	3,815,109
CONTRACT SUPPORT COSTS	0	662,970	0	717,970	0	800,000
FACILITIES:						
Maintenance & Improvement	0	53,614	0	73,614	0	76,981
Sanitation Facilities Constr.	175	79,423	175	99,423	175	103,036
Health Care Facs. Constr.	0	85,048	0	105,048	0	132,377
Facil. & Envir. Health Supp.	1,088	219,612	1,089	222,610	1,090	233,858
Equipment	0	22,537	0	22,537	0	23,654
Total, Facilities	1,263	460,234	1,264	523,232	1,265	569,906
Total IHS	8,859	$4,642,381	8,875	$4,807,589	8,891	$5,185,015

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

Indian Health Service

Authorizing Legislation

(Dollars in Thousands)

January 12, 2016

	FY 2015		FY 2016		FY 2017	
	Amount Authorized	Enacted	Amount Authorized	Enacted	Amount Authorized	Budget Request
1. Services Appropriation: Snyder Act, 25 U.S.C. 13. Transfer Act (P.L. 83-568), 42 U.S.C. 2001. Indian Health Care Improvement Act (IHCIA) (P.L. 94-437), as amended (most recently amended by the Patient Protection and Affordable Care Act (ACA) (P.L. 111-148), § 10221, 124 Stat. 119, 935 (2010)), 25 U.S.C. 1601 *et seq.* Indian Self Determination and Education Assistance Act (P.L. 93-638), as amended, 25 U.S.C. 450 *et seq.* Public Health Service Act, titles II & III, as amended, 25 U.S.C. 201-280m.	3,519,177	3,519,177	3,566,387	3,566,387	3,815,109	3,815,109
2. Contract Support Costs Appropriation: Indian Self Determination and Education Assistance Act (P.L. 93-638), as amended, 25 U.S.C. 450 *et seq.*	662,970	662,970	717,970	717,970	800,000	800,000
3. Facilities Appropriation: Indian Sanitation Facilities Act (P.L. 86-121), as amended, 42 U.S.C. 2004a. IHCIA, title III, as amended, 25 U.S.C. 1631-1638g. ISDEAA, sec. 102 & 509, as amended, 25 U.S.C. 450f & 458aaa-8. 5 U.S.C. 5911 note (Quarters Rent Funds).	460,234 8,000	460,234 8,000	523,232 8,500	523,232 8,500	569,906 8,500	569,906 8,500
4. Public and Private Collections: IHCIA sec. 206, 25 U.S.C. 1621e. Social Security Act, sec. 1880 & 1911, 42 U.S.C. 1395qq & 1396j.	1,150,695	1,150,695	1,193,577	1,193,577	1,193,577	1,193,577
5. Special Diabetes Program for Indians: 42 U.S.C. 245c-3.	150,000	150,000	150,000	150,000	150,000	150,000
Unfunded authorizations:	0	0	0	0	0	0
Total appropriations:	5,951,076	5,951,076	6,159,666	6,159,666	6,537,092	6,537,092
Total appropriations against Definite authorizations:	5,951,076	5,951,076	6,159,666	6,159,666	6,537,092	6,537,092

INDIAN HEALTH SERVICE
Appropriation History Table
Services

January 12, 2016

	Budget Request to Congress	House Allowance	Senate Allowance	Appropriation
2005	$2,612,824,000	$2,627,918,000	$2,633,624,000	$2,632,667,000
Rescission (PL 108-447, Sec. 501)				($15,638,000)
Rescission (PL 108-447, Sec. 122)				($20,936,000)
2006	$2,732,298,000	$2,732,298,000	$2,732,323,000	$2,732,298,000
Rescission (PL 109-54)				($13,006,000)
Rescission (PL 109-148)				($27,192,000)
2007	$2,822,449,000	$2,830,085,000	$2,835,493,000	$2,818,871,000
2008	$2,931,530,000	$3,023,532,000	$2,991,924,000	$3,018,624,000
Rescission (PL 110-161)				($47,091,000)
2009 Omnibus	$2,971,533,000	-	-	$3,190,956,000
2009 ARRA (PL 111-5)	-	-	-	$85,000,000
2010	$3,639,868,000	$3,657,618,000	$3,639,868,000	$3,657,618,000
2011	$3,657,618,000	-	-	$3,672,618,000
Rescission (PL 112-10)				($7,345,000)
2012	$4,166,139,000	$4,034,322,000	-	$3,872,377,000
Recission (PL 112-74)				($6,195,804)
2013	$3,978,974,000	-	$ 3,914,599,000	$3,914,599,000
Sequestration				($194,492,111)
Rescission				($7,829,198)
2014 Omnibus (PL 113-64)	$3,982,498,000	-	-	$3,982,842,000
2015 Omnibus (PL 113-235)	$4,172,182,000	$4,180,557,000	-	$4,182,147,000
2016 Omnibus (PL 114-39)	$3,745,290,000	$3,603,569,000	$3,539,523,000	$3,566,387,000
2017 President's Budget	$3,815,109,000	-	-	-

INDIAN HEALTH SERVICE
Appropriation History Table
Contract Support Costs

January 12, 2016

	Budget Request to Congress	House Allowance	Senate Allowance	Appropriation
2016 Omnibus (PL 114-39)	$717,970,000	$717,970,000	$717,970,000	$717,970,000
2017 President's Budget	$800,000,000	-	-	-

INDIAN HEALTH SERVICE
Appropriation History Table
Facilities

January 12, 2016

	Budget Request to Congress	House Allowance	Senate Allowance	Appropriation
2005	$354,448,000	$405,453,000	$364,148,000	$394,453,000
Rescission (PL 108-447, Sec. 501)				($2,343,000)
Rescission (PL 108-447, Sec. 122)				($3,137,000)
2006	$315,668,000	$370,774,000	$335,643,000	$358,485,000
Rescission (PL 109-54)				($1,706,000)
Rescission (PL 109-148)				($3,569,000)
2007	$347,287,000	$363,573,000	$357,287,000	$361,226,000
2008	$339,196,000	$360,895,000	$375,475,000	$380,583,000
Rescission (PL 110-161)				($5,937,000)
2009 Omnibus	$353,329,000	-	-	$390,168,000
2009 ARRA (PL 111-5)	-	-	-	$415,000,000
2010	$394,757,000	$394,757,000	$394,757,000	$394,757,000
2011	$394,757,000	-	-	$404,757,000
Rescission (PL 112-10)				($810,000)
2012	$457,669,000	$427,259,000	-	$441,052,000
Rescission (PL 112-74)				($705,683)
2013	$443,502,000	-	$ 441,605,000	$441,605,000
Sequestration				($22,152,062)
Rescission				($883,210)
2014 Omnibus (PL 113-64)	$448,139,000	-	-	$451,673,000
2015 Omnibus (PL 113-235)	$461,995,000	$461,995,000	-	$460,234,000
2016 Omnibus (PL 114-39)	$639,725,000	$466,329,000	$521,818,000	$523,232,000
2017 President's Budget	$569,906,000	-	-	-

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

(Dollars in Thousands)

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$3,197,036	$3,237,055	$3,473,587	+$236,532
FTE*	7,067	7,082	7,090	+8

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

SUMMARY OF THE BUDGET REQUEST

The FY 2017 budget request for Clinical Services of $3.473 billion is $236.532 million above the FY 2016 Enacted level. The detailed explanation of the request is described in each of the budget narratives that follow.

- An increase of $122.773 million for a total of $1.979 billion for **Hospitals and Health Clinics** provides essential personal health services and community based disease prevention and health promotion services. Health services include: inpatient care, routine and emergency ambulatory care; and medical support services including laboratory, pharmacy, nutrition, diagnostic imaging, medical records, physical therapy, and other services. Specialized programs are conducted to address: diabetes; maternal and child health; youth services; communicable diseases including HIV/AIDS, tuberculosis, and hepatitis; women's and men's health; geriatric health; disease surveillance; and healthcare quality improvement.

- An increase of $8.543 million for a total of $186.829 million for **Dental Health** to provide preventive care, basic care, and emergency care, with approximately 90 percent of services covering basic and emergency care. Basic services are prioritized over more complex rehabilitative care such as root canals, crown and bridge, dentures, and surgical extractions. The demand for dental treatment remains high due to the high dental caries rate in AI/AN children; however, a continuing emphasis on community oral health promotion/disease prevention is essential to impact long-term improvement of the oral health of AI/AN people.

- An increase of $29.043 million for a total of $111.143 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.

- An increase of $27.981 million for a total of $233.286 million for **Alcohol and Substance Abuse** to provide overall program support. The program exists as part of an integrated behavioral health approach to collaboratively reduce the incidence of alcoholism and other drug dependencies in AI/AN communities.

- An increase of $48.192 million for a total of $962.331 million for **Purchased/Referred Care** to purchase essential health care services not available in IHS and Tribal healthcare facilities including inpatient and outpatient care, routine emergency ambulatory care, transportation, and medical support services (e.g., laboratory, pharmacy, nutrition, diagnostic imaging, physical therapy, etc.). The demand for PRC remains high as the cost of medical care increases. The PRC Program continues to emphasize adherence to medical priorities,

enrolling patients in alternate resources available to them (such as Medicare, Medicaid and private insurance), negotiating discounted rates with medical providers, and implementing improvements recommended by Tribes and oversight authorities.

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

Performance Summary Table

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

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
28 Unintentional Injury Rates: Age-Adjusted Unintentional injuries mortality rate in AI/AN population (Outcome)	FY 2008: 94.5 (Target Not In Place)	94.5	TBD	N/A
31 Childhood Weight Control: Proportion of children, ages 2-5 years, with a BMI of 95 percent or higher. IHS - All (Outcome)	FY 2015: 21.8% (Target Not In Place)	22.8%	N/A	N/A

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

HOSPITALS AND HEALTH CLINICS

(Dollars in Thousands)

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$1,836,789	$1,857,225	$1,979,998	+$122,773
FTE*	6,094	6,099	6,100	+1

* 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

FY 2017 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 approximatly 2.2 million American Indians and Alaska Natives (AI/AN). The Indian Health Service (IHS) provides 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. The IHS and Tribes primarily serve small, rural populations with primary medical care and community-health services, relying on the private sector for much of the secondary and most of the tertiary medical care needs. Some IHS and Tribal hospitals provide secondary medical services such as ophthalmology, orthopedics, infectious disease, emergency medicine, radiology, general and gynecological surgery, and anesthesia.

The IHS system of care is unique in that personal health care services are integrated with community health services. The program includes public/community health programs targeting health conditions disproportionately affecting AI/ANs such as diabetes, maternal and child health, and communicable diseases including influenza, HIV/AIDS, and hepatitis. Although the health status of AI/ANs has improved significantly in the past 60 years since the inception of the IHS, the average life expectancy at birth is 73.7 years (data years 2007-2009) compared to the U.S. all races life expectancy of 78.1 years [1].

More than 60 percent of the H&HC budget is transferred under P.L. 93-638 contracts or compacts to Tribal governments or Tribal organizations that: design and manage the delivery of individual and community health services through 18 hospitals, 284 health centers, 79 health stations, and 163 Alaska village clinics; and coordinate care purchased from private providers. The remainder of the H&HC budget is managed by direct federal programs that provide health care at the Service Unit (SU) and community level. The federal system consists of 27 hospitals, 59 health centers, and 32 health stations.

[1] *Life Expectancy: American Indians and Alaska Natives, Data Years 2007-2009*. Indian Health Service Division of Program Statistics, Indian Health Service, United States Department of Health and Human Services, (Advance Data).

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 supports personal health services (including the Electronic Health Record and telemedicine) and public health initiatives that are primarily funded through the H&HC budget.

The services funded under H&HC align and integrate with the Department of Health and Human Services (HHS) FY 2014 – 2018 Strategic Plan goals and objectives including: 1B, Improve health care quality and patient safety (i.e., Improving Patient Care Program 2.0); 1E, Ensure access to quality, culturally competent care, including long-term services and supports, for vulnerable populations (i.e., HIV Program, Public Health Nursing); 3D, Promote prevention and wellness across the lifespan (i.e., Baby Friendly Hospital Initiative, Elder Care Program); and 3E, Reduce the occurrence of infectious diseases (i.e., Tribal Epidemiology Centers, childhood immunizations). These services are deployed in accordance with strategic planning, are data driven, and support program integrity through adherence to rigorous reporting requirements that align with HHS measures and HHS Arc #4, Keeping People Healthy and Safe: Ensure optimal health is achievable by everyone in this country by having a health care system that keeps people healthy and promoting prevention and wellness that is not delivered strictly through the health care system.

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 (IPC) Program 2.0 - The aim of IPC 2.0 (launched in FY 2015) is to transform the Indian health system through discovering, learning and applying quality improvement processes and the Patient Centered Medical Home (PCMH) model of care to continuously improve the health and wellness of AI/ANs. A regional model of collaborative learning to develop proficiency with the Model for Improvement will support a transition to a system-wide network focusing on development of the PCMH elements. Data management and analysis will drive improvements. Success will be measured in FY 2016 and beyond by achievement of clinical and process industry-benchmarks, as well as ultimate recognition or certification of participating sites as PCMHs. Participating teams report on clinical outcome measures aligned with the Government Performance and Results Act (GPRA) measures and some additional clinical process measures.

The IPC-facilitated learning strategies improve processes such as patient empanelment, diabetic retinal screening, depression screening and physical activity screening. Empanelment of patients supports population health management and continuity with the team and provider. Diabetic Retinal Screening helps to prevent one of the leading cause of blindness for AI/AN patients. Depression screening improves behavioral health integration through early identification and treatment of depression in the primary care setting. And physical activity screening identifies those patients at risk for obesity and metabolic disorders (i.e., Diabetes Mellitus Type 2). IPC program participant data is incorporated in the Agency's national reporting of GPRA measures including: Blood Pressure, LDL Cholesterol, Hemoglobin A1C, Body Mass Index (BMI), breastfeeding, depression screening, domestic violence, and tobacco cessation. For FY 2016, the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey is being considered to replace the current IHS Patient Satisfaction survey as a proven tool in AI/AN communities.

Nursing – Nursing represents the largest category of health care providers in the Indian health system and has a major impact on patient safety and health care outcomes. According to the 2015 IHS Nurse Position Report, there are 2,484 RNs and 427 Licensed Practical Nurses (LPNs)

employed with the I/T/U programs. The FY 2015 IHS Nurse Position Report identified a RN/Advanced Practice Nurse (APN) vacancy rate of 18 percent and a LPN vacancy rate of 11 percent. Nurses are actively engaged in the transformation of the health care system by placing more emphasis on prevention, wellness, and coordination of care.

IHS nurses are instrumental in promoting and sustaining 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.[2] Nationally, fewer than 10 percent of all U.S. hospitals are Baby-Friendly designated. The IHS adopted Baby-Friendly as the official standard of care for AI/AN mothers and babies in 2011. IHS received 100 percent Baby Friendly designation of all its obstetric care hospitals in 2014. With the transition from achieving designation to sustaining Baby Friendly practices in IHS, management of the BFHI has been transferred to the IPC Program in FY 2016. The program goals will be enhancing team-based care, self-management support, and integration with primary care services. IHS is committed to maintaining Baby Friendly practices and designation into FY 2017 and beyond.

Trauma Care – Trauma is the leading cause of death and disability among the AI/AN population under age 45, and AI/AN trauma death rates are three times higher than U.S. all races rates.[3] Local IHS hospitals are frequently the nearest emergency medical facility that can receive patients with traumatic injuries from emergency medical services providers (Paramedics, EMTs). Of the 27 IHS emergency departments (EDs) 74 percent are more than 50 miles from the nearest designated trauma center at any level and 52 percent are more than 100 miles. In 2014, the 27 IHS emergency departments had 373,309 patient visits. Recruitment and retention of competent and proficient staff for EDs at certain facilities has posed a significant challenge to continuity of emergency services in FY 2015 and FY 2016. A coordinated effort to address this challenge across all levels of the agency in FY 2016 is aimed at improving recruitment and retention activities.

Trauma Center designation is determined by state and local municipalities based on unique criteria such as: trauma readiness, resources available, policies, patient care, and performance improvement. Currently, out of 25 IHS hospitals with an ED, only one is designated a Level III (provides prompt assessment, resuscitation, surgery, intensive care, and stabilization of injured patients and emergency operations) and one other is designated a Level IV (provides evaluation, stabilization, and diagnostics for injured patients prior to the transfer of the patient to a higher Level Trauma Center).

Adequate staffing levels and capabilities, as well as state of the art equipment, are essential for quality care. Emergency medicine physicians, RNs, APNs, and other highly trained staff are essential for crisis and disaster management to improve patient outcomes. For RNs from rural IHS emergency departments and critical care areas, the IHS Capstone program develops critical thinking skills, competence and confidence as trauma nurses in the emergency department setting. This program includes population specific services, pediatric emergency services, and geriatric trauma. In 2015, the IHS Capstone program trained three nurses.

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

[3] U.S. Department of Health and Human Services, Indian Health Service, Trends in Indian Health 2014 Edition (Released March 2015), ISSN 1095-2896

HIV/AIDS Program – HIV is a significant public health concern for AI/AN people. Compared to other groups, AI/AN people ranked fifth in estimated new HIV infection diagnoses in 2013[4]. In 2010, the proportion of AI/AN persons surviving more than 36 months following diagnosis of an HIV infection was 88%,[5] the lowest rate among all racial groups. The HIV/AIDS Program goal is to ensure access to quality health services for AI/ANs living with HIV/AIDS and those at risk of contracting HIV and commonly co-occurring infections. The IHS has shown recent improvements in screening and HIV/AIDS care. As of FY 2015, 100 percent of IHS sites have served patients living with an HIV diagnosis. To improve access to care in remote areas, IHS has provided technical support to sites on screening and treatment, and extended the use of tele-health. IHS hosts a monthly secure webinar clinic for IHS HIV/AIDS-care providers in partnership with the University of New Mexico.

Hepatitis C virus (HCV) infections can result in illness varying in severity from mild, lasting a few weeks, to serious, a lifelong illness. The likelihood of liver damage is related to the duration and severity of untreated infection. New treatment medications that became available in FY 2015 are more effective than in the past, but are much more expensive. In the general U.S. population, people born from 1945-1965 ("Baby Boomers") have recently been identified to be at risk of infection with Hepatitis C. The Centers for Disease Control and Prevention (CDC) and the U.S. Preventive Services Task Force recommend a one-time HCV screening of all Baby Boomers in the United States. In addition to the Baby Boomer population, CDC estimates that the highest rate of acute infections in the United States is among AI/ANs. The latest Clinical Reporting System (2015) HCV screening results of federal sites show that IHS has screened 37% of its active-user Baby-Boomers. Among sites that have over a 50% screening rate (n=11), the seropositivity rate is 8% of all persons screened, although this rate ranges from a low of 2% to a high of 12%. IHS anticipates higher costs associated with HCV care in FY 2016 and 2017 associated with the increased rate of diagnosis (based on increased screening of Baby-Boomers) and the substantially higher cost of newer, curative medications.

Domestic Violence Prevention Program (DVPP) – Domestic and intimate partner violence has a disproportionately large impact on AI/AN communities. According to the CDC, 45.9 percent of AI/AN woman have experienced intimate partner violence – the highest rate of any race or ethnicity in the U.S.[6] In addition, one out of every three AI/AN women will be sexually assaulted in her lifetime,[7] 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.[8] Intimate partner violence and sexual assault have also 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, including an increased likelihood to smoke cigarettes, drink alcohol, use drugs, and engage in risky sexual behaviors.[9]

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[4] http://www.cdc.gov/hiv/group/racialethnic/aian/index.html for more.
[5] http://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-report-us.pdf

[6] *National Intimate Partner and Sexual Violence Survey. 2010.* Centers for Disease Control and Prevention. Available at, http://www.cdc.gov/violenceprevention/pdf/nisvs_report2010-a.pdf
[7] *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).
[8] *American Indians and Crime, 1992-96 Report*. Bureau of Justice Statistics, Office of Justice Programs, US Department of Justice.
[9] *Ibid*.

DVPP (formerly known as the Domestic Violence Prevention Initiative - DVPI) is a nationally-coordinated program that provides culturally appropriate domestic violence and sexual assault prevention and intervention resources to AI/AN communities. In August 2015, the demonstration phase ended. A new five-year funding cycle began in September 2015, with the award of 56 projects (which included 47 grants and 9 direct transfers to Federal sites). The new DVPP focuses on domestic and sexual violence prevention, advocacy, and coordinated community responses, as well as providing forensic healthcare services to victims of domestic and sexual violence.

DVPP projects adhere to reporting requirements established by IHS and report on data and program measures designed to help determine the most effective means for combating these issues in Tribal communities. A national evaluation of DVPP is anticipated to be completed following the demonstration phase that concluded in August 2015 and will allow identification of successful evidence-based and practice-based programs that can be replicated across the Indian health system. DVPP budget measures, H&HC-1, H&HC-2, and H&HC-3 will be retired after the FY 2015 reporting cycle. In FY 2017, the new DVPP projects will begin their third year of funding.

In the first five years of implementation (August 1, 2010 – August 31, 2015), DVPP resulted in over 78,500 direct service encounters including crisis intervention, victim advocacy, case management, and counseling services. More than 45,000 referrals were made for domestic violence services, culturally-based services, and clinical behavioral health services. In addition, a total of 688 forensic evidence collection kits were submitted to Federal, State, and Tribal law enforcement. The year five DVPP data is preliminary as all projects have not yet completed reporting. Final results are expected in February 2016.

FUNDING HISTORY

Fiscal Year	Amount	DVPI
2012 Enacted	$1,810,966,000	($9,440,870)
2013 Enacted	$1,749,072,000	($8,967,278)
2014 Final	$1,773,931,000	($8,967,278)
2015 Final	$1,836,789,000	($8,967,278)
2016 Enacted	$1,857,225,000	($8,967,278)

BUDGET REQUEST

The FY 2017 budget request for Hospitals and Health Clinics of $1,979,998,000 is $122,773,000 above the FY 2016 Enacted level.

FY 2016 Base Funding of $1,857,225,000 - supports the largest portion of clinical care at IHS and Tribal health facilities, including salaries and benefits for 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, an amount of H&HC funding that initially is allocated to Headquarters each year is reallocated on a non-recurring basis to Areas during the fiscal year and supports national activities. Also included in the base is funding to provide technical assistance to IHS facilities to promote efficient, effective, high quality care to the AI/AN population. IHS will target IHS facilities at risk or in jeopardy of not fully meeting accreditation standards. The IHS will establish a quality system that aligns with the Centers for Medicare and Medicaid Services regulations and recommendations for quality health care from the Agency for Healthcare Research and Quality. IHS will develop and disseminate tools to equip IHS facilities to identify and remediate quality of

care issues that may jeopardize accreditation of IHS facilities and improve the health of the AI/AN population. This funding level also includes $2 million for Accreditation Emergencies, which was first appropriated in the FY 2016 bill, because these activities are directly related to Hospitals and Health Clinics.

FY 2017 Funding Increase of $122,773,000 includes:

- Pay Costs +$16,798,000 – to fund pay increases for federal and Tribal employees, of whom approximately 90 percent are working at the service unit level providing health care and related services.

- Inflation +$25,636,000 – to fund inflationary costs of providing health care services.

- Population Growth +$21,261,000 – to fund the additional service needs arising from the growing AI/AN population. The growth rate is projected to be 1.8 percent in CY 2017 based on state births and deaths data.

- Staffing/Operating Cost Requirements for Newly Constructed Facilities +$20,078,000 – to fund four new and expanded healthcare facilities that are planned to open in FY 2017. Funding for these four facilities allows IHS to expand provision of health care in those areas where capacity has been expanded to address critical health care needs.

New Facilities	Amount	FTE/Tribal Positions
Kayenta Health Center, Kayenta, AZ	$182,000	1
Muskogee (Creek) Nation Health Center (JV), Eufaula, OK	$6,444,000	59
Flandreau Health Center (JV), Flandreau, SD	$4,330,000	40
Choctaw Nation Regional Medical Center (JV), Durant, OK	$9,122,000	73
Grand Total:	**$20,078,000**	**173**

Program Increases +$39,000,000

- Health Information Technology (HIT) +$20,000,000 - for improving the delivery of healthcare and the security of patient data through enhancement and modernization of the IHS Resource and Patient Management System (RPMS). Increased funding for development, operations, and maintenance of capabilities for the Electronic Health Record and supporting technologies will meet the Office of the National Coordinator for Health Information Technology 2015 Certification and the requirements of Meaningful Use, Stage 3. Please see separate HIT narrative for detail.

- Domestic Violence Prevention Program (DVPP) +$4,000,000 - for program expansion to fund approximately 30 additional IHS, Tribal, and Urban Indian organizations. Domestic violence, per the CDC, has been experienced by 45.9 percent of AI/AN women – the highest rate of any race or ethnicity in the U.S.[10] In addition, one out of every three AI/AN women will be sexually assaulted in her lifetime,[11] and AI/AN victims of intimate and family

[10] *National Intimate Partner and Sexual Violence Survey, 2010.* Centers for Disease Control and Prevention. Available at http://www.cdc.gov/violenceprevention/pdf/nisvs_report2010-a.pdf

[11] *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).

violence are more likely than victims of all other races to be injured and need hospital care.[12] In addition, domestic violence and sexual assault have been correlated with an increase in high-risk health behaviors, including an increased likeliness to smoke cigarettes, drink alcohol, use drugs, and engage in risky sexual behaviors.[13] DVPP is a nationally-coordinated initiative established in 2010 that provides culturally appropriate domestic violence and sexual assault prevention and intervention resources to AI/AN communities. DVPP 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 domestic and sexual violence (DSV) in Tribal and Urban Indian communities.

- IHS Quality Consortium for Federal Hospitals (QC) +$2,000,000 - for the coordination of quality improvement activities among the 27 IHS Hospitals and Critical Access Hospitals to reduce Hospital Acquired Conditions and Avoidable Readmissions, while also developing standardized processes and procedures for inpatient care. In 2014, performance showed at least two hospitals with statistically significant reduction in those Hospital Acquired Conditions they could measure, and one hospital with a statistically significant reduction in Avoidable Readmissions. Adoption of evidence-based best practices and development of a culture of safety in the inpatient setting will be supported by improvement work based on the Model for Improvement. Activities of the QC will be directed by an Executive Council composed of Area Directors and clinical leaders supported by the Office of Clinical and Preventive Services (OCPS) at IHS Headquarters. Additional QC staff in OCPS will support data analytics of patient safety reporting and quality improvement results.

- Tribal Clinic Lease, Operations & Maintenance +$9,000,000 – to fund Tribal clinic leases and maintenance costs, specifically where Tribal space currently is not eligible for IHS Maintenance & Improvement funding. This will assist Tribes by ensuring funding is available to address facility needs, including lease costs and/or maintenance, without impacting health program funds. This funding increase brings total funding for Tribal Clinic Lease, Operations and Maintenance to $12 million, which is included in the Hospitals and Health Clinics funding line, which has historically housed funding that supports activities related to Hospitals and Health Clinics. This amount includes $2 million provided in the FY 2016 appropriation.

Performance Discussion

IHS has retired H&HC-1, H&HC-2, and H&HC-3 as budget measures as the DVPP demonstration pilot project phase ended on August 31, 2015. IHS is in the development stage of determining the reporting requirements for newly funded projects.

In recent years, IHS has experienced positive and sustained performance results. After several years of meeting all clinical targets, IHS set more aggressive performance goals for most indicators in FYs 2016 and 2017.

Funding will continue to support care teams and laboratories performing diabetic nephropathy screening to continue reducing the incidence of chronic kidney disease in diabetic patients. Additionally, diabetic retinopathy screening via telehealth within the IHS system of care will be supported in FY 2016 and beyond. This capability at remote locations has been demonstrated to greatly increase screening rates when compared to traditional referral for screening. Providing

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

on-site cancer screenings (e.g., Pap smear, mammogram, colonoscopy) by qualified providers with current technologies is supported by H&HC funds and will support continued increases in screening rates at IHS facilities. To align with current screening recommendations for HIV and Hepatitis C, additional funding is necessary to support the increased volume of testing as well as the treatment costs associated with a higher discovery rate of affected individuals.

In FY 2015, IHS healthcare facilities in the Great Plains Area conducted a pilot of accreditation through a new source (Det Norske Veritas) and achieved initial accreditation. Since becoming accredited, one facility has lost its Provider Agreement with CMS. IHS will be re-evaluating accreditation by DNV in FYs 2016 and 2017 to ensure compliance with agency policy and restore the accreditation measure to 100 percent.

Immunization targets were narrowly missed for FY 2015. The value of immunizations for prevention of infectious diseases is unquestionable and AI/ANs have contributed substantially to vaccine development in past decades. Funding resources have been applied to provider and staff training via televideo across IHS to maintain currency with new immunization practices. The number and frequency of vaccinations in infancy is challenging and sometimes met with parental resistance. IHS is committed to meeting its FYs 2016 and 2017 goals for immunizations through continued provider, staff, patient and parent education, procurement of vaccine in an environment of rising costs, and leveraging Public Health Nurses as extensions of clinical care teams to provide immunizations in the home. Resourcing of appropriate staff numbers to provide optimal care across the age spectrum is requisite for success in this area.

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

In FY 2017, these efforts will continue through the Agency's focus on system-wide priorities that include improving quality and access to health care, as well as an emphasis on team work, strengthening of partnerships and relationships with tribes and customers, and effectiveness.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/-FY 2016 Target
5 Diabetes: Nephropathy Assessment: Proportion	FY 2015: 62 % Target:	61.1 %	63.3 %	+2.2 %

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/-FY 2016 Target
of patients with diagnosed diabetes assessed for nephropathy. IHS-All (Outcome)	60 % (Target Exceeded)			
5 Tribally Operated Health Programs (Outcome)	FY 2015: 58 % Target: 57.8 % (Target Exceeded)	58.9 %	59.2 %	+0.3 %
6 Diabetic Retinopathy: Proportion of patients with diagnosed diabetes who receive an annual retinal examination. (Outcome)	FY 2015: 61.3 % Target: 60.1 % (Target Exceeded)	61.6 %	63.1 %	+1.5 %
6 Tribally Operated Health Programs (Outcome)	FY 2015: 59.9 % Target: 57 % (Target Exceeded)	59.6 %	61.7 %	+2.1 %
7 Pap Screening Rates: Proportion of eligible women who have had cervical cancer screening appropriate for their age (Outcome)	FY 2015: 54.9 % Target: 54.6 % (Target Exceeded)	55.6 %	56.1 %	+0.5 %
7 Tribally Operated Health Programs (Outcome)	FY 2015: 54.4 % Target: 55.1 % (Target Not Met)	56.1 %	55.5 %	-0.6 %
8 Mammogram Rates: Proportion of eligible women who have had mammography screening within the previous two years. (Outcome)	FY 2015: 54.5 % Target: 54.8 % (Target Not Met but Improved)	55.9 %	56.7 %	+0.8 %
8 Tribally Operated Health Programs (Outcome)	FY 2015: 55 % Target: 55.9 % (Target Not Met)	57.1 %	57.3 %	+0.2 %
9 Colorectal Cancer Screening Rates: Proportion of eligible patients who have had appropriate colorectal cancer screening. (Outcome)	FY 2015: 38.6 % Target: 35.2 % (Target Exceeded)	38.7 %	40.2 %	+1.5 %

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/-FY 2016 Target
9 Tribally Operated Health Programs (Outcome)	FY 2015: 40.1 % Target: 36.4 % (Target Exceeded)	40.9 %	41.7 %	+0.8 %
16 Domestic (Intimate Partner) Violence Screening: Proportion of women who are screened for domestic violence at health care facilities. IHS-All (Outcome)	FY 2015: 63.6 % Target: 61.6 % (Target Exceeded)	Retire after 2015	Retire after 2015	Maintain
16 Tribally Operated Health Programs (Outcome)	FY 2015: 61 % Target: 56 % (Target Exceeded)	Retire after 2015	Retire after 2015	Maintain
20 100 percent of hospitals and outpatient clinics operated by the Indian Health Service are accredited or certified (excluding tribal and urban facilities). (Outcome)	FY 2015: 99 % Target: 100 % (Target Not Met)	100 %	100 %	Maintain
24 American Indian and Alaska Native patients, aged 19-35 months, receive the following childhood immunizations: 4 DTaP (diphtheria, tetanus, and acellular pertussis); 3 IPV (polio); 1 MMR (measles, mumps, rubella); 3 or 4 Hib (Haemophilus influenzae type b); 3 HepB (hepatitis B); 1 Varicella (chicken pox); 4 Pneumococcal conjugate. (Outcome)	FY 2015: 73.3 % Target: 73.9 % (Target Not Met)	76.8 %	74.8 %	-2.0 %
24 Tribally Operated Health Programs (Outcome)	FY 2015: 67.1 % Target: 68 % (Target Not Met)	71 %	68.5 %	-2.5 %
25 Influenza vaccination rates among adult patients aged 65 years and older. (Outcome)	FY 2015: 65.4 % Target: 67.2 % (Target Not Met)	Retire after 2015	Retire after 2015	Maintain

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/-FY 2016 Target
25 Tribally Operated Health Programs (Outcome)	FY 2015: 62.1 % Target: 64.6 % (Target Not Met)	Retire after 2015	Retire after 2015	Maintain
26 Pneumococcal vaccination rates among adult patients aged 65 years and older. IHS-All (Outcome)	FY 2015: 84.9 % Target: 85.7 % (Target Not Met)	87.3 %	86.7 %	-0.6 %
26 Tribally Operated Health Programs (Outcome)	FY 2015: 80.5 % Target: 81.7 % (Target Not Met)	83.3 %	82.2 %	-1.1 %
30 American Indian and Alaska Native patients, 22 and older, with Coronary Heart Disease are assessed for four cardiovascular disease (CVD) risk factors. (Outcome)	FY 2015: 55 % Target: 47.3 % (Target Exceeded)	53.3 %[14]	Retire after 2016	N/A
30 Tribally Operated Health Programs (Outcome)	FY 2015: 51.8 % Target: 46 % (Target Exceeded)	49.3 %	Retire after 2016	N/A
32 Tobacco Cessation Intervention: Proportion of tobacco-using patients that receive tobacco cessation intervention. IHS-All (Outcome)	FY 2015: 52.1 % Target: 46.3 % (Target Exceeded)	49.1 %	53.2 %	+4.1 %
32 Tribally Operated Health Programs (Outcome)	FY 2015: 44.9 % Target: 43.4 % (Target Exceeded)	43.9 %	45.8 %	+1.9 %
33 HIV Screening: Proportion of pregnant women screened for HIV. (Outcome)	FY 2015: 86.6 % Target: 86.6 % (Target Met)	Retire after 2015	Retire after 2015	Maintain
43 Proportion of infants 2 months old (45-89 days old) that are exclusively or mostly breastfed (Outcome)	FY 2015: 35.7 % Target: 29 % (Target Exceeded)	35.8 %	36.4 %	+0.6 %
43 Tribally Operated Health Programs (Outcome)	FY 2015: 36.2 % Target:	38.6 %	37 %	-1.6 %

[14]In FY 2015 the CVD measure included five risk factors. In FY 2016 the measure will include four risk factors.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/-FY 2016 Target
	27.8 % (Target Exceeded)			
44 Years of Potential Life Lost (YPLL) in the American Indian/Alaska Native population (Outcome)	FY 2008: 89.3 years (Target Not In Place)	TBD	TBD	Maintain
45 Hospital admissions per 100,000 service population for long-term complications of diabetes (Efficiency)	FY 2013: 83.6[15] Target: 83.6 (Baseline)	TBD	TBD	Maintain
46 Controlling High Blood Pressure (Outcome)	FY 2015: 58.5 % Target: 59.5 % (Target Not Met)	60.6 %	59.7 %	-0.9 %
46 Tribally Operated Health Programs (Outcome)	FY 2015: 57.3 % Target: 59.1 % (Target Not Met)	60.2 %	58.5 %	-1.7 %
47 HIV Screening Ever: Percentage of 13-64 year olds screened for HIV (Outcome)	FY 2016: Result Expected Sep 30, 2016 Target: Set Baseline (Pending)	Baseline	TBD	N/A
47 TOHP HIV Screening Ever (Outcome)	FY 2016: Result Expected Sep 30, 2016 Target: Set Baseline (Pending)	Baseline	TBD	N/A
48 Influenza Vaccination Rates Among Children 6 months to 17 years (Outcome)	FY 2016: Result Expected Sep 30, 2016 Target: Set Baseline (Pending)	Baseline	TBD	N/A
48 TOHP Influenza 6 months to 17 years (Outcome)	FY 2016: Result Expected Sep 30, 2016 Target: Set Baseline (Pending)	Baseline	TBD	N/A
49 Influenza Vaccination Rates Among Adults 18	FY 2016: Result Expected Sep 30, 2016	Baseline	TBD	N/A

[15]Results available in 2016.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/-FY 2016 Target
years and older (Outcome)	Target: Set Baseline (Pending)			
49 TOHP Influenza 18 years and older (Outcome)	FY 2016: Result Expected Sep 30, 2016 Target: Set Baseline (Pending)	Baseline	TBD	N/A
51 Statin Therapy for the Prevention and Treatment of Cardiovascular Disease among American Indians and Alaska Natives (Outcome)	FY 2017: Result Expected Sep 30, 2017 Target: Set Baseline (Pending)	N/A	Baseline	Maintain
51 TOHP Statin Therapy for the Prevention and Treatment of Cardiovascular Disease among American Indians and Alaska Natives (Outcome)	FY 2017: Result Expected Sep 30, 2017 Target: Set Baseline (Pending)	N/A	Baseline	Maintain
64 TOHP IPV/DV Screening (Output)	FY 2016: Result Expected Dec 31, 2016 Target: Set Baseline (Pending)	Baseline	TBD	N/A
64 IPV/DV Screening (Output)	FY 2016: Result Expected Dec 31, 2016 Target: Set Baseline (Pending)	Baseline	TBD	N/A
H&HC-1 Percentage of Domestic Violence Prevention Initiative-funded programs providing case management services to victims and children of victims (Output)	FY 2015: 93.8 % Target: 61.9 % (Target Exceeded)	Retire after 2015	Retire after 2015	Maintain
H&HC-2 Percentage of sexual assault community developed model (SACDM) programs that have an active interdisciplinary	FY 2015: 47.4 % Target: 42.1 % (Target Exceeded)	Retire after 2015	Retire after 2015	Maintain

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/-FY 2016 Target
Sexual Assault Response Team (SART) (Output)				
H&HC-3 Percentage of SANE/SART Programs with written sexual assault response policies and procedures (Output)	FY 2015: 100 % Target: 87.5 % (Target Exceeded)	Retire after 2015	Retire after 2015	Maintain
H&HC-4 Inpatient Admissions - IHS Direct (Output) (Output)	FY 2014: 18,818 admissions Target: 19,900 admissions (Target Exceeded)	19,500 admissions	Retire after 2016	N/A
TOHP-2 Number of designated annual clinical performance goals met. (Outcome)	FY 2015: 6[16] Target: 13[17] (Target Not Met)	13[18]	16[19]	+3

GRANTS AWARDS - H&HC funds support one grant program: the Healthy Lifestyles in Youth Grant, a $1,000,000 limited cooperative agreement with the National Congress of American Indians. This grant program promotes healthy lifestyles among AI/AN youth using the curriculum "Together Raising Awareness for Indian Life" at selected Boys and Girls Club sites across the country and represents responsiveness to Tribal input for more prevention activities. In addition, 47 grants were awarded under the Domestic Violence Prevention Program.

CFDA No. – 93.933 – Demonstration Projects for Indian Health			
	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	1	48	48
Average Award	$1,000,000	$142,348	$142,348
Range of Awards	$1,000,000	$49,750 - $1,000,000	$49,750 - $1,000,000
Total Awards	$1,000,000	$6,832,680	$6,832,680

[16]FY 2015 result is 6 of 18 clinical performance goals met.
[17]FY 2015 target is for 13 of 16 annual clinical performance goals to be met.
[18]FY 2016 target is for 13 of 18 annual clinical performance goals to be met.
[19]FY 2017 target is for 16 of 22 annual clinical performance goals to be met.

AREA ALLOCATION

Hospital and Health Clinics

(dollars in thousands)

DISCRETIONARY	FY 2015 Final			FY 2016 Enacted			FY 2017 President's Budget			FY '17 +/- FY '16
SERVICES	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$126,309	$191,944	$318,253	$127,184	$194,610	$321,794	$133,557	$209,510	$343,067	$21,272
Albuquerque	30,327	46,086	76,413	30,537	46,726	77,263	32,067	50,304	82,371	5,108
Bemidji	38,748	58,883	97,631	39,017	59,701	98,718	40,971	64,272	105,243	6,526
Billings	24,984	37,967	62,951	25,157	38,494	63,651	26,418	41,441	67,859	4,208
California	28,115	42,724	70,838	28,309	43,317	71,627	29,728	46,634	76,362	4,735
Great Plains	65,989	100,279	166,267	66,446	101,671	168,117	69,775	109,456	179,230	11,113
Nashville	25,575	38,865	64,441	25,753	39,405	65,158	27,043	42,422	69,465	4,307
Navajo	88,167	133,982	222,150	88,778	135,843	224,622	93,226	146,244	239,470	14,849
Oklahoma	132,091	200,730	332,821	133,006	203,518	336,524	139,670	219,100	358,770	22,246
Phoenix	64,828	98,515	163,343	65,277	99,883	165,160	68,548	107,531	176,079	10,918
Portland	29,350	44,601	73,951	29,553	45,220	74,773	31,034	48,683	79,716	4,943
Tucson	7,783	11,827	19,610	7,837	11,991	19,828	8,229	12,910	21,139	1,311
Headquarters	66,723	101,395	168,119	67,185	102,804	169,989	70,552	110,675	181,226	11,237
Total, H&HC	**$728,990**	**$1,107,799**	**$1,836,789**	**$734,039**	**$1,123,186**	**$1,857,225**	**$770,817**	**$1,209,181**	**$1,979,998**	**+$122,773**

Note: Allocation amounts are estimates.

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

HOSPITALS AND HEALTH CLINICS

Tribal Epidemiology Centers

(Dollars in Thousands)

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA – Hospitals and Health Clinics	$1,836,789	$1,857,225	$1,979,998	+$122,773
Epi Centers	*$4,679*	*$4,718*	*$4,912*	*+$194*

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

FY 2017 Authorization.....Permanent

Allocation Method.....Cooperative Agreements

PROGRAM DESCRIPTION and ACCOMPLISHMENTS

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

The TECs play a critical role in IHS' overall public health infrastructure. 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 a variety of reports annually or bi-annually that describe activities and progress towards public health goals, and provide critical support to Tribes who self-govern their health programs.

The TEC program funds eleven TECs that provide comprehensive geographic coverage for all IHS administrative areas and one additional TEC serving AI/AN populations residing in major urban centers nationally. The IHS Division of Epidemiology and Disease Prevention (DEDP) functions as the national coordinating center and provides technical support and guidance to TECs. The 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 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.

Over 90 percent of the TEC Program budget is distributed through cooperative agreements based on a 5-year competitive award cycle. In the most recent award cycle, all 12 TECs were awarded an average of $360,000 (FY 2011). Up to $1,000,000 in funding for each TEC was initially authorized by the Indian Health Care Improvement Act.

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. The 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). TEC activities and accomplishments include:

Data
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. The Indian Health Care Improvement Act (Section 130) included language to designate the TECs as public health authorities. To ensure secured data access, data sharing agreements are required, thereby mitigating risk against improper use.

TECs assist Tribes with projects such as conducting behavioral risk factor surveys to establish a base of measurement for successfully evaluating intervention and prevention activities. Because national surveys (e.g., Behavioral Risk Factor Surveillance System Survey, Youth Risk Behavior Survey) that collect data about health-related risk behaviors, chronic health conditions, and use of preventive services do not consistently capture representative data for AI/AN populations, TECs currently pilot adapted versions of these national surveys targeting limited AI/AN populations. These surveys provide baseline and trend data used by Tribes and Urban Indian Health organizations (UIHOs) to identify health-related needs and to prioritize interventions and prevention services. For example, one TEC combines these surveys and other data to generate reports on the health disparities of urban Indians and distributes nationally to all 34 UIHOs to determine health priorities, identify opportunities for new data collection, and to support competitive, evidence-driven applications for funding opportunities to address these priorities.

Disease Surveillance
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.

Evaluation
TEC efforts build capacity in the Indian health system by evaluating and monitoring the effectiveness of health programs.

Collaboration
The DEDP collaborates with the National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC), and other federal agencies to supplement the TECs, create stronger interagency partnerships, and prevent costly duplication of effort.

TECs support national public health goals by working to improve data for the Government Performance and Results Act, agency performance reports, and monitoring of the Healthy People 2020 objectives at the Tribal level. TECs also support the HHS Strategic Plan 2014-2018 by increasing access to and sharing of data and supporting epidemiology programs at the state, local, and tribal government levels and by urban Indian organizations (HHS Strategic Goal 2: Objective E). It also supports the HHS Secretary's Arcs, specifically, "#2. Delivery System Reform: Find better ways to 1) pay providers, 2) deliver care, and 3) distribute information, resulting in better care, wiser spending of our health dollars, and healthier communities, economy, and country." Health status reports across all TECs will lead to a more comprehensive picture of Indian health.

FUNDING HISTORY

Fiscal Year	Amount*
2012 Enacted	*$4,678,847*
2013 Enacted	*$4,433,361*
2014 Final	*$4,678,847*
2015 Final	*$4,678,847*
2016 Enacted	*$4,718,000*

*Funded under the H&HC budget.

BUDGET REQUEST

The FY 2017 budget request for Hospitals and Health Clinics (H&HC) of $1,979,666 is an increase of $122,773,000 above the FY 2016 Enacted level. Funding for the Tribal Epidemiology Centers is included within the H&HC total. The FY 2017 budget request for the Tribal Epidemiology Centers of $4,912,000 is an increase of $194,000 above the FY 2016 Enacted level.

FY 2016 Base Funding $4,718,000
Current funding, on average of $360,000 per TEC, covers the salaries of a Director, one full-time Epidemiologist, administrative assistance/support, and one or two pressing disparity projects or tribal priorities.

FY 2017 Funding Increase of $194,000 includes:

- Pay costs +$39,000 – estimated at 1.6 percent to cover pay raises for Federal and Tribal employees.

- Inflation +$70,000 – estimated at 2.1 percent, to cover non-medical inflationary costs.

- Population growth +$85,000 – to fund the additional services need arising from the growing AI/AN population. The growth rate is projected to be 1.8 percent in CY 2017 based on State births and deaths data.

Performance Discussion

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

FY 2017 Tribal Epidemiology Centers Allocation			
1	Alaska Native Tribal Health Consortium	Anchorage, AK	$380,000
2	Albuquerque American Indian Health Board	Albuquerque, NM	$380,000
3	Great Lakes Inter-Tribal Council	Lac du Flambeau, WI	$380,000
4	Inter-Tribal Council of Arizona	Phoenix, AZ	$380,000
5	Montana/Wyoming Tribal Leaders Council	Billings, MT	$380,000
6	Navajo Nation Division of Health	Window Rock, AZ	$380,000
7	Northern Plains – Great Plains Area	Rapid City, SD	$380,000
8	Northwest Portland Area Indian Health Board	Portland, OR	$380,000
9	Oklahoma City Area Inter-Tribal Health Board	Oklahoma City, OK	$380,000
10	Seattle Indian Health Board	Seattle, WA	$380,000
11	United South and Eastern Tribes, Inc.	Nashville, TN	$380,000
12	California Rural Indian Health Board	Sacramento, CA	$380,000
	Administrative and technical support	IHS Headquarters	$352,000
	TOTAL		**$4,912,000**

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/-FY 2016 Target
EPI-1 Health Status and Monitoring (Output)	FY 2015: 12 of 12 TECs Target: 12 of 12 TECs (Target Met)	Retire after 2015	Retire after 2015	Maintain
EPI-2 Provide regional profiles (Output)	FY 2015: 10 of 12 TECs Target: 12 of 12 TECs (Target Not Met)	Retire after 2015	Retire after 2015	Maintain
EPI-3 Tribal support - technical training in public health practice (Output)	FY 2015: 12 of 12 TECs Target: 12 of 12 TECs (Target Met)	Retire after 2015	Retire after 2015	Maintain
EPI-4 New EPI Measure under development with Tribal Epi Centers (Output)		TBD[1]	TBD	N/A

GRANTS AWARDS

CFDA 93.231 – Epidemiology Cooperative Agreements			
	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	12	12	12
Average Award*	$360,000	$360,000	$380,000
Range of Awards	$350,000 - $500,000	$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.

[1]Measure implementation initiated along with any applicable database or performance structure.

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 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$1,836,789	$1,857,225	$1,979,998	+$122,773
HIT	*$182,149*	*$182,149*	*$202,149*	*+$20,000*

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

FY 2017 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) programs that care for 2.2 million American Indian and Alaska Native (AI/AN) people across the Indian health system. IHS provides the technology infrastructure for a nationwide health care system, including a secure wide area network, enterprise e-mail services, and regional and national Help Desk support for approximately 20,000 network users. IHS HIT also supports the mission-critical health care operations of the I/T/U with a comprehensive health information solution that includes an Electronic Health Record (EHR) which has received certification for meeting reqiurements set by the Centers for Medicare and Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC) which established standards and other criteria for structured data that EHRs must use. The IHS HIT program directly supports the Secretary's policy Arc #2 to find better ways to 1) pay providers, 2) deliver care, and 3) distribute information, resulting in better care, wiser spending of our health dollars, and healthier communities, economy, and country.

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

1) **RPMS** is the key 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 criteria published by the ONC and is in use at approximately 400 health care facilities across the country. The rapid deployment of the 2014-certified RPMS EHR during FY 2015 is paving the way for continued participation in

the Meaningful Use (MU) incentive programs. RPMS was significantly enhanced in FY 2014 to incorporate health information sharing and patient engagement features, collectively called the RPMS Network, that began adoption in FY 2015 and continues through FY 2016.

2) **IOAT** provides the technical infrastructure for federal and some tribal healthcare facilities and is the foundation upon which RPMS is delivered. The IOAT investment includes a highly available and secure wide-area network which includes locations with unique telecommunication challenges, a national e-mail and collaboration capability that is designed specifically to support health care communication and data sharing, enterprise application services and supporting hardware including servers and end-user devices. The IT infrastructure incorporates government and industry standards for the collection, processing, storage, and transmission of information and is poised to respond to new and pioneering opportunities, including cloud computing for flexible storage options and providing for the high availability for critical services.
3) **NPIRS** is an enterprise-wide data warehouse and business intelligence 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 add rigor to the analytic platform, is extending standards and best practices and exploiting the capabilities of Business Intelligence, and is enabling IHS to produce and make more informed, quality decisions against agency-level measurement, performance and enterprise data.

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

Accomplishments

The Office of Information Technology (OIT) achieved numerous accomplishments during FY 2015, some examples follow:

FY 2015 Accomplishments and Progress to Date

- Implemented the Methamphetamine and Suicide Prevention Initiative (MSPI) application that replaces the manual collection and paper process with a fully automated, web-based solution for the submittal and reporting of methamphetamine, suicide, prevention and treatment data.
- Won the Federal Information Systems Security Educators' Association (FISSEA) award for best Security Awareness Newsletter. The award winning newsletter was sent to IHS-all as part of the National Cybersecurity Awareness Month in October of 2014. These awards are hosted by the National Institute of Standards and Technology and showcase security awareness training efforts by agencies across government and commercial industries.
- Deployment of the 2014 Certified RPMS EHR throughout the IHS has resulted in substantial benefit to IHS hospitals and clinics through the collection of MU incentive payments. Through the second quarter of FY 2015, nearly $149 million was received as a result of adoption and/or meaningful use of the RPMS EHR by Indian Health System eligible hospitals and providers.
- Successfully implemented the 10th edition of the International Classification of Diseases (ICD-10).
- Continued implementation of a Department of Veterans Affairs (VA)-developed Bar Code Medication Administration (BCMA) solution, which is designed to prevent medication errors in healthcare settings and improve the quality and safety of medication administration, across the Indian health system. The overall goals of BCMA are to improve accuracy, prevent

errors, and generate online records of medication administration. IHS will complete deployments to all 21 of its priority hospitals.
- IHS and the VA became the first two federal agencies enabled to exchange healthcare information used in the delivery of patient care.
- Began initial analysis for the the deployment of systems changes needed in support of the proposed Meaningful Use 3 initiative.
- Began analysis for the implantation of systems changes required to support the implementation of Medicare Access and CHIP Reauthorization Act.

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

Immediate Priorities and Challenges

The HIT Program will continue to face increased systems reliance, rising costs, and increased IT security responsegoing forward because of ever-growing and more complex requirements for health information technology capabilities. These requirements come from government and industry initiatives, program needs of the IHS, and operational requests of I/T/U health care facilities. Virtually any new program initiative has information technology requirements for data collection or reporting which then must be added to the HIT portfolio. IHS forecasts the following to be major workload and cost drivers for HIT in FY 2016, FY 2017 and beyond.

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

FUNDING HISTORY

Fiscal Year	Amount
2012 Enacted	$172,149,000
2013 Enacted	$172,149,000
2014 Final	$172,149,000
2015 Final	$182,149,000
2016 Enacted	$182,149,000

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

BUDGET REQUEST

The FY 2017 budget request for Health Information Technology within the Hospitals and Health Clinics budget of $202,149,000 is an increase of $20,000,000 over the FY 2016 Enacted Budget. The FY 2017 increase supports the new level of Operation and Maintenance costs and will allow the IHS to address improvements to the IT infrastructure and additional initiatives such as:

- **Enterprise Services -** *Management and operations costs for enterprise systems* that have been developed to upgrade for MU and other initiatives, including at a minimum: HIE, Master Patient Index, the PHR patient portal, Electronic Prescribing, Terminology Services, centralized Pharmacy order checks, and more.
- **Quality Reporting -** Analytical and technical work to accomplish alignment of measurement and reporting processes for various clinical quality reporting mandates including Government Performance and Results Act (GPRA), MU Clinical Quality Measures, Inpatient Quality Reporting (IQR) and the Physician Quality Reporting Initiative (PQRI).
- **Process Improvement** – IHS will reengineer and retool its software development practice and custom support practice to be more agile, user-centric, and customer-focused to capitalize on the lessons learned from Meaningful Use Stage 2. This re-tooling is also necessary to keep pace with rapidly changing health IT environment.
- **Interoperability** – IHS will expand on its interoperability capabilities to support improved interoperability at the local facility level and to support the objectives of the ONC 10-Year Interoperability Roadmap.
- **Electronic Prescribing for Controlled Substances and Prescription Drug Monitoring** – IHS will implement solutions to align with standards and best practices for electronic prescribing and prescription drug monitoring for controlled substances.
- **Telemedicine and Mobile Health** – IHS will lead the development of an Indian health system telemedicine and mobile health strategy.
- **Identity and Access Management** – IHS will develop an integrated Identity and Access Management (IAM) strategy to facility adoption of mobile health and cloud computing technologies in a secure, user-friendly manner.
- **Data Quality and Governance** – IHS will begin formulation of a national data quality strategy to improve on performance reporting, quality reporting, and patient care.
- **Data Center Consolidation** - IHS seeks to reduce data center footprints and share technical expertise in the field. Although this should save long term maintenance costs, there will be a start-up investment for these transitions especially with the move of IHS to 5600 Fishers Lane in FY2016.
- **Security Threats** - IHS HIT will be expected to continue to respond in a timely way to new security threats, regulatory mandates for government IT systems, and industry standards and best practices.
- **Affordable Care Act** - IHS HIT will be expected to support provisions of the Affordable Care Act (ACA) Arc #2 that calls for new data or data systems to implement new business processes or reporting requirements. Many of these requirements are still evolving in the regulatory process so their impacts on IHS HIT are not fully known.
- **Network Reliability** - IHS network will continue to require upgrades in order to achieve the necessary bandwidth and reliability recommended by the Federal Communications Commission (FCC) in order to support robust health information exchange required by MU and expanding telehealth initiatives.
- **Internet Protocol version 6 (IPv6) -** Network Operations Support Center (NOSC) in coordination with Area IT staff will continue to make progress with the implementation of IPv6.

<u>FY 2016 Base Funding of $182,149,000</u> - to continue progress made in the past several years by keeping infrastructure costs as low as possible and maintaining a high level of productivity and commitment by both federal and contractor staff supporting the IHS-developed health information solutions. IHS uses open source tools where possible to minimize acquisition costs and is reducing use of more costly assisted acquisition providers such as the General Services Administration. The success of HIT in completing the 2014 EHR certification initiative was the

direct result of IHS Service Units contributing a portion of Stage 1 MU incentive payments to enable development for Stage 2. Diminution of the MU incentive programs, together with inflationary costs will constrain the ability of the HIT investments to maintain current services or to enhance systems in response to the requirements described in the previous paragraphs. The request includes funding to support the President's information technology initiatives and Departmental enterprise information technology initiatives identified through the HHS strategic planning process. Performance and project milestones will be monitored through normal Enterprise Performance Life Cycle processes. The following initiatives will continue as part of the base funding in FY 2016:

- ICD-10 – Finalization of the system enhancements required for ICD-10 that were delayed into FY 2015, with post-implementation costs beginning in FY 2016.
- Certified 2014 EHR - FY 2015 saw expanded costs for operational support and training on new capabilities delivered with the 2014 Certified EHR. Operational and maintenance costs will rise and exceed historical levels because the breadth and complexity of new capabilities in the IHS HIT systems. RPMS in particular, has been increasing exponentially over the past several years.
- Certified 2015 EHR - Analysis and development of the expected 2015 Certification standards for EHR must be completed by 2017 in order for IHS facilities to continue to participate in the MU initiative. This is expected to be no less complex and no less costly than the 2014 Certification experience.
- Meaningful Use Stage 3 - Analysis and field/provider preparation for the expected Meaningful Use Stage 3 rule must also be completed by 2017 in order for IHS facilities to continue to participate in the MU initiative.
- NPIRS expansion - Continued expansion of the NPIRS national data warehouse to serve as the enterprise data analytics and performance measurement hub for IHS. NPIRS includes data from non-RPMS systems, which requires additional processing for data integration.

Program Increase +$20,000,000

Health Information Technology +$20,000,000 – to allow for improvements for HIT including the enhancements needed for the 2015 Certification and deployment for Meaningful Use, Stage 3 which addresses interoperability and to improve the delivery of healthcare and the security of patient data through the enhancement and modernization of the IHS RPMS through increased funding for development, operations, and maintenance of capabilities for the EHR.

IHS Investments

(Dollars in Thousands)

Program Name	IT Investment Title	Unique Investment Identifier	FY 2015 Enacted	FY 2016 Enacted	FY 2017 Request
Hospitals & Health Clinics	IHS Resource and Patient Management System – Maintenance & Enhancements	009-17-01-02-01-1010-00	$111,625	$110,857	$115,457
Hospitals & Health Clinics	IHS National Patient Information and Reporting System – Maintenance & Enhancements	009-17-01-02-01-1020-00	$9,448	$9,761	$11,761
Hospitals & Health Clinics	IHS Infrastructure, Office Automation, & Telecommunications (IOAT)	009-17-02-00-01-1040-00	$56,218	$57,454	$64,754
Hospitals	Non-major Investments	N/A	$9,858	$4,077	$5,177

& Health Clinics	including Security and Enterprise Architecture Programs				
Total			**$187,149**	**$182,149**	**$197,149**

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

OUTPUTS / OUTCOMES

Measure	**Year and Most Recent Result / Target for Recent Result / (Summary of Result)**	**FY 2016 Target**	**FY 2017 Target**	**FY 2017 Target +/- FY 2016 Target**
HIT-1 OMB IT Dashboard - All IHS Major Investments will Maintain a score of 4/5 or greater (Outcome)	FY 2015: 5.0[1] Target: 4.0[2] (Target Exceeded)	4.0[3]	4.0[4]	Maintain
HIT-2 HHS CIO Workplan - The IHS will score 90% or greater on the annual scoring of the HHS CIO Workplan (Outcome)	FY 2015: Result Expected Aug 31, 2016 Target: 90 % (Pending)	90 %[5]	90 %[6]	Maintain
RPMS-2 Derive all clinical measures from RPMS and integrate with EHR. (Output)	FY 2015: 75 Measures / 12 IHS Areas Target: 73 Measures / 12 IHS Areas (Target Exceeded)	75 Measures / 12 IHS Areas	75 Measures / 12 IHS Areas	Maintain

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

[1]FY 2015 result is 5.0 out of 5.0 met.
[2]>=4 out of 5 for all investments
[3]>=4 out of 5 for all investments
[4]>=4 out of 5 for all investments
[5]>90 percent.
[6]> 90 percent.

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

(Dollars in Thousands)

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$173,982	$178,286	$186,829	+$8,543
FTE*	585	585	586	+1

.* 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 2017 Authorization.....Permanent

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

PROGRAM DESCRIPTION and ACCOMPLISHMENTS

The purpose of the Indian Health Service (IHS) Dental Health Program (DHP) is to raise the oral health status of the American Indian/Alaska Native (AI/AN) population to the highest possible level through the provision of quality preventive and treatment services, at both community and clinic sites. The DHP is a service-oriented program providing basic dental services (e.g., diagnostic, emergency, preventive, and basic restorative care). Approximately 90 percent of the dental services provided fall into the basic dental services category. In FY 2015, the dental program provided a total of 3,752,821 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 234,041 dental services provided in FY 2015.

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

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

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

Access to dental services is a prerequisite to the control of oral disease in susceptible or high-risk populations. The access to care Government Performance and Results Act (GPRA) objective is currently aligned with Healthy People 2020 methodology as a percentage of patients who have visited the dentist within the previous 12 months. The access to care performance was 29.2 percent in fiscal year (FY) 2015, exceeding the 2015 goal of 27.9 percent and meeting the FY 2014 goal of 29.2 percent. This is the fourth year-on-year improvement in dental access since 2010, and is the highest rate of dental access on record. Additionally, the DHP aligns and integrates the Department's Strategic Goal 1: Strengthen Health Care under Objective E by ensuring AI/ANs have access to quality, culturally competent health care and HHS Arc 4: Keeping People Healthy and Safe: Ensure optimal health is achievable by everyone in this country by having a health care system that keeps people healthy and promoting prevention and wellness that is not delivered strictly through the health care system.

Topical fluorides and dental sealants have been extensively researched and documented in the dental literature as safe and effective preventive interventions to reduce tooth decay. In FY 2013, the tracking of dental sealants and the tracking of patients receiving topical fluoride measures changed from simple counts of procedures or patients to the percentage of children receiving either sealants or topical fluorides. New annual targets were set for these two objectives as of July 1, 2013. The 26.4 percent FY 2015 topical fluoride goal for children ages 1 to 15 receiving one or more topical fluoride applications was met with a result of 29.4 percent. In FY 2015, the 14.1 percent dental sealant performance goal was exceeded with a resultant 16.3 percent performance. These fluoride patient and sealant patient rates are the highest percentages shown in the three years since IHS started using the current logic for this measure. This high number of young patients with sealants represents a notable accomplishment for the IHS DHP as significant numbers of susceptible tooth surfaces are now protected by dental sealants.

The IHS Early Childhood Caries (ECC) Collaborative is focused on preventing tooth decay (ECC) in AI/AN children under the age of 71 months. ECC is the most common health problem in children, almost eight times more common than childhood asthma, and have significant consequences such as delayed speech development, more missed school days when children begin school, poor self-esteem, and a greater chance of tooth decay in permanent teeth.[3] AI/AN children suffer disproportionately from this disease, with more than double the number of decayed teeth as the next highest minority population, U.S. Hispanics, and more than 3 times the number of decayed teeth as U.S. White children.[4] The ECC Collaborative began in 2010 with the goal of reducing ECC in the AI/AN population through a coordinated, nationwide collaborative utilizing not only dental programs but also medical and community partners such as medical providers, public health nurses, community health representatives, pharmacists, Head Start teachers, and more. By the end of the first five years of this initiative, the IHS had increased access to dental care for AI / AN children under 71 months by 7.9 percent and significantly increased prevention and early intervention efforts (sealants increased by 65.0 percent, the number of children receiving fluoride varnish increased by 68.2 percent, and the number of therapeutic fillings increased by 161.0 percent), resulting in a net decrease of ECC prevalence

[3] 1. US Department of Health and Human Services, National Institute of Dental and Craniofacial Research, US Public Health Service. Oral Health in America: Report of the US Surgeon General. NIH publication no. 00-213. Washington, DC: DHHS, NIDCR, USPHS; 2000

[4] Indian Health Service. The 2010 Indian Health Service. The 2010 Indian Health Service Oral Health Survey of American Indian and Alaska Native Preschool Children. Rockville, MD: U.S. Department of Health and Human Services, Indian Health Service, 2013. Available at http://www.ihs.gov/doh .

from 54.9 percent in 2010 to 52.6 percent in 2014.[5] To support this initiative, the IHS conducted a nationwide surveillance of 1-5 year-old AI/AN children through two coordinated efforts of 8,451 children in 2010[3] and 11,873 in 2014 – the largest oral health surveillance sample size ever of this age group in the AI / AN population.[5] In FY 2015, the IHS ECC Collaborative continued through promoting early access to dental care for 1-5 year-olds as well as increased attention to prevention activities in IHS dental programs. At the same time, and continuing into FY 2016, the IHS ECC Collaborative has focused on identifying best practices in ECC prevention from programs that have had the most significant successes so that those best practices can be shared throughout IHS, Tribal, and Urban dental programs.

In recent years, the DHP has utilized field dental programs in conjunction with its Dental Clinical and Preventive Support Centers (DSC) to achieve national performance objectives and IHS Area initiatives. The DSCs were designed and implemented in FY 1999 and FY 2000 to augment the dental public health infrastructure necessary to best meet the oral health needs of AI/AN communities. A new five-year cycle began September 15, 2015 with eight DSCs, three are funded by program awards and five are funded through grants. The primary purpose of a DSC is to provide technical support, training, and assistance in clinical and preventive aspects of dental programs providing care to AI/AN communities. As a direct result of the advocacy efforts of the DSCs, the number of key preventive procedures has increased significantly in recent years. For example, the number of dental sealants placed per year has tripled in the last decade, and the number of patients receiving topical fluoride treatments has more than doubled in the last five years. In FY 2013, the DHP began tracking the coverage or prevalence of children and adolescents receiving sealants and topical fluoride, rather than simply counting procedures. These assessments allow improved comparisons with data from the U.S. population compiled by the Healthy People 2020 initiative.

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

- All centers advocated for an appropriate focus on the dental GPRA performance objectives to increase specific clinical services.
- All centers provided continuing education opportunities to enhance the quality of care delivered.
- Several centers provided on-site clinical and community based program reviews to enhance the quality of care, assuring that field programs maintained a high level of expertise with respect to challenges such as infection control, preparing for accreditation and certification reviews, 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 or arranged for 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.

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[5] Ricks TL, Phipps KR, Bruerd BB. The Indian Health Service Early Childhood Caries Collaborative: A Five-year Summary. Ped Dent 2015, 37;3: 275-80.

[5] Phipps KR and Ricks TL. The Oral Health of American Indian and Alaska Native Children aged 1-5 years; results of the 2014 IHS oral health survey. Indian Health Service data brief. Rockville, MD: Indian Health Service. 2015. Available at http://www.ihs.gov/doh .

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

- Overseeing an ongoing annual surveillance of oral health. In FY 2013, the program began an assessment of the DSCs project. During FY 2014, three support centers have undergone comprehensive, on-site evaluations, completing a long-term assessment of all eight centers. Additional ongoing feedback is provided to all centers via response to their quarterly reports by their project officer. Overall challenges include support for data analytic work needed to ensure timely feedback based on program data to field programs.
- Using the quarterly GPRA Dashboard and providing IHS Area-specific reports to each of the 12 IHS Area Dental Officers. Areas with performance measures that are not on target are provided assistance through a webinar to discuss measure performance as well as provide ideas and allow for brainstorming to improve measure performance.
- Monitor the oral health status of AI/ANs to determine disparities in oral disease burden and to serve as a foundation for prevention and treatment priorities in the IHS dental programs.
- In support of the HHS Arc 2: Delivery System Reform: Promote the adoption and meaningful use of health information technology through the IHS Electronic Dental Record (EDR).
- Promote evidence-based practices in health promotion and disease prevention, including the integration of oral and primary health care and improving oral health literacy.

FUNDING HISTORY

Fiscal Year	Amount
2012 Enacted	$159,440,000
2013 Enacted	$156,653,000
2014 Final	$165,290,000
2015 Final	$173,982,000
2016 Enacted	$178,286,000

BUDGET REQUEST

The FY 2017 budget request for Dental Health Services of $186,829,000 is an increase of $8,543,000 above the FY 2016 Enacted level.

FY 2016 Base Funding of $178,286,000 is necessary to support the oral health care services provided by IHS and Tribal programs, maintain the program's progress in raising the quality of and access to oral care through continuing recruitment of oral health care professionals to meet workforce needs, and to meet or exceed agency targets.

FY 2017 Funding Increase of $9,262,000 includes:

- Pay Costs +$1,858,000 – to fund pay raises for federal and Tribal employees of which about 90 percent are working at the service unit level providing health care and related services.

- Inflation +$2,056,000 – to fund inflationary costs of providing health care services.

- Population Growth +$1,992,000 – to fund the additional services need arising from the growing AI/AN population. The growth rate is projected to be 1.8 percent in CY 2017 based on state births and deaths data.

- Staffing/Operating Cost Requirements for Newly Constructed Facilities +$2,637,000 – Dental funding is requested for three new and expanded healthcare facilities that are planned to open in FY 2016. Funding for three facilities allows IHS to expand provision of health care in those areas where capacity has been expanded to address critical health care needs.

Staff and Operating Costs for New Facility	Amount	FTE/Tribal Positions
Muskogee (Creek) National Health Center (JV), Eufala, OK	$1,290,000	12
Flandreau Health Center (JV), Flandreau, SD	$402,000	4
Choctaw Nation Regional Medical Center (JV), Durant, OK	$945,000	9
Grand Total:	**$2,637,000**	**25**

Performance Impact

All three dental GPRA measures showed marked improvement from FY 2014 to 2015, with access to dental care increasing by 1.4 percent (from 28.8 to 29.2 percent), the proportion of 2-15 year-olds receiving preventive dental sealants increasing by 11.6 percent (from 14.6 to 16.3 percent), and the proportion of 1-15 year-olds receiving preventive topical fluoride increasing by 5.4 percent (from 27.9 to 29.4 percent). Each of the 12 IHS Areas were provided specific data and goals related to the three dental GPRA measures in November 2015, and specific best practices and strategies for reaching goals for each of these measures were provided to the 12 Area Dental Officers.

Improvements over the last decade have been even more positive. After hovering around 25 percent for the first half of the last decade (and since FY 2003), dental access has steadily increased from FY 2011 to reach an all-time high of 29.2 percent in FY 2015. This represents a 22 percent increase for the last decade in access to dental care (from 24 percent in FY 2005 to 29.2 percent in FY 2015). In the past decade, topical fluoride applications have increased year-on-year to an all-time high, with a 10 percent increase in topical fluoride coverage for children since FY 2013, when the measure was updated (from 26.7 percent in FY 2013 to 29.3 percent in FY 2015). Also, in the last decade, dental sealants have increased year-on-year to an all-time high, with a 17 percent increase in sealant coverage for children since FY 2013 (from 13.9 percent in FY 2013, when the measure was updated, to 16.3 percent in FY 2015).

The primary challenge in meeting the dental GPRA measures annually is resource allocation. Staff vacancies, although down from just 6 years ago, still impact the ability of some I/T/U dental programs to increase dental access and care and to carry out community-based prevention programs which include dental sealants and topical fluoride applications. The IHS plans to address this challenge in FY 2016 through an increased emphasis on dental staff retention, continued recruitment to fill critical vacancies, allocation of funding to 11 I/T/U dental programs to promote community-based prevention activities through health promotion and disease prevention funding initiatives, collaboration with the updated grants and program awards of the Dental Clinical and Preventive Support Centers, and communication of GPRA best practices nationwide.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
12 Topical Fluorides: Percentage of patients, ages 1 to 15, who received one or more topical fluoride application during the report period (Outcome)	FY 2015: 29.4 % Target: 26.4 % (Target Exceeded)	28.3 %	29.9 %	+1.6 %
13 Dental Access: Percent of patients who receive dental services. (Outcome)	FY 2015: 29.2% Target: 27.9% (Target Exceeded)	29.3%	29.7%	+0.4 %
14 Dental Sealants: Percentage of patients, ages 2 to 15, with at least one or more intact dental sealant (Outcome)	FY 2015: 16.3 % Target: 14.1 % (Target Exceeded)	14.8 %	16.6 %	+1.8 %

GRANTS AWARDS

CFDA No. 93.933—Demonstration Projects for Indian Health			
	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	5	5	5
Average Award	$250,000	$250,000	$250,000
Range of Awards	$250,000	$250,000	$250,000
Total Awards	**$1,250,000**	**$1,250,000**	**$1,250,000**

AREA ALLOCATION

Dental Health

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2015 Final			FY 2016 Enacted			FY 2017 President's Budget			FY '17 +/- FY '16
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$12,109	$19,325	$31,434	$12,485	$19,727	$32,211	$12,789	$20,965	$33,755	$1,543
Albuquerque	3,268	5,215	8,483	3,369	5,323	8,692	3,451	5,658	9,109	417
Bemidji	1,674	2,671	4,344	1,725	2,726	4,452	1,768	2,898	4,665	213
Billings	2,924	4,666	7,590	3,014	4,763	7,777	3,088	5,062	8,150	373
California	768	1,225	1,993	792	1,251	2,043	811	1,329	2,141	98
Great Plains	6,716	10,717	17,433	6,924	10,940	17,864	7,093	11,627	18,720	856
Nashville	1,107	1,766	2,873	1,141	1,803	2,944	1,169	1,916	3,086	141
Navajo	11,544	18,422	29,966	11,902	18,806	30,708	12,192	19,987	32,179	1,471
Oklahoma	15,116	24,123	39,240	15,585	24,625	40,210	15,965	26,172	42,137	1,927
Phoenix	5,273	8,414	13,687	5,436	8,589	14,025	5,569	9,129	14,698	672
Portland	2,993	4,776	7,769	3,086	4,876	7,961	3,161	5,182	8,343	381
Tucson	728	1,161	1,889	750	1,186	1,936	769	1,260	2,029	93
Headquarters	2,805	4,476	7,281	2,892	4,569	7,461	2,962	4,856	7,819	358
Total, Dental	**$67,023**	**$106,959**	**$173,982**	**$69,101**	**$109,185**	**$178,286**	**$70,788**	**$116,041**	**$186,829**	**+$8,543**

Note: Allocation amounts are estimates.

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

(Dollars in Thousands)

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$81,145	$82,100	$111,143	+$29,043
FTE*	197	197	198	+1

* 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 2017 Authorization.....Permanent

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

PROGRAM DESCRIPTION and ACCOMPLISHMENTS

The Indian Health Service (IHS) Mental Health/Social Services (MH/SS) Program is a community-based clinical and preventive service program that provides ongoing 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 outpatient service staffed by one or more mental health professionals providing individual, family, and group psychotherapeutic services and case management. After hours 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 hospitals providing mental health services. Intermediate level services such as group homes, transitional living support, intensive case management, and related activities are typically offered through state and local resources. Additionally, slightly more than one-half of the Tribes administer and deliver their own mental health programs.

Activities performed through the MH/SS program align with and integrate the Department Strategic Goal 1: Strengthen Health Care under Objective E by ensuring American Indian/Alaska Native (AI/AN) people have access to quality, culturally competent care. By focusing on the program's achievement of the Department's Strategic Plan, the agency's program integrity and performance management activities have been successfully integrated. The MH/SS program supports the Department's performance goal to increase the proportion of adults ages 18 and over who are screened for depression in an effort to identify and treat symptoms before feelings of sadness, hopelessness, worthlessness, nervousness, or restlessness escalate into serious psychological distress or even suicide. This program supports HHS ARC#4, Keeping People Healthy and Safe: Ensure optimal health is achievable by everyone in this country by having a health care system that keeps people healthy and promoting prevention and wellness that is not delivered strictly through the health care system, such as facilitating the integration of traditional medicine which typically occurs outside of the health care setting.

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

Suicide Prevention: During 2007–2009, the suicide rate for AI/ANs was 1.6 times greater than the U.S. all-races rate for 2008 (18.5 vs. 11.6 per 100,000 population).[1] Strategies to address mental health, alcohol, substance abuse, and suicide require comprehensive clinical approaches, 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. The National AI/AN Suicide Prevention Strategic Plan advances the National Suicide Strategic Plan with culturally relevant approaches and strategies specific for AI/AN communities.

The IHS leads the AI/AN Task Force of the National Action Alliance for Suicide Prevention to establish effective long-term strategic approaches to address suicide prevention. In March 2015, the AI/AN Task Force published an article in the American Journal of Public Health entitled, *Advancing Suicide Prevention Research with Rural American Indian and Alaska Native Populations*, which proposed expansion of the Action Alliance's prioritized research agenda and offered pathways to advance the field of suicide research in Indigenous communities and beyond.[2] In September 2015, the AI/AN Task Force released its *Hope for Life Day* toolkit, to coincide with World Suicide Prevention Day. The toolkit provides resources specifically for AI/AN communities to further the progress of the Action Alliance's priority to change the public conversation around suicide. The AI/AN Task Force future plans to expand the toolkit and develop an evaluation metric to study the impact of the toolkit in FY 2016.

The IHS utilizes a suicide surveillance reporting tool to document incidents of suicide in a standardized and systematic fashion. The suicide surveillance tool captures data related to a specific incident of suicide, including date and location of act, method, contributing factors, and other useful epidemiological information to better understand the issue, identified risk factors and target resources appropriately. In FY 2015, the use of the suicide surveillance reporting tool assisted one local service unit to improve clinical processes to ensure follow-up services are provided for patients who report with suicidal behavior. In FY 2015 IHS launched the Zero Suicide Initiative in partnership with the Substance Abuse and Mental Health Services Administration (SAMHSA), an approach developed by the Education Developmental Center, Inc. and the Suicide Prevention Resource Center. Zero Suicide is a priority to transform health systems to significantly reduce suicides for those individuals under our care. The initiative includes educating healthcare providers on screening for suicide, conducting suicide risk assessments, and ensuring the infrastructure exists to support evidence-based suicide care. As a result, 50 participants representing nine IHS service areas began implementation of Zero Suicide. During 2016, ten pilot sites are assisting in building the model of suicide care in AI/AN communities.

Trauma-Informed Care: Family violence affects all members of the community. According to the Centers for Disease Control, 45.9 percent of AI/AN woman have experienced intimate partner violence – the highest rate of any race or ethnicity in the U.S.[3] In addition, one out of every three AI/AN women will be sexually assaulted in her lifetime, and AI/AN victims of intimate and

[1]U.S. Department of Health and Human Services, Indian Health Service. Trends in Indian Health 2014 Edition. Released March 2015. ISSN 1095-286
[2] Wexler, L. et al. (2015). Advancing Suicide Prevention Research with Rural American Indian and Alaska Native Populations. American Journal of Public Health Framing Health Matters. Published online ahead of print March 19, 2015, e1-e9.
[3] *National Intimate Partner and Sexual Violence Survey. 2010.* Centers for Disease Control and Prevention. Available at, http://www.cdc.gov/violenceprevention/pdf/nisvs_report2010-a.pdf

family violence are more likely than victims of all other races to be injured and need hospital care.[4] Homicide is the third leading cause of death among AI/AN aged 15 to 24 year olds.[5] AI/AN young men are particularly vulnerable to suicide. The suicide rate among 15 – 24 year olds is 2.5 times greater than the all races rate for 2008.[6] The statistics speak to the need to address trauma as a critical part of effective behavioral health service delivery. The MH/SS program provides training and workforce development to IHS, Tribal, and Urban Indian healthcare providers to incorporate a framework for culturally relevant and trauma-informed approaches.

Behavioral Health Integration with Primary Care: IHS supports changing the paradigm of mental health and substance abuse disorder services from being episodic, fragmented, specialty, and/or disease focused to incorporating it into the patient-centered medical home. The statistics facing AI/AN people for suicide, alcohol-related deaths, domestic and sexual violence, and homicide require the Indian health system to develop a system of comprehensive screening and effective intervention to reduce morbidity and early mortality. In FY 2014, IHS supported a six site pilot project, the Behavioral Health Integration Initiative (BH2I), for one year to develop a series of recommendations needed for IHS to implement a system-wide, rapidly paced change initiative. Key areas of the BH2I include formalizing integration across the system, developing care teams, strengthening infrastructure, and enhancing clinical processes. IHS held its National Behavioral Health Conference: "Behavioral Health Integration with Primary Care" in August 2015 to disseminate the needed knowledge and tools for integrated care in the Indian health system. Over 500 virtual and 200 in-person participants attended the conference. A roundtable consisting of BH2I pilot sites convened during the conference with a focus on successes, barriers, and lessons learned. Three BH2I pilot sites focused on improving the use of the Patient Health Questionnaire (PHQ)-9, a patient depression questionnaire, in the primary care clinic. Two sites faced challenges with integration due to staff turnover and continue to work on integration of behavioral health with primary care. The other pilot site initiated an integrated health home in the behavioral health department to serve patients with serious mental illness. Those patients are able to receive primary care services during their behavioral health visit.

Another success of the BH21 was the active involvement of behavioral health professionals in the Improving Patient Care (IPC) program. Building off this success, IHS is in the planning stages of launching an IPC intensive focused on behavioral health integration with primary care. The intensive will focus on the key areas of the BH2I: formalizing integration across the system, developing care teams, strengthening infrastructure, and enhancing clinical processes. The goal will be increased depression screening in primary care clinics through utilization of the PHQ-2 and PHQ-9.

TeleBehavioral Health and Workforce Development: The IHS TeleBehavioral Health Center of Excellence (TBHCE) was established in 2009, utilizing funds from the Methamphetamine and Suicide Prevention Initiative, to assess the feasibility of providing behavioral health services via televideo. Due to the rural nature of many IHS and Tribal facilities, our patients face many issues surrounding access to care, particularly specialty care. Providers working in these remote areas often face barriers in maintaining the required continuing education (CE) credits required for licensure and to remain up to date on current clinical guidelines. The TBHCE assists IHS, Tribal, and Urban Indian healthcare providers and facilities to overcome these challenges by providing a

[4] *American Indians and Crime, 1992-96 Report*. Bureau of Justice Statistics, Office of Justice Programs, US Department of Justice.
[5] U.S. Department of Health and Human Services, Indian Health Service. Trends in Indian Health 2014 Edition. Released March 2015. ISSN 1095-286.
[6] *Ibid.*

range of behavioral health services, training, and technical assistance via televideo. There are 21 sites now receiving direct care services through the TBHCE. In addition, the TBHCE has developed a robust weekly schedule designed to meet the specific training needs of IHS, Tribal, and Urban Indian health care providers. In FY 2015, 3,047 hours of direct clinical behavioral health service were provided to more than 5,685 patients. In FY 2015, the TBHCE awarded 3,141 hours of CE to more than 10,551 providers during 13 online seminars.

FUNDING HIS`TORY

Fiscal Year	Amount
2012 Enacted	$72,786,000
2013 Enacted	$74,131,000
2014 Final	$77,980,000
2015 Final	$81,145,000
2016 Enacted	$82,100,000

BUDGET REQUEST

The FY 2017 budget request for Mental Health of $111,143,000 is an increase of $29,043,000 above the FY 2016 Enacted level.

FY 2016 Base Funding of $82,100,000 - The base funding is necessary to maintain the program's progress in addressing mental health needs by improving access to behavioral health services through tele-behavioral health efforts and providing a comprehensive array of preventive, educational, and treatment services.

FY 2017 Funding Increase of $29,043,000 includes:

- Pay Costs +$816,000 – to cover pay raises for federal and Tribal employees of which about 90 percent are working at the service unit level providing health care and related services.

- Inflation +$1,068,000 – to cover inflationary costs of providing health care services.

- Population Growth +$928,000 – to fund the additional services need arising from the growing AI/AN population. The growth rate is projected to be 1.8 percent in CY 2017 based on state births and deaths data.

- Staffing/Operating Cost Requirements for Newly Constructed Facilities +$1,231,000 – Mental health funding is requested for three new and expanded healthcare facilities that are planned to open in FY 2017. Mental health funding for three of these facilities allows IHS to expand provision of health care in those areas where capacity has been expanded to address critical health care needs.

New Facilities	Amount	FTE/Tribal Positions
Muskogee (Creek) Nation Health Center (JV), Eufaula, OK	$731,000	7
Flandreau Health Center (JV), Flandreau, SD	$106,000	1
Choctaw Nation Regional Medical Center (JV), Durant, OK	$394,000	4
Grand Total:	**$1,231,000**	**12**

Program Increases +$25,000,000

Behavioral Health Integration Initiative (BH2I) +$21,400,000 - to ensure integrated approaches exist between medical care, behavioral health, and Tribal community organizations to provide the entire spectrum of prevention to impact health outcomes. IHS is working to integrate behavioral health with primary care through its Behavioral Health Integration Initiative (BH2I). The BH2I is working to increase the coordination between medical care and behavioral health in a system where mental health and substance use treatment programs may be operated by different entities in AI/AN communities. To foster and further this collaboration, IHS is proposing a funding increase to expand the behavioral health care being provided within the health care system and outside of the typical health care setting. The increased funding will allow broader engagement of public health officials, Tribal government agencies, and community-based organizations to develop new health policy and to integrate clinical and non-clinical approaches to improving health outcomes for AI/AN communities.

The FY 2017 $21,400,000 will be used to:

- Fund IHS, Tribes, Tribal organizations, and Urban Indian organizations to develop innovative programs to address behavioral health services and deliver those services within and outside of the traditional health care system;
- Provide training, technical assistance, and evaluation services; and
- Hire additional behavioral health staff to provide services in IHS, Tribal, and Urban Indian Patient-Centered Medical Homes or through community based programs and organizations.

Zero Suicide Initiative +$3,600,000 - to fund pilot projects to implement the Zero Suicide in IHS, Tribes, Tribal organizations, and tribal health care facilities and Urban Indian organizations. Zero Suicide is a comprehensive approach for health care settings incorporating the best and promising practices in their clinical practice to prevent suicide. The foundational belief of Zero Suicide is that suicide deaths for individuals under care within health and behavioral health systems are preventable.

In December 2015, no IHS, Tribe, Tribal organization, or tribal health care facilities or Urban Indian organization had yet adopted a full-scale Zero Suicide approach. Organizations report that it takes at least a year and a half, and in most cases longer, to really embed all components of the model. Fewer evidence-based strategies or programs exist for AI/AN populations, and the Zero Suicide model currently used has not yet been tested or adapted for AI/AN communities. It will take careful consideration, evaluation, and support to develop a model that is culturally responsive and feasible to implement in AI/AN communities.

The FY 2017 $3,600,000 will be used to:

- Fund IHS facilities, Tribes, Tribal organizations, and Urban Indian organizations to implement Zero Suicide;
- Provide training, technical assistance, and evaluation services; and
- Implement health information technology support for clinical documentation of suicide screening and assessments.

Performance Impact

The mental health needs for all 12 Areas of the IHS vary as each faces different challenges, service gaps, and coordination between existing Federal, State, and Tribal programs. There are, however, significant opportunities that IHS uses to increase access to treatment services, such as tele-health and digital networks, intensive outpatient mental health treatment, and fostering more regional collaboration among psychiatric service systems that offer acute inpatient psychiatric care.

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 (EHR). The EHR screening tool has been implemented in 400 of 652 IHS, Tribal, and Urban Indian facilities as of FY 2015. In FY 2015, IHS exceeded its depression screening target by 3.1 percent.

While depression can begin at any age, the first episode of major depressive disorder (MDD) often occurs during childhood or adolescence. The linkage between suicide deaths and longer-term MDD among adolescents warrants widespread depression screening in the Indian health system given the high rates of suicide among AI/AN youth. In FY 2017, IHS will add a new depression screening measure for patients 12 through 17 years of age . Additionally, IHS will focus on medication management measures for depression in patients 18 years and older. Monitoring medication management for depression will involve two separate measures: one focusing on patients who are newly diagnosed with MDD and remain on an antidepressant medication for 12 weeks and the second for patients who are newly diagnosed with MDD and remain on an antidepressant medication treatment for at least 6 months. Baseline results will be reported in FY 2017. The new measures support the program expansion for BH2I and Zero Suicide.

Beginning in FY 2015, IHS began reporting on a national telebehavioral health measure through clinic encounters tracked in the EHR in the Mental Health budget. This measure was previously reported in the Alcohol and Substance Abuse budget for the Methamphetamine and Suicide Prevention Initiative's pilot project. IHS will continue to work to increase the use of telebehavioral health to increase access to care. In FY 2015, IHS increased the number of sites receiving telebehavioral health services from TBHCE for a total of 21 sites. IHS is in the planning stages of developing program measures to assess the effectiveness of tele-behavioral health encounters, such as reduced costs, improved patient wait times, and improved patient outcomes.

In FY 2016, IHS continues to provide training on the Suicide Reporting Form (SRF) and emphasize the importance of suicide surveillance activities among providers, facility and Area managers, and administrators. Similarly, Resource Patient Management System Site Managers and EHR Clinical Application Coordinators will continue annual training on the SRF and the appropriate application set-up and exporting processes. IHS will continue to work with its public and private partners to implement the National Strategy for Suicide Prevention's fourth strategic direction, which addresses suicide prevention surveillance, research, and evaluation activities, by incorporating the importance of utilizing the SRF as a part of Zero Suicide.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/-FY 2016 Target
18 Proportion of American Indian and Alaska Native adults 18 & over who are screened for depression (Outcome)	FY 2015: 67.4 % Target: 64.3 % (Target Exceeded)	67.2 %	70 %	+2.8 %
18 Tribally Operated Health Programs (Outcome)	FY 2015: 63.9 % Target: 59.2 % (Target Exceeded)	62.2 %	65 %	+2.8 %
29 Suicide Surveillance: Increase the incidence of suicidal behavior reporting by health care (or mental health) professionals (Outcome)	FY 2015: 2,346 completed reporting forms Target: 1,419 completed reporting forms (Target Exceeded)	1,798 completed reporting forms	2,536 completed reporting forms	+738 completed reporting forms
77 Anti-Depressant Medication Management: Acute Treatment (Intermediate Outcome)	FY 2017: Result Expected Dec 31, 2017 Target: Set Baseline (Pending)	N/A	Baseline	Maintain
77 TOHP Anti-Depressant Medication Management: Acute Treatment (Intermediate Outcome)	FY 2017: Result Expected Dec 31, 2017 Target: Set Baseline (Pending)	N/A	Baseline	Maintain
78 Anti-Depressant Medication Management: Continuous Treatment (Intermediate Outcome)	FY 2017: Result Expected Dec 31, 2017 Target: Set Baseline (Pending)	N/A	Baseline	Maintain
78 TOHP Anti-Depressant Medication Management: Continuous Treatment (Intermediate Outcome)	FY 2017: Result Expected Dec 31, 2017 Target: Set Baseline (Pending)	N/A	Baseline	Maintain
79 Depression Screening of American Indians and Alaska Natives ages 12-17. (Output)	FY 2017: Result Expected Dec 31, 2017 Target: Set Baseline (Pending)	N/A	Baseline	Maintain
79 TOHP Depression Screening of American Indian and Alaska Native patients ages 12-17. (Output)	FY 2017: Result Expected Dec 31, 2017 Target: Set Baseline (Pending)	N/A	Baseline	Maintain
MH-1 Increase Tele-behavioral health encounters nationally	FY 2015: 9,773 Target: 8,600	8,901	10,359	+1,458

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/-FY 2016 Target
(Output)	(Target Exceeded)			

* In FY 2017, IHS is proposing to report MH-1 under the Mental Health budget. The measure was new in FY 2016 PB and previously reported as ASA-5 under the Alcohol and Substance Abuse budget. IHS will begin reporting on the measure in FY 2015.

GRANTS AWARDS –The proposed FY 2017 budget increases will be used, in part, for grants for IHS facilities, Tribes, Tribal organizations, and Urban Indian organizations to develop innovative programs to address behavioral health services and deliver those services within and outside of the traditional health care system. Grants will be publicly competed. The actual number of grants to be awarded is to be determined.

AREA ALLOCATION

Mental Health
(dollars in thousands)

DISCRETIONARY SERVICES	FY 2015 Final			FY 2016 Enacted			FY 2017 President's Budget			FY '17 +/- FY '16
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$3,574	$8,053	$11,628	$3,609	$8,155	$11,765	$4,944	$10,982	$15,927	$4,162
Albuquerque	1,341	3,022	4,364	1,355	3,060	4,415	1,855	4,121	5,977	1,562
Bemidji	703	1,585	2,289	710	1,605	2,315	973	2,161	3,135	819
Billings	1,192	2,686	3,879	1,204	2,720	3,924	1,649	3,663	5,312	1,388
California	617	1,389	2,006	623	1,407	2,029	853	1,894	2,747	718
Great Plains	2,983	6,720	9,703	3,012	6,805	9,817	4,126	9,164	13,290	3,473
Nashville	538	1,211	1,749	543	1,226	1,769	744	1,652	2,395	626
Navajo	4,436	9,994	14,430	4,479	10,121	14,600	6,136	13,629	19,764	5,165
Oklahoma	4,650	10,478	15,128	4,696	10,610	15,306	6,433	14,288	20,721	5,415
Phoenix	2,328	5,246	7,574	2,351	5,312	7,663	3,221	7,154	10,374	2,711
Portland	1,271	2,863	4,133	1,283	2,899	4,182	1,758	3,904	5,661	1,479
Tucson	450	1,014	1,464	454	1,027	1,481	623	1,383	2,005	524
Headquarters	860	1,939	2,799	869	1,963	2,832	1,190	2,644	3,834	1,002
Total, Mental	**$24,944**	**$56,201**	**$81,145**	**$25,188**	**$56,912**	**$82,100**	**$34,504**	**$76,639**	**$111,143**	**+$29,043**

Note: Allocation amounts are estimates.

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

ALCOHOL AND SUBSTANCE ABUSE

(Dollars in Thousands)

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$190,981	$205,305	$233,286	+$27,981
FTE*	191	201	206	+5

* 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 2017 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 substance abuse treatment into primary care. Additionally, the ASAP aligns and integrates the Department's Strategic Goal 1: Strengthen Health Care under Objective E by ensuring AI/ANs have access to quality, culturally competent care and the HHS ARC 4 Keeping People Healthy and Safe: Ensure optimal health is achievable by everyone in this country by having a health care system that keeps people healthy and promoting prevention and wellness that is not delivered strictly through the health care system. For instance, the Substance Abuse and Suicide Prevention Program (SASP) (formerly known as the Methamphetamine and Suicide Prevention Initiative) provides community developed and delivered prevention and intervention resources to address the dual crises of methamphetamine and suicide in AI/AN communities.

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] The age-adjusted AI/AN drug-related death rate is 4.1 deaths per 100,000 population for the three-year period 1979-1981, as compared to the AI/AN death rate of 22.7 in 2007-2009. This is an increase of 454 percent since drug-related

[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.

death rates were first introduced for AI/AN in 1979. The 2007-2009 AI/AN rate is 1.8 times greater than the U.S. all races rate of 12.6 for 2008.[2]

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

Integrated Substance Abuse Treatment in Primary Care: IHS continues to support the integration of substance abuse treatment into primary care and emergency services. Integrating treatment into health care offers immediate and same-day opportunities for health care providers to identify patients with substance use disorders, provide them with medical advice, help them understand the health risks and consequences, obtain substance abuse consultations, and refer patients with more severe substance use-related problems to treatment.[3] One integration activity is Screening, Brief Intervention, Referral to Treatment (SBIRT), which is an early intervention and treatment service for people with substance use disorders and those at risk of developing these disorders. IHS is broadly promoting SBIRT as an integral part of a sustainable, primary care-based, behavioral health program through reimbursement from the Centers for Medicare and Medicaid Services (CMS). As a result, IHS developed guidelines for documenting SBIRT in the electronic health record and plans to provide training on SBIRT in FY 2016.

Medication Assisted Treatment (MAT): Medication Assisted Treatment (MAT) is an approach that uses Food and Drug Administration approved pharmacological treatments, often in combination with psychosocial treatments, for patients with opioid use disorders.[4] In FY 2016, IHS will provide the necessary waiver training for physicians to prescribe MAT through its Tele-Behavioral Health Center of Excellence (TBHCE) for IHS, Tribal, and Urban Indian (I/T/U) health facilities. IHS also works to provide training on proper opioid prescribing through the TBHCE. As of November 2015, more than 1800 I/T/U health care providers have received the training. IHS will continue to offer the training on a regular basis in FY 2016 with refresher courses offered every three years. To provide clinical support for providers, the TBHCE recently launched weekly Pain and Addiction consultations. Healthcare providers may receive a no-cost consultation from an expert panel on the most challenging pain and addiction cases.

Youth Regional Treatment Centers (YRTCs): YRTCs provide residential substance abuse and mental health treatment services to AI/AN youth. Congress authorized the establishment of these YRTCs in each of the 12 IHS Areas, with two (northern and southern) specifically authorized for the California Area. The Southern California facility is expected to open in FY 2016. 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 provides funding to the Fetal Alcohol and Drug Unit (FADU), located within the University of Washington's Alcohol and Drug Abuse Institute. Over 400 high-risk, substance-abusing pregnant and parenting women and their families have

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[2] U.S. Department of Health and Human Services, Indian Health Service. Trends in Indian Health 2014 Edition. Released March 2015. ISSN 1095-286

[3] U.S. Office of National Drug Control Policy. Integrating Treatment into Healthcare. *Available at* http://www.whitehouse.gov/ondcp/integrating-treatment-and-healthcare.

[4] U.S. Office of National Drug Control Policy. Medication Assisted Treatment for Opioid Addiction. *Available at* http://www.whitehouse.gov/sites/default/files/ondcp/recovery/medication_assisted_treatment_9-21-20121.pdf.

received evaluation, diagnosis, and referral services through the FADU. Additionally, the FADU offered two webinars through the TBHCE in FY 2015 on FASD with over 200 participants in attendance.

Screening with intervention has been shown to be effective in reducing alcohol misuse during pregnancy and to reduce the incidence of FASD. The IHS increased the alcohol screening rate since 2004 until this fiscal year. Beginning in FY 2016, IHS will move the training and technical assistance to the TBHCE for workforce development and telehealth services related to FASD.

Substance Abuse and Suicide Prevention Program (SASP) (formerly known as the Methamphetamine and Suicide Prevention Initiative): The SASP is a nationally-coordinated program providing substance abuse and suicide prevention and intervention resources that are culturally appropriate to AI/AN communities with the greatest need for this funding. The demonstration pilot project operated from September 2009 to September 2015. National program evaluation is a central component to SASP and is the last phase of the demonstration project. The national evaluation is scheduled to be complete in FY 2016. Early lessons learned were used to identify successful practice-based and evidence-based interventions to be replicated across the Indian health system in the new funding cycle.

On September 30, 2015, 118 SASP projects were awarded to participate in the new five year funding cycle scheduled to operate from 2015 to 2020. Projects applied for funding in at least one of four purpose areas: 1) Community Needs Assessment and Strategic Planning; 2) Suicide Prevention, Intervention, and Postvention, 3) Methamphetamine Prevention, Treatment, and Aftercare, and 4) Generation Indigenous Support. SASP projects work to address the SASP goals that are pertinent to their funded activities.

The goals of SASP are to: 1) increase Tribal, UIHP, and Federal capacity to operate successful methamphetamine prevention, treatment, and aftercare and/or suicide prevention, intervention, and postvention services through implementing community and organizational needs assessment and strategic plans; 2) develop and foster data sharing systems among Tribal, Urban Indian, and Federal behavioral health service providers to demonstrate efficacy and impact; 3) identify and address suicide ideations, attempts, and contagions among AI/AN populations through the development and implementation of culturally appropriate and community relevant prevention, intervention, and postvention strategies; 4) identify and address methamphetamine use among AI/AN populations through the development and implementation of culturally appropriate and community relevant prevention, treatment, and aftercare strategies; 5) increase provider and community education on suicide and methamphetamine use by offering appropriate trainings; and 6) promote positive AI/AN youth development and family engagement through the implementation of early intervention strategies to reduce risk factors for suicidal behavior and substance use.

IHS will continue to collect a rich and wide range of data submitted by SASP projects during the five year funding cycle.

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

requirements as well as quality performance measurements for numerous screening and prevention initiatives including screening for alcohol and substance use, depression, domestic violence, smoking, and suicide data collection.

Partnerships: IHS is collaborating with other agencies working in the field of substance disorders such as the Substance Abuse and Mental Health Services Administration (SAMHSA), Veterans Health Administration, Health Resources and Services Administration, Office of National Drug Control Policy, and CMS to ensure that the best available information, trainings, protocols, evaluations, performance measures, data needs, and management skills are incorporated and shared with all agencies and organizations working on substance use disorders.

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

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

In FY 2016, the IHS and BIA entered into a formal partnership to reduce deaths from prescription drug and heroin overdoses by providing naloxone, a medication that reverses the effects of heroin or prescription opioid overdose and saves lives. IHS plans to provide training and medication to more than 500 BIA law enforcement officers across the country beginning in FY 2016.

FUNDING HISTORY

Fiscal Year	Amount	MSPI	Gen I
2012 Enacted	$194,297,000	($16,332,045)	
2013 Enacted	$185,154,000	($15,512,557)	
2014 Final	$186,378,000	($15,512,557)	
2015 Final	$190,981,000	($15,475,000)	
2016 Enacted	$205,305,000	($15,475,000)	($10,000,000)

BUDGET REQUEST

The FY 2017 budget request for Alcohol & Substance Abuse of $233,286,000 is an increase of $27,981,000 above the FY 2016 Enacted level.

FY 2016 Base Funding of $205,305,000 - The base funding is necessary to maintain the program's progress in addressing alcohol and substance abuse needs by improving access to

behavioral health services through tele-behavioral health efforts and providing a comprehensive array of preventive, educational, and treatment services.

FY 2017 Funding Increase of $27,981,000 includes:

- Pay Costs +$1,639,000 – to cover pay raises for federal and Tribal employees of which about 90 percent are working at the service unit level providing health care and related services.

- Inflation +$3,404,000 – to cover inflationary costs of providing health care services.

- Population Growth +$2,493,000 – to fund the additional services need arising from the growing AI/AN population. The growth rate is projected to be 1.8 percent in CY 2017 based on state births and deaths data.

- Staffing/Operating Cost Requirements for Newly Constructed Facilities +$3,645,000 – Alcohol and Substance Abuse funding is requested for four new and expanded health care facility and one youth regional treatment center that are planned to open in FY 2016. Funding for these facilities allows IHS to expand provision of health care in those areas where capacity has been expanded to address critical health care needs.

New Facilities	Amount	Tribal Positions
Muskogee (Creek) Nation Health Center (JV), Eufaula, OK	$307,000	3
Northern CA Youth Treatment Center, Davis, CA	$3,064,000	33
Flandreau Health Center (JV), Flandreau, SD	$102,000	1
Choctaw Nation Regional Medical Center (JV), Durant, OK	$172,000	2
Grand Total:	**$3,645,000**	**39**

Program Increase +$16,800,000

Tribal YRTC Aftercare Pilot Project $1,800,000 - IHS currently funds eleven YRTCs to provide a range of clinical services rooted in a culturally relevant, holistic model of care. These services include clinical evaluation, substance abuse education, group, individual and family psychotherapy, art therapy, adventure-based counseling, life skills, medication management or monitoring, evidence-based/practice-based treatment, aftercare relapse prevention, and limited post-treatment follow-up services. Once American Indian and Alaska Native (AI/AN) youth are discharged home, they are faced with leaving a structured treatment environment to return home where little work has occurred with their families and often times, aftercare services are limited.

The IHS requests additional funding to establish a pilot project to fill this gap in services and provide a continuum of care for AI/AN youth after they are discharged home from YRTCs. The goal of the pilot project will be to promote integration of cultural practices with evidence based treatment in aftercare services for AI/AN youth. Funded projects will hire and train clinical staff in evidence-based treatment approaches, such as dialectical behavior therapy, with the incorporation of new staff to provide culturally appropriate interventions and activities. YRTCs will be able to hire staff, such as a cultural teacher or cultural knowledge keeper, tribal elder, and/or peer specialist. Pilot projects will incorporate cultural approaches that are appropriate for their regional or local service area, such as dancing, ceremonial practices, canoe journeys, and traditional teachings.

SASP Expansion – Generation Indigenous (Gen I) +$15,000,000 - to expand SASP under Purpose Area #4 – "Generation Indigenous Initiative Support" to focus on hiring additional staff to improve behavioral health services and prevention programming for AI/AN youth. Strategies to address mental health, alcohol, substance use, and suicide require comprehensive clinical approaches, collaborations, and partnerships with consumers and their families to reduce morbidity and early mortality. The SASP Expansion will support Gen I by removing barriers to behavioral health treatment and provide prevention programming to ensure that comprehensive, culturally appropriate approaches exist for Native children and youth to reach their full potential. The SASP Expansion – Gen I supports the HHS Arc of delivery system reform and finds better ways to deliver care for AI/AN youth.

The IHS is seeking $15,000,000 above the FY 2016 Enacted level for the Alcohol and Substance Abuse budget to:

- Provide funds to currently funded SASP projects under Purpose Area #4 to hire behavioral health professionals, peer specialists, and other professionals to provide services for AI/AN children, youth, and their families.
- Increase the number of additional Tribes, Tribal organizations, and Urban Indian organizations to participate in SASP Purpose Area #4.

Performance Impact

Alcohol and substance abuse in AI/AN communities results in devastating intergenerational social, economic, physical, mental, and spiritual health disparities. Alcohol and substance abuse among the AI/AN populations contribute to high rates of mortality: liver disease is 3.68 times greater, unintentional injuries are 1.4 times greater, and suicide is 0.6 times greater than U.S. all races death rates in 2008.[5] For example, the age-adjusted[6] alcohol related death rate for AI/ANs is 49.6 per 100,000 population (2007-2009) and is 6 times greater than the U.S. all races rate of 8.0 per 100,000 population (2008).[7]

As a routine part of women's health, IHS providers screen for alcohol use among women of child-bearing age. The overall percentage of female patients screened for alcohol use improved in FY 2015. However, the Alcohol Screening measure was missed by 0.1 percent. To provide more comprehensive routine screening, IHS will expand its Alcohol Screening measure to include all patients 12 and over in FY 2017 and retire the Alcohol Screening measure for female patients.

The SBIRT and MAT services are a critical piece for IHS to be able to provide integrated behavioral health care, as well as overcome the shortage of inpatient treatment options and long wait times for available inpatient services. IHS is planning to report a new SBIRT measure with baseline results in 2017. In FY 2017, IHS will continue education on SBIRT, promote the use of MAT, train providers on proper opioid prescribing, and develop a national prescription drug abuse measure to better assess the impact of prescription drug abuse. The national prescription drug abuse measure was initially planned for rollout in FY 2017 and will now be released in FY 2018. The additional time will allow IHS to ensure systems are in place to provide appropriate pharmacotherapy and psychosocial treatment for individuals with opioid use disorders.

[5] U.S. Department of Health and Human Services, Indian Health Service. Trends in Indian Health 2014 Edition. Released March 2015. ISSN 1095-286.
[6] Rates have been adjusted to compensate for misreporting of AI/AN race on state death certificates.
[7] U.S. Department of Health and Human Services. Indian Health Service. Trends in Indian Health, 2014 Edition. Released March 2015. ISSN 1095-286

For youth with substance use disorders, the YRTCs provide invaluable treatment services. The accreditation measure for YRTCs reflects an evaluation of the quality of care by either the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities (CARF), or State licensure. The 100 percent accreditation performance measure was not met in FY 2015 as a result of the accreditation for one federally-operated YRTC. However, an appeal was submitted and subsequent accreditation for the YRTC was issued in FY 2016.

Additional funding for the SASP provides community and clinical preventive services, education, and outreach. As a result, the SASP resulted in 12,209 individuals entering treatment for methamphetamine abuse; 16,569 encounters via tele-behavioral health; 16,250 professionals and community members trained in suicide crisis response; and 690,597 encounters with youth provided as part of evidence-based and practice-based prevention activities from 2009 - 2015. Despite the overall success of the SASP, the target for number of individuals trained in suicide crisis response was missed by a small margin of 79 individuals. This missed target is similar to the mature phases of other demonstration projects when high visibility, high-outreach events are held less often. Another contributing factor in training less individuals is attributed to staff turnover who are available to conduct suicide crisis response training. Recruitment, training, and certification of new staff is required before training events can be resumed. The demonstration pilot project phase of the SASP ended August 31, 2015. As a result, IHS is retiring the ASA-1, ASA-2, ASA-3, and ASA-4 budget measures after the FY 2015 reporting cycle.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/-FY 2016 Target
10 YRTC Improvement/Accreditation: Accreditation rate for Youth Regional Treatment Centers (in operation 18 months or more). (Outcome)	FY 2015: 90 % Target: 100 % (Target Not Met)	100 %	100 %	Maintain
11 Alcohol Screening (FAS Prevention): Alcohol-use screening (to prevent Fetal Alcohol Syndrome) among appropriate female patients. (Outcome)	FY 2015: 66.6 % Target: 66.7 % (Target Not Met but Improved)	Baseline	Retire after 2016	Maintain
11 Tribally Operated Health Programs (Outcome)	FY 2015: 63.9 % Target: 62.4 % (Target Exceeded)	Baseline	Retire after 2016	Maintain
60 Universal Alcohol Screening (Outcome)	FY 2017: Result Expected Sep 30, 2017 Target: Set Baseline (Pending)	N/A	Baseline	Maintain
60 TOHP Tribally Operated Health Programs (Outcome)	FY 2017: Result Expected Sep 30, 2017 Target: Set Baseline (Pending)	N/A	Baseline	Maintain
76 Screening, Brief, Intervention, and Referral Treatment (SBIRT) (Outcome)	FY 2017: Result Expected Sep 30, 2017 Target: Set Baseline (Pending)	N/A	Baseline	Maintain
76 TOHP Screening, Brief, Intervention and Referral to Treatment (SBIRT) (Outcome)	FY 2017: Result Expected Sep 30, 2017 Target: Set Baseline (Pending)	N/A	Baseline	Maintain
ASA-1 The number of identified meth using patients who enter methamphetamine treatment program (Output)	FY 2015: 2,732 Patients Target: 2,583 Patients (Target Exceeded)	Retire after 2015	Retire after 2015	Maintain
ASA-2 The number of youth (ages 6-21) who participate in evidence-based and/or promising practice prevention or intervention programs (Output)	FY 2015: 162,291 Youth Target: 161,651 Youth (Target Exceeded)	Retire after 2015	Retire after 2015	Maintain

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/-FY 2016 Target
ASA-3 The number of individuals trained in suicide crisis response (Output)	FY 2015: 3,099 individuals trained Target: 3,178 individuals trained (Target Not Met but Improved)	Retire after 2015	Retire after 2015	Maintain
ASA-4 Increase Tele-behavioral health encounters (Output)	FY 2015: 4,375 encounters Target: 3,261 encounters (Target Exceeded)	Retire after 2015	Retire after 2015	Maintain

GRANTS AWARDS

CFDA No. 93.933 Demonstration Projects for Indian Health			
	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	14	14	118*
Average Award	$100,000	$100,000	$109,345
Range of Awards	n/a	n/a	n/a
Total Awards	$1,388,7450	$1,400,00	$23,400,000

*With the FY 2016 increase for SASP, the number of grants will increase in FY 2017. The total number of actual grants is to be determined.

AREA ALLOCATION

Alcohol and Substance Abuse

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2015 Final			FY 2016 Enacted			FY 2017 President's Budget			FY '17 +/- FY '16
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$3,320	$28,779	$32,098	$3,564	$30,942	$34,506	$4,035	$35,174	$39,209	$4,703
Albuquerque	1,260	10,919	12,178	1,352	11,739	13,091	1,531	13,345	14,876	1,784
Bemidji	1,040	9,016	10,056	1,116	9,693	10,810	1,264	11,019	12,283	1,473
Billings	1,147	9,940	11,086	1,231	10,687	11,918	1,394	12,148	13,542	1,624
California	1,129	9,789	10,918	1,212	10,525	11,737	1,372	11,964	13,337	1,600
Great Plains	1,448	12,550	13,998	1,554	13,494	15,048	1,760	15,339	17,099	2,051
Nashville	911	7,902	8,813	978	8,496	9,474	1,108	9,658	10,765	1,291
Navajo	1,956	16,954	18,910	2,100	18,229	20,328	2,377	20,722	23,099	2,771
Oklahoma	1,670	14,475	16,144	1,792	15,563	17,355	2,029	17,691	19,721	2,365
Phoenix	1,716	14,877	16,593	1,842	15,996	17,838	2,086	18,183	20,269	2,431
Portland	1,677	14,536	16,213	1,800	15,629	17,429	2,038	17,766	19,804	2,375
Tucson	323	2,802	3,125	347	3,012	3,359	393	3,424	3,817	458
Headquarters	2,156	18,692	20,848	2,315	20,097	22,412	2,621	22,846	25,466	3,054
Total, ASA	**$19,752**	**$171,229**	**$190,981**	**$21,204**	**$184,101**	**$205,305**	**$24,006**	**$209,280**	**$233,286**	**+$27,981**

Note: Allocation amounts are estimates.

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

(Dollars in Thousands)

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$914,139	$914,139	$962,331	+$48,192
FTE*	0	0	0	0

*PRC is not used for Federal or 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 2017 Authorization.....Permanent

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

PROGRAM DESCRIPTION and ACCOMPLISHMENTS

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

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

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

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

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

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

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

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

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

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

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

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

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

Accomplishments

Medicare-like Rates (MLR) – On December 5, 2014, the IHS published a notice of proposed rulemaking in the Federal Register to establish MLR for IHS payment for physician and other non-hospital based services. This regulation is consistent with the recommendations from the Government Accountability Office (GAO)[7] and the HHS Office of Inspector General[8] and could potentially achieve substantial PRC savings that may be used to expand IHS beneficiary access to care. The IHS sought comment on how to establish reimbursement rates that are consistent across federal health care programs, align payment with inpatient services, and enable IHS to expand beneficiary access to medical care. In addition, the IHS also sought comment on whether an I/T/U should be allowed to negotiate a higher rate than MLR so as not to have a detrimental financial impact to the most rural providers and potentially negatively impact access to care. The comment period closed on February 4, 2015. The majority of commenters favored the rule but recommended incorporating additional flexibilities to allow the PRC programs to continue to negotiate rates with the private sector, when warranted. IHS is finalizing the rule to include flexibilities that Tribes need to make the rule work for them and non-I/T/U providers. The majority of commenters also requested additional Tribal consultation. Tribal calls and listening sessions were conducted to allow for Tribal consultation and the IHS will publish the final rule with a 45-day comment period.

Purchased/Referred Care – Recent program funding increases have allowed some of the IHS and Tribally-managed PRC programs to approve referrals in priority categories other than Medical Priority I (life or limb), including some preventive care services, thus increasing access to patient care services. In FY 2014, 66 percent of IHS-operated PRC programs were able to purchase services beyond Medical Priority I – Emergent or Acutely Urgent Care Services. Recent funding increases as well as alternate resources and increased third-party collections due to implementation of the Affordable Care Act ensure programs can purchase preventive care beyond emergency care services, such as mammograms or colonoscopies.

The IHS PRC Workgroup helped IHS develop a more accurate form for reporting denied and deferred PRC services each year. In FY 2015, PRC denied an estimated $644,953,000 for an estimated 132,000 services needed by eligible AI/ANs. Due to the fact that Tribally-managed programs are not required to report on denials, it is difficult to provide a verifiable and complete measure of the total unmet need for the entire system. Therefore, the denied services estimate is based on actual data from federal programs and estimated Tribal data.

Catastrophic Health Emergency Fund (CHEF) – In FY 2015, 1,531 high cost cases were reimbursed from CHEF funds on a rolling basis at a total cost of $51,500,000. It is estimated that more cases may qualify for CHEF reimbursement but were not reported by the local IHS and Tribally-managed PRC programs due to the depletion of CHEF before the end of FY 2015. When CHEF funds are depleted, requests for reimbursements from IHS Headquarters are denied. Recent funding increases helped ensure CHEF funds were depleted later than in previous years; in FY 2015 funding was fully depleted in mid-September.

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

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

FUNDING HISTORY

Fiscal Year	PRC	CHEF	TOTAL
2012 Enacted	$792,157,000	$51,418,000	**$843,575,000**
2013 Enacted	$752,420,000	$48,838,000	**$801,258,000**
2014 Final	$827,075,000	$51,500,000	**$878,575,000**
2015 Final	$863,139,000	$51,500,000	**$914,139,000**
2016 Enacted	$863,139,000	$51,500,000	**$914,139,000**

BUDGET REQUEST

The FY 2017 budget request for Purchased/Referred Care of $966,229,000 is an increase of $48,192,000 above the FY 2016 Enacted level.

FY 2016 Enacted of $914,139,000 would provide the following services:

- $51,500,000 for CHEF high cost cases
- $862,639,000 to purchase:
  - 32,100 Inpatient admissions
  - 646,600 Outpatient visits
  - 40,400 Patient travel trips

FY 2017 Increase of $52,090,000 would provide:

- $1,500,000 million increase for CHEF to fund high cost cases
- Funds to maintain the current level of services
  - Medical Inflation +37,382,000 addressing the rising cost of health care calculated at the OMB medical inflation rate.
  - Population Growth +13,208,000 to cover the cost of health care due to the increase in the service population.

The PRC Program is observing the effects of the ACA and Medicaid expansion. While there is a positive trend associated with these health care reform efforts, the PRC Program is still immediately impacted by any changes in funding.

Performance Impact

Since 2011, the GAO has published four reports on the PRC program.[9] The IHS PRC Workgroup has reviewed the recommendations and the Agency is implementing a majority of the GAO recommendations, including the MLR regulatory proposal described above and many programmatic and policy improvements. In addition, the program has identified several risk categories and is working to ensure proper policies and procedures are in place to maintain programmatic consistency across all Areas. These ongoing activities continue to be monitored by PRC staff at the IHS Area office and Headquarters level.

In its 2013 report, the GAO recommended the PRC program modify the IHS GPRA measure on the timeframe for payment of referrals to track results for IHS authorized referrals and patient self-referrals separately. In the FY 2017 Budget, IHS is adopting the GAO recommendation in

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

recognition of the differences in payment processes for these two types of referrals and retiring the current PRC-1 measure "average days between service end and purchase order issued." The two new measures track IHS authorized referrals[10] and establish a timeframe for payment and track patient self-referrals[11] and establish a separate target timeframe for authorization and payment of referrals. The two new proposed measures better assess the timeliness of provider payments, ensuring continued access to care and program quality in monitoring timely payment to external providers and reinforce partnerships.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/-FY 2016 Target
PRC-1 PRC: Average days between service end and purchase order (PO) issued. (Outcome)	FY 2015: 73.7 days Target: 74 days (Target Exceeded)	Retire after 2015	Retire after 2015	Maintain
PRC-2 Track IHS PRC referrals (Outcome)	FY 2016: Result Expected Dec 31, 2016 Target: Set Baseline (Pending)	Baseline	TBD	N/A
PRC-3 Track PRC self-referrals (Outcome)	FY 2016: Result Expected Dec 31, 2016 Target: Set Baseline (Pending)	Baseline	TBD	N/A

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

GRANT AWARDS. This program does not award grants.

AREA ALLOCATION

Purchased/Referred Care
(dollars in thousands)

DISCRETIONARY SERVICES	FY 2015 Final			FY 2016 Enacted			FY 2017 President's Budget			FY'17 +/- FY'16
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$32,442	$56,431	$88,874	$32,442	$56,431	$88,874	$33,916	$59,643	$93,559	$4,685
Albuquerque	16,183	28,149	44,331	16,183	28,149	44,331	16,918	29,751	46,669	2,337
Bemidji	22,792	39,646	62,438	22,792	39,646	62,438	23,828	41,902	65,730	3,292
Billings	23,334	40,587	63,921	23,334	40,587	63,921	24,394	42,897	67,291	3,370
California	18,089	31,464	49,552	18,089	31,464	49,552	18,910	33,254	52,164	2,612
Great Plains	32,972	57,351	90,323	32,971	57,352	90,323	34,469	60,615	95,085	4,762
Nashville	12,780	22,230	35,010	12,780	22,230	35,010	13,361	23,495	36,856	1,846
Navajo	36,547	63,571	100,118	36,547	63,571	100,118	38,207	67,189	105,396	5,278
Oklahoma	41,636	72,423	114,060	41,636	72,423	114,060	43,528	76,545	120,073	6,013
Phoenix	27,340	47,556	74,896	27,340	47,556	74,896	28,582	50,262	78,844	3,948
Portland	35,360	61,506	96,866	35,360	61,506	96,866	36,966	65,006	101,973	5,107
Tucson	6,996	12,169	19,165	6,996	12,169	19,165	7,314	12,862	20,176	1,010
Headquarters	27,226	47,358	74,585	27,226	47,358	74,585	28,463	50,053	78,517	3,932
Total, PRC	**$333,698**	**$580,441**	**$914,139**	**$333,697**	**$580,442**	**$914,139**	**$348,857**	**$613,474**	**$962,331**	**+$48,192**

Note: Allocation amounts are estimates.

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

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

(Dollars in Thousands)

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$153,961	$155,734	$166,075	+$10,341
FTE*	228	228	228	0

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

SUMMARY OF THE BUDGET REQUEST

The FY 2017 budget request for Preventive Health programs of $166.075 million is $10.341 million above the FY 2016 Enacted level. The detailed explanation of the request is described in each of the budget narratives that follow.

- An increase of $5.417 million for a total of $82.040 million for **Public Health Nursing** (PHN) to support prevention-focused nursing care interventions for individuals, families, and community groups as well as improving health status by early detection through screening and disease case management. The PHN Program home visiting service provides primary, secondary, and tertiary prevention focused health interventions.
  - *Primary prevention* targets healthy populations with activities aimed at preventing the onset of disease in high risk populations through education, health awareness, immunizations, and risk reduction. PHNs provide childhood obesity prevention activities through breastfeeding promotion to the prenatal patient and during postpartum home visits to mother and baby after hospital discharge.
  - *Secondary prevention* detects and treats problems in the early stages of illness or disease. These interventions target disease before complications arise and before signs or symptoms appear and include health screening for diabetes and hypertension, fall risk assessments, and school health assessments.
  - *Tertiary prevention* reduces further complications from a disease or illness and restores the individual to their optimum level of health. Interventions include chronic disease care, self-management education, medication management, and care coordination. For example a PHN's make home visits after patients are discharged from the hospital to help reduce preventable complications and hospital readmissions.

- An increase of $1.290 million for a total of $19.545 million for **Health Education** to support the provision of community health, school health, worksite health promotion, and patient education. The Health Education Program standardizes, coordinates, and integrates education initiatives within IHS, including health literacy for American Indian/Alaska Native (AI/AN) individuals and communities, provision of professional education and training, and developing educational materials for staff, patients, families, and communities.

- An increase of $3.522 million for a total of $62.428 million for **Community Health Representatives** (CHRs) to help to bridge the gap between AI/AN individuals and health care resources through outreach by specially trained indigenous community members. CHRs use local community knowledge to help integrate and disseminate basic information about health promotion/disease prevention and self-management support to patients. With more pilot sites participating in the Agency's Improving Patient Care and Partnership for Patients

efforts, several are reporting how valuable the input and services provided by CHRs are to improving patient care.

- An increase of $112,000 for a total of $2.062 million for **Hepatitis B and Haemophilus Immunization Programs (Alaska)** will support the provision of vaccines for preventable diseases, immunization consultation/ education, research, and liver disease treatment and management through direct patient care, surveillance, and education for Tribal facilities throughout Alaska. The Hepatitis B and Haemophilus Immunization Programs (Alaska) budget supports these priorities through direct patient care, surveillance, and educating Alaska Native patients.

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

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

PUBLIC HEALTH NURSING

(Dollars in Thousands)

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$75,640	$76,623	$82,040	+$5,417
FTE*	202	202	202	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 2017 Authorization.....Permanent

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

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

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

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

PHNs conduct home visiting services for:

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

The PHN Program aligns with the Agency's priorities and contributes to the sustained progress towards meeting all Government Performance and Results Act (GPRA) measures and integrates the Department's Strategic Goal to strengthen health care. The PHN program ensures AI/ANs have access to quality, culturally competent care that aims to promote health and quality of life through a community population focused nurse visiting program. For example, in GPRA year 2015, the PHNs provided the following six major GPRA related activities (the number of PHN contacts is reported from the PHN Data Mart): Tobacco Screening (6,484); Domestic Violence Screening (13,037); Depression Screening (22,061); Alcohol Screening (15,238); Adult Influenza Vaccines (50,049))and Adult Pneumococcal Vaccines (5,274).

In 2015, the PHN Program supported the IHS' goal to decrease childhood obesity and prevent diabetes by sustaining Baby Friendly designation efforts by performing the following activities: providing patient education, assessment and referral services for prenatal and postpartum clients during home visits, and utilizing a standardized PHN electronic health record template to document this intervention. The data logic to measure this intervention of promoting breastfeeding during the nurse home visit was developed in 2015 and added to the PHN data mart reportable tables. The monitoring of these interventions by use of the PHN data mart provides a mechanism to evaluate this evidence-based prevention service of promoting breastfeeding during the nurse home visit. This supports sustaining the Baby Friendly program which is an official standard of care for AI/AN mothers and babies within the IHS health care system.

In FY 2015 the IHS successfully established a Memorandum of Understanding with the Department of Veterans Affairs (VA) and the University of Tennessee to begin the implementation of the Resource to Enhance All Caregivers Health (REACH) program, an evidenced-based program that provides a structured intervention to support caregivers of individuals suffering from dementia. Caregivers supported by the REACH-VA program show improvement in depression, the effect of depression on daily life, and caregiver burden and frustration. In 2015, training, certification and support from the VA and University of Tennessee is being offered to all federal PHN Programs. In 2015, the data logic to capture the PHN activity dedicated to this service was established and will be utilized to monitor efforts to reach the goal of expanding this service to 50 tribal communities.

The PHN Program supports HHS ARC 4 of Keeping People Healthy and Safe: Ensure optimal health is achievable by everyone in this country by having a health care system that keeps people healthy and promoting prevention and wellness that is not delivered strictly through the health care system. The PHNs support this service to keep people healthy and safe by ensuring optimal health is achievable by promoting disease prevention and wellness services that are delivered outside of the four walls of the health care system through home visits and community based interventions.

FUNDING HISTORY

Fiscal Year	Amount
2012 Enacted	$66,632,000
2013 Enacted	$66,282,000
2014 Final	$70,909,000
2015 Final	$75,640,000
2016 Enacted	$76,623,000

BUDGET REQUEST

The FY 2017 budget request for Public Health Nursing of $82,040,000 is an increase of $5,417,000 above the FY 2016 Enacted level.

FY 2016 Base Funding of $76,623,000 – The base funding is necessary to support the public health nursing services provided by IHS and Tribal programs, maintain the programs progress in raising the quality of and access to public health nursing care through continuing recruitment of nursing professionals to meet workforce needs, and to meet or exceed agency targets.

FY 2017 Funding Increase of $5,417,000 includes:

- Pay Costs +$796,000 – to cover pay raises for federal and Tribal employees of which about 90 percent working at the service unit level providing health care and related services.

- Inflation +$2,058,000 – to cover inflationary costs of providing health care services.

- Population Growth +$874,000 – to fund the additional services need arising from the growing AI/AN population. The growth rate is projected to be 1.8 percent in CY 2017 based on state births and deaths data.

- Staffing/Operating Cost Requirements for Newly Constructed Facilities +$1,689,000 – Public Health Nursing funding is requested for three new and expanded healthcare facilities that are planned to open in FY 2016. Funding these facilities allows IHS to expand provision of health care in those areas where capacity has been expanded to address critical health care needs.

New Facilities	**Amount**	**FTE/Tribal Positions**
Muskogee (Creek) National Health Center (JV), Eufala, OK	$679,000	5
Flandreau Health Center (JBV), Flandreau, SD	$557,000	4
Choctaw Nation Regional Medical Center (JV), Durant, OK	$453,000	3
Grand Total:	**$1,689,000**	**12**

With the FY 2017 budget request, the PHN Program will continue working towards providing services and achieving its performance targets:

1. Providing approximately 381,314 individual patient encounters for a vast array of health activities and nursing services to AI/AN patients;
2. Continuing to support national measures of maternal-child health (such as childhood immunizations, prenatal visits, postpartum visits, childhood obesity prevention through

breastfeeding promotion and sustain Baby Friendly activity, and collaboration with related federal, state, local, and private maternal child health programs);
3. Continued progress to contribute to targeted GPRA measures including tobacco screening, depression screening, domestic violence screening, and adult pneumococcal vaccinations;
4. Continued provision of community immunizations and immunizations to homebound individuals and elderly (support increasing Influenza vaccination coverage rates to meet the Healthy People 2020 goal of 70 percent);
5. Integration of PHN Case Management best practices into the cooperative agreement grant, program awards;
6. Continued support of injury prevention; and
7. Other services will be sustained with minimal expansion.

The PHN programs will continue to report on clinical performance measures for PHN home visits following a hospital discharge as a means to reduce avoidable hospital readmissions. IHS will continue focusing on reducing preventable complications during transition from one care setting to another, thereby reducing overall hospital readmissions. Sustaining these efforts will support patient recovery from illness without incidence of preventable complications requiring re-hospitalization.

Congressional appropriations created funding for the PHN Program to award 10 grants and 5 program awards in calendar year (CY) 2013 with continuation funding through CY 2017. These grants and program awards provide funding to increase local nursing services through public health nursing case management programs for high risk and vulnerable patients and families. Research indicates nurse case management is a cost effective approach to maximize health outcomes. Case management involves the client, family, and the health care team to support appropriate and timely interventions. In addition to reducing the cost of health care, nurse case management has proven its worth in terms of improving client self-determination. The intent of this program is to make available an array of PHN Best Practices/Promising Practices to support a PHN Case Management Program through the cooperative agreement grants to Tribes and Urban programs and the federal program award process. For example, in 2015, the Pine Ridge PHN Case Management Program was established to focus on suicide prevention in the community. This program will be shared with other PHN Programs as a best practice and shared with other programs to replicate, to target this intervention in other AI/AN communities.

Performance Impact

The overall goal for PHN activities is to improve patient outcomes. The educational development of the community nurses prepares them to provide effective encounters to improve self-efficacy and clinical outcomes for patients with chronic conditions.[1] The public health activities implemented by PHNs are evidenced based practices that support agency and federal prevention objectives such as sustaining Baby Friendly, meeting Healthy People 2020 objectives and supporting the Million Hearts initiative. Furthermore, the PHN Program has fostered a relationship with the VA, as recommended by the Tribes, to improve the Indian Health system by collaborating on the implementation of the REACH program.

There are documented results which suggest that nurse-led home visits had a positive effect on maternal child health outcomes for all participants. [2] The overall PHN activity contributes to the

[1] Copper, J and McCarter, KA. Public Health Nursing: The development of a community and home-based chronic care management program, Jan-FEb2014; 31(1): 36-43.
[2] Horowitz, JA and Murphy, CA. Obstetric Gynecology Neonatal Nurse: Nurse home visits improve maternal/infant interaction and decrease severity of postpartum depression. May-June2013: 42(3): 287-300.

Agency meeting many of the GPRA measures. The services provided by the professional PHNs in rural and urban Indian communities align with the needed services. It is also documented that once identified, patients and their families have a wide range of unmet needs that may be addressed with better preparation of healthcare providers.

The PHN activity target for FY 2017 is 381,314. This conservative target takes into account the decreased PHN activity reported for 2015 as the target was not met by 47,766. Recent changes in the data exporting process has impacted the overall PHN performance outcome. Several Tribal programs have migrated away from the Resource Patient Management System to use a commercial electronic health record package which changed how the PHN visits are coded resulting in less visits being exported to the agency's National Data Warehouse database. The end result has been a significant decrease in the number of PHN activities being reported. Although efforts to collaborate with Tribal sites to export all PHN related data continues, the trend has been a decrease in the PHN activity for FY 2013, FY 2014, and FY 2015.

In FY 2017, to capture and improve reporting of outcome, IHS will seek to standardize various PHN documentation templates to improve the capturing of those PHN initiatives that target Agency initiatives such as increasing breastfeeding rates, decreasing avoidable hospital re-admissions and improving quality and access to care especially in the community. With the use of the PHN data mart, in FY 2017, the PHN Program will post various PHN data briefs and report the activity in meeting specific Agency targets. This will provide an avenue to monitor the PHN Programs' support of health care delivery services in the home through benchmarks. For example, in 2015 the first data brief for a PHN home visit after a hospital discharge was developed and the following data available: in GPRA year 2015, 117,687 PHN encounters were made to the 67,312 patients discharged from the hospital with 23% of the PHN visits made within 30 days of discharge. In 2016, the goal will be 30% to serve as a means to reduce avoidable hospital readmissions by the PHN Program following up with a home visit after discharge. Early investments in home visiting programs have been shown to reduce the costs caused by foster care placements, hospitalizations and emergency visits, unintended pregnancies, and other more costly interventions.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
23 Public Health Nursing: Total number of public health activities captured by the PHN data system; emphasis on primary, secondary and tertiary prevention activities to individuals, families and community groups. (Outcome)	FY 2015: 377,913Target: 425,679 (Target Not Met)	390,556	381,314	-9,242

GRANTS AWARDS

CFDA No. 93.933/Community Based Model of PHN Case Management Services			
	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	15	15	15
Average Award	$150,000	$150,000	$150,000
Range of Awards	$150,000	$150,000	$150,000
Total Awards	**$2,250,000**	**$2,250,000**	**$2,250,000**

Note: Allocation amounts are estimates.

AREA ALLOCATION

Public Health Nursing

(dollars in thousands)

DISCRETIONARY	FY 2015 Final			FY 2016 Enacted			FY 2017 President's Budget			FY '17 +/- FY '16
SERVICES	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$3,191	$6,688	$9,879	$3,228	$6,779	$10,007	$3,371	$7,343	$10,714	$707
Albuquerque	1,062	2,225	3,287	1,074	2,255	3,329	1,122	2,443	3,565	235
Bemidji	679	1,423	2,101	687	1,442	2,129	717	1,562	2,279	150
Billings	1,309	2,743	4,052	1,324	2,781	4,105	1,383	3,012	4,395	290
California	323	678	1,001	327	687	1,014	342	744	1,086	72
Great Plains	2,896	6,070	8,966	2,929	6,153	9,082	3,059	6,665	9,724	642
Nashville	497	1,042	1,539	503	1,056	1,559	525	1,144	1,669	110
Navajo	4,152	8,701	12,852	4,199	8,820	13,019	4,386	9,554	13,940	920
Oklahoma	4,508	9,448	13,956	4,560	9,578	14,138	4,762	10,375	15,137	999
Phoenix	2,384	4,997	7,381	2,412	5,065	7,477	2,519	5,487	8,006	529
Portland	919	1,926	2,845	930	1,952	2,882	971	2,115	3,086	204
Tucson	317	664	981	320	673	994	335	729	1,064	70
Headquarters	2,196	4,603	6,800	2,222	4,666	6,888	2,320	5,055	7,375	487
Total, PHN	**$24,433**	**$51,207**	**$75,640**	**$24,715**	**$51,908**	**$76,623**	**$25,811**	**$56,229**	**$82,040**	**+$5,417**

Note: Allocation amounts are estimates.

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

(Dollars in Thousands)

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$18,026	$18,255	$19,545	+$1,290
FTE*	21	21	21	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 2017 Authorization.....Permanent

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

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

The IHS Health Education Program is essential to the mission of the IHS to promote and measure evidenced-based practices of education and education outcomes. The IHS Health Education Program assists in developing policy, planning national health education programs, setting priorities that impact meeting and monitoring "Healthy People 2020," and complying with the 2003, National Health Education Standards.

The IHS Health Education Program aligns and integrates with the Department's Strategic Goal 3.D. to promote prevention and wellness across the lifespan. This is accomplished by working in partnership with individuals, groups, and communities in the provision of health education services and continued investment in the IHS Health Education Program to integrate education and prevention services with clinical services to improve healthcare services for AI/AN people. IHS Health Education promotes the use of Plain Language and Culturally and Linguistically Appropriate Services in the development of written health education and patient education materials to meet literacy needs of patients.

The Health Education Program supports the IHS' performance goals to report the number of visits with Health/Patient Education, and the proportion of tobacco-using patients that receive tobacco cessation intervention. The IHS Health Education Program continues to meet its performance measures as documented in the outputs and outcomes table. Educational services provided by IHS demonstrate a steady increase in the number of AI/AN patients that have a documented educational encounter. The number of visits in which education was provided has

increased from approximately 3,840,886 visits in FY 2014 to 3,936,342 visits in FY 2015, an increase of 98,456 visits

In FY 2015, the National Patient Education Committee (NPEC) identified commonly used ICD-10 codes for health education. For example, IHS was involved with the Million Hearts Campaign in FY 2015 which required specific education documentation. The NPEC, based upon experience with the Million Hearts Campaign, will phase out the current system and focus on protocols/guides for a well-defined and specific subset within the Resource Patient Management System. NPEC will also formalize an education data mart to provide reports for commonly used health education codes. The Health Education Program maintains data tracking of key program objectives. Data tracked include educational encounters; the number of patients who received health education services; provider credentials, location; information provided; amount of time spent on health education; patient understanding; and, behavior goals.

In partnership with other IHS programs, disciplines and staff, the Health Education Program staff continue to:

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

FUNDING HISTORY

Fiscal Year	Amount
2012 Enacted	$17,057,000
2013 Enacted	$16,552,000
2014 Final	$17,001,000
2015 Final	$18,026,000
2016 Enacted	$18,255,000

BUDGET REQUEST

The FY 2017 budget request for Health Education of $19,545,000 is an increase of $1,290,000 above the FY 2016 Enacted level.

FY 2016 Base Funding of $18,255,000 is necessary to maintain the progress in addressing the health education needs, improving access to health information, developing standardized nationwide patient health education programs and ensuring that health information is quality assured and culturally and linguistically appropriate.

FY 2017 Funding Increase of $1,290,000 includes:

- Pay Costs +$175,000 to cover pay raises for federal and Tribal employees of which about 90 percent are working at the service unit level providing health care and related services.
- Inflation +$598,000 to cover inflationary costs of providing health care services.
- Population Growth +$210,000 – to fund the additional services need arising from the growing AI/AN population. The growth rate is projected to be 1.8 percent in CY 2016 based on state births and deaths data.
- Staffing/Operating Cost Requirements for Newly-Constructed Facilities +$307,000 – Health Education funding is requested for two new and expanded healthcare facilities that are planned to open in FY 2017. Health Education funding is included for three facilities and will allow IHS to expand provision of health care in these facilities where capacity has been expanded to address critical health care needs.

Staff and Operating Costs for New Facility	Amount	Tribal Positions
Muskogee (Creek) National Health Center (JV), Eufaula, OK	$205,000	2
Flandreau Health Center (JV), Flandreau, SD	$102,000	1
Grand Total:	**$307,000**	**4**

Performance Impact

The Health Education Program demonstrated its effectiveness by exceeding its target by- 98,456 documented patient education visits in FY 2015. The Health Education Program will strive for continued success in FY 2016 and FY 2017 by maintaining or exceeding documented patient education visits. The Health Education Program will continue to provide training for providers on the use of these protocols and the codes used for tracking.

The Health Education Program will strive for continued success by maintaining or exceeding the level of services provided in FY 2016 and will continue to work towards strengthening the following areas:

- The development of standardized, nationwide patient and health education programs through the integration of the IHS Patient Education Protocols into all IHS software packages including the Patient Care Component and the EHR;
- Provide ongoing training to IHS and Tribal staff on the documentation and coding of patient and health education;
- To update and modernize the documentation of patient education utilizing national standards and improved user interface that aligns with clinical practice;
- Support Healthy People 2020 objectives aligned with literacy.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/-FY 2016 Target
HE-1 Number of visits with Health/Patient Education (Output)	FY 2015: 3,936,342 visits Target: 3,430,486 visits (Target Exceeded)	3,894,658 visits	3,987,514 visits	+92,856 visits

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

AREA ALLOCATION

Health Education

(dollars in thousands)

DISCRETIONARY	FY 2015 Final			FY 2016 Enacted			FY 2017 President's Budget			FY '17 +/- FY '16
SERVICES	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$354	$2,108	$2,461	$358	$2,135	$2,493	$380	$2,289	$2,669	$176
Albuquerque	167	993	1,160	169	1,006	1,174	179	1,078	1,257	83
Bemidji	86	515	601	87	521	609	93	559	652	43
Billings	167	998	1,165	169	1,010	1,180	180	1,083	1,263	83
California	46	274	320	47	278	324	49	298	347	23
Great Plains	268	1,598	1,866	271	1,618	1,890	288	1,735	2,023	134
Nashville	96	574	670	97	581	678	103	623	726	48
Navajo	319	1,905	2,225	324	1,929	2,253	343	2,069	2,412	159
Oklahoma	408	2,430	2,838	413	2,461	2,874	438	2,639	3,077	203
Phoenix	262	1,561	1,823	265	1,581	1,846	281	1,695	1,976	130
Portland	130	773	902	131	782	914	139	839	978	65
Tucson	30	181	211	31	183	213	33	196	229	15
Headquarters	256	1,529	1,786	260	1,548	1,808	276	1,660	1,936	128
Total, Health Ed	**$2,589**	**$15,437**	**$18,026**	**$2,622**	**$15,633**	**$18,255**	**$2,783**	**$16,762**	**$19,545**	**+$1,290**

Note: Allocation amounts are estimates.

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

(Dollars in Thousands)

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$58,469	$58,906	$62,428	+$3,522
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 2017 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 Service (IHS) public health system as they link available health programs to American Indian and Alaska Native (AI/AN) patients and communities. The National CHR program was founded on the concept that Tribal health workers are especially well adapted to serve Tribal communities, as they are familiar with Native languages, customs, and traditions. The National CHR program addresses the identified need for a cultural liaison between Tribal members and communities to provide: (1) a greater involvement of AI/AN people in their own health and in the identification and treatment of their health problems; (2) a greater understanding between AI/AN people and IHS staff; (3) improving cross-cultural communication between the AI/AN community and health service providers; and, (4) increasing basic health care and instruction in AI/AN homes and communities.

The need for CHR services is essential due to the remote and rural location of the Indian health system. CHRs serve to link the patient to the Indian healthcare system and help to prevent avoidable hospital readmissions and emergency department visits. This is accomplished by providing medically-guided home visits, case finding and case management of patients with chronic health conditions such as asthma, diabetes and hypertension. The aim of the CHR Program is to help AI/AN patients and communities to achieve an optimal state of well-being by providing health promotion and disease prevention, wellness and injury prevention education, translation and interpretation, transportation to medical appointments and delivery of medical supplies and equipment within their tribal community.

In FY 2014, the National CHR Program implemented changes to the CHR Basic and Refresher training and CHR Patient Care Component (PCC) training formats and venues in response to the Efficient Spending Policy with the goal to increase the number of CHRs trained to meet the health care needs of the AI/AN communities. By adopting a hybrid training format (on-line and on-site) the National CHR Program has been successful in reducing travel costs to Tribal CHR programs and in addition, has reduced training backlogs. The National CHR Program continues

to partner with other federal Agencies such as the Administration on Aging to leverage webinars and training opportunities that support CHR program goals and objectives.

The IHS does not have authority to direct tribally-managed CHR programs on their utilization of health information technologies. However, Tribal CHR programs that use the Resource Patient Management System (RPMS) are encouraged to use the CHR PCC to document patient care services to export their data to the Indian Health Performance Evaluation System (IHPES). The aim of IHPES is to accurately capture the scope of CHR services provided and to link the CHR program contributions to community based prevention, education and services which contribute to Government Performance and Results Act (GPRA) measures and HHS Arc 4: Keeping People Healthy and Safe: Ensure optimal health is achievable by everyone in this country by having a health care system that keeps people healthy and promoting prevention and wellness that is not delivered strictly through the health care system.

Exported CHR program data in FY 2015 demonstrated that CHRs conducted 246,556 home visits and provided 1,194,171 patient contacts/services on a variety of health related conditions. The top 5 of the 104 types of CHR services provided below document chronic disease case management. CHR services will increase as CHR Tribal programs continue to export CHR PCC data. The present data demonstrates that:

- 14.8 percent of services involved collection of patient data (e.g., taking vital signs, delivering medication, delivering medical equipment and providing emotional support).
- 19.3 percent of services were related to case finding as a result of patient screening (for example, identifying a patient with elevated blood pressure and referring the patient for medical follow up).
- 15.1 percent of services were performing case management activities.
- 12.5 percent of services were providing health education to individuals and communities.
- 6.8 percent of services were providing transportation for coordination of care.

FUNDING HISTORY

Fiscal Year	Amount
2012 Enacted	$61,407,000
2013 Enacted	$58,304,000
2014 Final	$57,895,000
2015 Final	$58,469,000
2016 Enacted	$58,906,000

BUDGET REQUEST

The FY 2017 budget request for Community Health Representatives of $62,428,000 is an increase of $3,522,000 above the FY 2016 Enacted level.

Base Funding for Community Health Representatives is $58,906,000.

FY 2017 Funding Increase of $3,522,000 includes:

- Pay Costs +$500,000 - to cover pay raises for Federal and Tribal employees of which about 90 percent are working at the service unit level providing health care and related services.

- Inflation +$2,337,000 – to cover inflationary costs of providing health care services.

- Population Growth +$685,000 – to fund the additional services need arising from the growing AI/AN population. The growth rate is projected to be 1.8 percent in FY 2016 based on state births and deaths data.

Funding will be used as follows:

- For contracting, compacting and Tribal CHR programs to provide direct health care, health promotion and disease prevention services in homes and other community-based settings.
- 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 2017, but are not limited to:
    - Sustaining the CHR Basic and Advanced on-line training to support CHR skills and competencies.
    - Provide training, web management, listserv, and other program administrative, technical and logistical assistance to Tribes and Areas.
    - Continue health information technology development, refinement, and data support to enhance the CHR data application in RPMS and integration into the EHR.
    - Train CHRs nationally on the CHR PCC data system.
    - Continue efforts to integrate CHR's into the patient's health care team and medical home.
    - Share information on the use and benefits of the CHR Data Mart, an online tracking system which allows authorized local CHR Program staff to monitor exported CHR PCC patient data and workload management.

Performance Impact

The National CHR Program will continue to work toward improving access to care, decreasing health care costs and improving the patient experience with the budget proposed for FY 2017. The National CHR Program measures: (1) number of patient contacts; (2) patient contacts for chronic disease services and (3) number of CHRs trained to serve AI/AN communities. Training conducted on the CHR PCC demonstrated that CHRs routinely under-report by 2-3 patient services the number of services provided during a patient contact. A patient contact is defined by the number of services provided during a single contact or home visit. For example, a CHR conducts a home visit to check a patient's home for hazards as part of injury prevention efforts and subsequently provided homemaker services, a blood pressure (BP) screening, provided BP health education, discussed national requirements to maintain or lower BP, performed a diabetic foot examination, provided diabetic education and coordinated referral appointments. The CHR would document using the CHR PCC a single patient contact with 8 patient services provided.

In FY 2017 the CHR Program will strive to maintain the level of services provided in FY 2016 and will continue to work towards addressing the following challenges:

1) Support training of CHRs through enhancement to the IHS online training system for CHRs;
2) Provide accessible training and technical assistance to current CHRs to develop and maintain skills and competencies;
3) Coordinating health documentation, data validations, and promoting on-going use of the RPMS CHR PCC data application by Tribes. The CHR PCC is the mechanism by which

CHRs report services provided to patients and communities. The CHR PCC also provides verifiable documentation for budget justification and program performance.

4) Education on necessary federal security requirements for Tribal CHRs to request and maintain access to RPMS.
5) Implementation of culturally–based, evidence-based best practices and intervention strategies to improve health outcomes and reduce the economic burden of disease; and
6) Support CHR program long-term sustainability through the promotion of a vital workforce, encourage opportunities for reimbursement for preventive services, and leverage of public health agencies to ensure a credible workforce that provides quality services.

The table below highlights the three CHR program performance targets which captures the IHS National CHR Program attempt to collect data on a 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.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
CHR-1 Number of patient contacts (Output) [1,2]	FY 2015: 1,194,171 patient contacts Target: 796,740 patient contacts (Target Exceeded)	992,464 patient contacts	1,212,084 patient contacts	+219,620 patient contacts
CHR-2 CHR patient contacts for Chronic Disease Services (Output)[3,4]	FY 2015: 490,837 patient contacts Target: 347,848 patient contacts (Target Exceeded)	429,814 patient contacts	498,200 patient contacts	+68,386 patient contacts
CHR-3 Number of CHRs Trained (Output)[5]	FY 2015: 506 CHRs Target: 400 CHRs (Target Exceeded)	551 CHRs	600 CHRs	+49 CHRs

[1] 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).

[2] Patient contacts are the number of services multiplied by number served. The methodology to establish CHR-1 and CHR-2 targets was changed in FY 2013 from using extrapolated data and service hours to actual services.

[3] 87 of 309, about 28.2 percent, CHR Programs assigned Program Codes reported and exported data in RPMS CHR PCC during FY 2015 (October 1, 2014 thru April 28, 2015), 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 (41 percent reported in FY 2014; 38 per cent reported in FY 2012; 47 percent reported in FY 2011; 42 percent in FY 2009; 55 percent in FY 2008).

[4] 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.

[5] In FY 2014 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.

GRANTS AWARDS – No grant awards are anticipated for FY 2017.

AREA ALLOCATION

Community Health Representatives

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2015 Final			FY 2016 Enacted			FY 2017 President's Budget			FY '17 +/- FY '16
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$61	$4,183	$4,243	$61	$4,214	$4,275	$64	$4,466	$4,531	$256
Albuquerque	48	3,289	3,336	48	3,313	3,361	51	3,512	3,562	201
Bemidji	66	4,520	4,586	66	4,554	4,620	70	4,827	4,896	276
Billings	61	4,183	4,244	61	4,214	4,275	64	4,467	4,531	256
California	27	1,881	1,909	27	1,895	1,923	29	2,009	2,038	115
Great Plains	99	6,810	6,908	99	6,861	6,960	105	7,271	7,376	416
Nashville	49	3,369	3,418	49	3,394	3,443	52	3,597	3,649	206
Navajo	94	6,469	6,563	95	6,518	6,612	100	6,908	7,008	395
Oklahoma	124	8,525	8,649	125	8,589	8,713	131	9,103	9,234	521
Phoenix	85	5,870	5,955	86	5,914	6,000	90	6,268	6,359	359
Portland	64	4,398	4,462	64	4,431	4,495	68	4,697	4,764	269
Tucson	27	1,847	1,874	27	1,861	1,888	28	1,973	2,001	113
Headquarters	33	2,287	2,321	33	2,304	2,338	35	2,442	2,478	140
Total, CHR	**$836**	**$57,633**	**$58,469**	**$842**	**$58,064**	**$58,906**	**$887**	**$61,541**	**$62,428**	**+$3,522**

Note: Allocation amounts are estimates.

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

HEPATITIS B AND HAEMOPHILUS IMMUNIZATION PROGRAMS (ALASKA)

(Dollars in Thousands)

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$1,826	$1,950	$2,062	+$112
FTE*	0	0	0	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 2017 Authorization.....Permanent

Allocation Method ..... Self-Governance Compact

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

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

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

The Hepatitis B Program and the Hib Program of the Alaska Native Tribal Health Consortium (ANTHC), in collaboration with Alaska Tribal Health Care System partners, provides clinical expertise and consultation, trainings, research, evaluation and surveillance with the goal to reduce the occurrence of infectious disease and improve access to healthcare in the Alaska Native population. The programs support the HHS Strategic Plan (Goal 1, Objective F and Goal 3, Objective E) through its activities: immunization, patient screening, development of electronic health record reminders and systems, providing an infrastructure to maintain high immunization coverage, and high clinical management coverage of hepatitis B and C in Alaska Natives. The programs' activities support IHS priorities by improving the quality of and access to care for Alaska Natives. It also support HHS Arc #2 Delivery System Reform by distributing information via training, research, evaluation and surveillance resulting in better care and healthier communities and Arc #4 Keeping People Healthy and Safe by providing services to reduce the occurrence of infectious disease and improving access to healthcare.

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

Hepatitis B Program

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

- In FY 2015, hepatitis A and hepatitis B vaccination coverage exceeded the target. Hepatitis A vaccination coverage was 93 percent (90 percent Target) and hepatitis B vaccination coverage was 97 percent (90 percent Target).
- For FY 2015, at least 66 percent of AI/ANs with chronic hepatitis B or C infection were screened for liver cancer and for liver aminotransferase levels (64 percent and 72 percent of the population, respectively).
- Continuing in FY 2015, the program maintains its practice of encouraging hepatitis patients to have regular, bi-annual screening.
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In FY 2014, non-alcoholic fatty liver disease was excluded from target data, affecting outcome data to reflect new target populations.

Haemophilus Immunization (Hib) Program

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

In FY 2015:

- Immunization Coverage for Alaska Native 19-35 month olds was 75 percent, which is approaching 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, 1 Var, 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.
- Maintained increased Tdap vaccine coverage in 19-64 year olds from 71 percent in 2013 to 82 percent in 2014 and 83 percent in 2015.
- Assisted tribal facilities using the RPMS immunization package in maintaining their interface to share vaccine records with the Alaska State Immunization Information System (SIIS).
    - Provided consultation with numberous facilities who were implementing new Electronic Health Records (EHR) on immunization documentation and helped facilitate SIIS interface implementation.
    - Completed the development and implementation of alternative reminder-recall systems.

A summary of immunization results is included below:

Immunization Measure	Age Group	Alaska Native coverage as of 12/31/2015
4:3:1:3*:3:1:4	19-35 months	75%
4:3:1:3:3:1	19-35 months	82%
3 Hib vaccines doses		93%
3 PCV (pneumococcal conjugate vaccine)	19-35 months	95%
1+ HPV	13-17 years female	84%
Pneumococcal vaccine	65+ years	94%
Tdap	19-64 years	83%

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

FUNDING HISTORY

Fiscal Year	Amount
2012 Enacted	$1,927,000
2013 Enacted	$1,826,000
2014 Final	$1,826,000
2015 Final	$1,826,000
2016 Enacted	$1,950,000

BUDGET REQUEST

The FY 2017 budget request of $2,062,000 for the Hepatitis B Program and the *Haemophilus* Immunization (Hib) Program is an increase of $112,000 above the FY 2016 Enacted level.

FY 2016 Base Funding of $1,950,000 – Funding will continue to provide coordination of vaccine coverage reporting for Tribal facilities, training of Tribal immunization coordinators, and clinic staff in vaccine recommendations and documentation, consultation in the migration to EHRs, and regular notification to hepatitis patients of the need to complete liver function screenings so that program clinicians can identify serious liver disease or liver cancer when it is at an early and treatable stage.

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

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

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

FY 2017 Funding Increase of $112,000 includes:

- Pay Costs +$17,000 – to cover pay raises for Tribal employees, of which about 90 percent are working at the service unit level providing health care and related services.

- Inflation +$74,000 – to cover inflationary costs of providing immunization services in Alaska.

- Population Growth +$21,000 – to fund the additional services need arising from the growing AI/AN population. The growth rate is projected to be 1.8 percent in FY 2016 based on state births and deaths data.

Performance Impact

There have been relatively the same funding levels over the past three years allowing us to maintain and grow our efforts to screen hepatitis patients and monitor and assist Tribes in achieving their immunization targets. The general trend shows most output measure targets are not met or exceeded; targets not met were due primarily to new clinical follow-up criteria for other liver diseases and the exclusion of hepatitis C cases which are no longer classified as chronic. In FY 2015, 266 new cases of hepatitis C infection were identified and as clinically indicated these patients will be targeted and screened. New drug regimens for treating hepatitis C have very high cure rates and we anticipate some degree of leveling in number of hepatitis C patients targeted once those who have been cured no longer need clinical follow-up. Patients with chronic hepatitis B infection continue to require screening given their high risk of liver cancer. Patients with other liver diseases (i.e., autoimmune liver diseases) continue to be monitored given their risk of more serious liver disease and/or drug toxicity resulting from their treatment. These liver diseases are one of many autoimmune diseases having a significant impact on the Alaska Native population[1].

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

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/-FY 2016 Target
AK-1 Chronic Hepatitis B Patients Screened/Targeted (Output)*	FY 2015: 694 Screened Target: 628 Screened[2] (Target Exceeded)	628 Screened[3]	628 Screened[4]	Maintain
AK-2 Chronic Hepatitis C Patients Screened/Targeted (Output)**	FY 2015: 1138 Screened Target: 976 Screened[5] (Target Exceeded)	976 Screened[6]	976 Screened[7]	Maintain
AK-3 Other Liver Disease Patients Screened (Output)***	FY 2015: 199 Screened Target: 501 Screened[8] (Target Not Met but Improved)	199 Screened	199 Screened	Maintain
AK-4 Hepatitis A vaccination (Output)****	FY 2015: 93 % Target: 90 % (Target Exceeded)	90 %	90 %	Maintain
AK-5 Hepatitis B vaccinations (Output)****	FY 2015: 97 % Target: 90 % (Target Exceeded)	90 %	90 %	Maintain

Hepatitis Program (Known Cases Screened)

*Sum of known hepatitis B cases FY 2015: 1,048. Decline in hepatitis B cases due to an aging cohort and their deaths; discovery of new cases is rare given hepatitis B vaccinations.

**Sum of known hepatitis C cases FY 2015: 1,585. With new treatment regimens available screening rates have increased; number of new hepatitis C cases identified did not decline in this report period.

***Sum of known other liver disease cases FY 2015: 215. Other liver disease includes autoimmune hepatitis and primary biliary cirrhosis. Nonalcoholic fatty liver disease has been dropped from this report given new criteria for clinical follow-up; thus, number targeted for screening shows a decline.

****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.

[2] FY 2015 Targets Targeted T 1060 Screened S 628

[3] FY 2016 Targets Targeted T 1060 Screened S 628

[4] FY 2017 Targets Targeted T 1060 Screened S 628

[5] FY 2015 Targets Targeted T 1600 Screened S 976

[6] FY 2016 Targets Targeted T 1600 Screened S 976

[7] FY 2017 Targets Targeted T 1600 Screened S 976

[8] FY 2015 Targets Targeted T 667 Screened S 501

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

(Dollars in Thousands)

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$43,604	$44,741	$48,157	+$3,416
FTE*	5	5	6	+1

* 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 2017 Authorization.....Permanent

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The Office of Urban Indian Health Program (OUIHP) was established in 1976 to make health services more accessible to urban American Indians and Alaska Natives (AI/AN). The IHS enters into limited, competing contracts and grants with 34 urban Indian 501(c)(3) non-profit organizations to provide health care and referral services for urban Indians residing in 59 sites throughout the United States. Urban Indian Organizations (UIO) define their scope of work and services based upon the service population, health status, and documented unmet needs of the urban Indian community they serve. Each UIO is governed by a Board of Directors that must be made up of at least 51 percent urban AI/AN. UIO provide unique access to culturally appropriate and quality health care for urban AI/AN.

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

- Twenty-one are full ambulatory programs providing direct medical care to the population served for 40 or more hours per week.
- Six are limited ambulatory programs providing direct medical care to the population served for less than 40 hours per week.
- Six are outreach and referral programs providing case management of behavioral health counseling and education services, health promotion/disease prevention education, and immunization counseling but not direct medical care services.
- One is a residential treatment facility.
- Another (not included in the 34) provides national education and research services for UIO and the Office of Urban Indian Health Program (OUIHP) through a cooperative agreement.
- In addition, funding is also provided for dental services through the Albuquerque Area IHS Dental Program.

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

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

From July 1, 2014 to June 30, 2015, the UIO 2015 GPRA cycle accomplishments included:
- 100 percent of the UIO reported on 16 of the 16 performance measures,
- 24 UIO reported through the Clinical Reporting System (CRS),
- 10 UIO reported using 100 percent review of appropriate data source (as opposed to sampling a smaller percentage of records), and
- In FY 2015, UIO improved performance on 11 of the GPRA measures with comparable FY 2014 data.

Through the National Data Warehouse Reporting System, UIO reported the amounts and purposes for which funding is used, identified the number of eligible urban AI/AN for whom services are provided, and the number and type of services provided to urban AI/AN for FY 2015. IHS is currently in the process of conferring with UIO to develop a new system of data collection and reporting for evaluation purposes that more accurately reflects workload based upon level of service, including access to culturally competent care and case management services, clinical status and quality of care, continuity of care, provider productivity, and cost effectiveness. In addition, five UIO are accredited by the Accreditation Association for Ambulatory Healthcare. One UIO is accredited by the Joint Commission. One UIO is accredited by the Commission on Accreditation of Rehabilitation Facilities and seven UIO have achieved Patient Centered Medical Home (PCMH) status.

As of March 2015, twenty-seven UIO have implemented the IHS Resource and Patient Management System (RPMS)/Electronic Health Record (EHR) (19 of the 27 implemented EHR) and six UIO utilize non-RPMS health information technology systems. Nineteen UIO had providers that registered and attested for meaningful use and ten UIO received CMS incentive payments. OUIHP works collaboratively with IHS Headquarters and Area Offices to provide support and deliver information technology technical assistance to twenty-eight UIO.

IHS is completing development of a national performance data mart. During FY 2016 and FY 2017, IHS will evaluate and validate the new performance data mart which contains urban program data submitted to the National Data Warehouse. The plan is to report performance data from the data mart in FY 2018. With the addition of UIO data, the IHS will report aggregated results in FY 2018 from federal, tribal and urban sites. Currently, aggregated performance results include only federal and tribal sites.

Five significant program challenges exist:

1. Recruitment and retention of UIO health professionals, mainly physicians, mid-levels, and nursing staff;
2. Continuous demand for health information technology training and technical assistance;
3. Increased funding for urban Indian health program expansion to new urban centers;
4. Responding to UIO facilities maintenance and improvement needs; and
5. Implementation of new program authorities with the reauthorization of IHCIA including: 25 U.S.C. § 1659 Facilities Renovation; Sec. 163. Requirement to Confer with Urban Indian Organizations {25 U.S.C. § 1660d}; 25 U.S.C. § 1660e Expanded Program Authority for Urban Indian Organizations; 25 U.S.C. § 1660f Community Health Representatives; and 25 U.S.C. § 1660h Health Information Technology.

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

FUNDING HISTORY

Fiscal Year	Amount
2012 Enacted	$43,053,000
2013 Enacted	$40,729,000
2014 Final	$40,729,000
2015 Enacted	$43,604,000
2016 Enacted	$44,741,000

BUDGET REQUEST

The FY 2017 budget request for the Urban Indian Health program of $48,157,000 is an increase of $3,416,000 above the FY 2016 Enacted level.

Base Funding of $44,741,000 – The base funding is necessary to support the UIO funding and accomplishments to strengthen and enhance the HHS Strategic Plan for Fiscal Years 2014-2018. The funding addresses Goal 1-Strengthen Health Care; Goal 2-Advance Scientific Knowledge and Innovation; Goal 3-Advance the Health, Safety, and Well-Being of the American People; Goal 4-Ensure Efficiency, Transparency, Accountability, and Effectiveness of Health and Human Service programs by:

- Improving urban AI/AN access to health care to improve health outcomes in urban centers
- Strengthening programs that serve urban AI/AN in 59 sites throughout the United States
- Providing outreach, information and assistance to assure that eligible urban AI/AN are enrolled in the Health Insurance Marketplace
- Enhancing third party revenue, implementing payment reforms such as the transition to a new prospective payment system, and increasing quality improvement efforts
- Increasing the number of accredited programs and patient centered medical homes for urban AI/AN. Seven UIO are currently accredited. Seven have achieved PCMH status and four are working towards achieving PCMH recognition. All UIO participate in the IHS' Improving Patient Care Initiative

- Emphasizing preventive health including evaluation, dissemination, and promotion of effective clinical preventive services
- Applying innovative solutions to public health challenges to increase understanding of what works in public health
- Implementing and utilizing advancd health information technology
- Expanding access to quality, culturally competent care for urban AI/AN through collaboration with other federal agencies
- Investing in the number of health care providers to provide quality health services for urban AI/AN and to meet the increased workload demands
- Implementing the new IHCIA authorities specific to Urban Indian Organizations.

Current Services Increase of +$2,452,000 includes:

- Pay Costs +$265,000 – to cover payroll and related costs, of which about 90 percent are working at the headquarters level, providing legislative oversight and administration of programs, functions, services, and activities related to urban Indian health care that is provided in urban centers throughout the U.S.

- Inflation +$1,535,000 – needed to cover inflationary costs to provide health care services.

- Population Growth +479,000 – to fund the additional services need arising from the growing urban AI/AN population. The growth rate is projected to be 1.8 percent in CY 2017 based on state births and deaths data.

- Program Increase of +1,137,000 will provide – resources for the development of a strategic plan for the Urban Indian Health Program through conferring with urban AI/AN in collaboration with the National Academy of Public Administration. In addition, funds will be utilized to strengthen UIO operations and improve urban AI/AN access to health care to achieve improved health outcomes. OUIHP is actively working with the IHS Division of Acquisitions Planning to contract with the National Academy of Public Administration (NAPA). After a contract is in place, OUIHP will begin conferring with UIO to gain input from urban AIAN into the strategic plan. This activity will be completed and the strategic plan will be published not later than one year after the date of enactment of the bill. However, there will be additional costs, other than contracting with NAPA, associated with the development and implementation of the strategic plan that include, but are not limited to:
  - Conferring with Urban Indian Organizations (36 plus other UIO that may have interest)
  - Collaboration with the National Council of Urban Indian Health
  - Travel costs for federal and urban Indian health representatives

  These additional costs will go into FY 2017 as we work to implement activities outlined in the published strategic plan, including any necessary revisions.

- Extend 100% Federal Medical Assistance Percentage (FMAP) – included in the request is a legislative proposal to extend the 100% FMAP under the Medicaid program to all Indian health programs for AI/AN patients, including urban Indian health programs.

Performance Discussion

For the past 26 years, one UIO has provided a youth summer camp for children aged 5-12. Youth participate in activities such as swimming, horseback riding, zip-line and rock wall, mountain/ road biking, archery, hiking, and cultural activities such as drumming, singing, dancing,

storytelling, and shawl making. Targeted goals are improved physical health and well-being, enhanced mental health and individual functioning, improved socialization skills, and youth workers. To address childhood obesity through nutrition, a detailed camp menu is developed and reviewed by a Registered Dietitian.
Affecting lifestyle changes among urban AI/AN families requires a culturally sensitive approach. The existing UIO have operated culturally appropriate initiatives to reduce childhood obesity, prevent diabetes and its complications, and reduce risk factors related to heart disease and cancer. Their continued efforts to target behavioral or lifestyle changes offer the best hope for impacting the major health challenges of the urban AI/AN population. UIO are working to integrate behavioral health activities into their clinical and case management services.

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

President Obama launched the Generation Indigineous (Gen-I) Initiative at the 2014 White House Tribal Nations Conference to focus on improving the lives of Native youth, by removing the barriers that stand between Native youth and their opportunity to succeed. Gen-I takes a comprehensive, culturally appropriate approach to ensure all young Native people can reach their full potential. UIO are working to incorporate Gen-I into urban Indian health program activities.

OUTPUTS / OUTCOMES

The Outcomes and Outputs Table(s) list the proposed measure changes for this budget narrative.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/-FY 2016 Target
UIHP-2 Percent of AI/AN patients with diagnosed diabetes served by urban health programs that achieve good blood sugar control. (Outcome)	FY 2015: 46.3 % Target: 47.7 % (Target Not Met)	49.5 %	48.4 %	-1.1 %
UIHP-3 Percent decrease in obesity rates in children. (Outcome)	FY 2015: 23.5 % (Historical Actual)	22.8 %	N/A	N/A
UIHP-6 Increase the number of diabetic AI/ANs that achieve ideal blood pressure control(<140/90). (Outcome)	FY 2015: 68 % Target: 70.1 % (Target Not Met but Improved)	68.9 %	69.4 %	+0.5 %
UIHP-7 Number of AI/ANs served at Urban Indian clinics. (Outcome)	FY 2014: 53,408 Target: 51,425 (Target Exceeded)	53,408	53,408	Maintain

GRANTS AWARDS - Funding for UIO for FY 2015 included both grants and contracts awarded to the programs.

CFDA No. 93.193 – Urban Indian Health Services			
	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	34	35	35
Average Award	$246,856	$246,856	$246,856
Range of Awards	$122,832 - $626,765	$122,832 - $626,765	$122,832 - $800,000

AREA ALLOCATION

Urban Indian Health
(dollars in thousands)

DISCRETIONARY	FY 2015 Final			FY 2016 Enacted			FY 2017 President's Budget			FY '17 +/- FY '16
SERVICES	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Albuquerque	633	1,785	2,418	642	1,839	2,481	688	1,982	2,670	189
Bemidji	1,083	3,053	4,135	1,097	3,146	4,243	1,177	3,390	4,567	324
Billings	596	1,680	2,276	604	1,732	2,336	648	1,866	2,514	178
California	1,656	4,669	6,324	1,678	4,811	6,489	1,800	5,185	6,985	495
Great Plains	399	1,125	1,524	404	1,159	1,563	434	1,249	1,683	119
Nashville	246	694	939	249	715	964	267	770	1,038	74
Navajo	188	531	720	191	547	738	205	590	795	56
Oklahoma	540	1,522	2,062	547	1,569	2,116	587	1,691	2,278	162
Phoenix	648	1,827	2,475	657	1,883	2,539	704	2,029	2,733	194
Portland	1,444	4,073	5,517	1,464	4,197	5,661	1,571	4,523	6,093	432
Tucson	135	380	514	136	391	528	146	422	568	40
Headquarters	3,848	10,850	14,698	3,900	11,182	15,082	4,184	12,049	16,233	1,151
Total, Urban Health	**$11,416**	**$32,188**	**$43,604**	**$11,570**	**$33,171**	**$44,741**	**$12,412**	**$35,745**	**$48,157**	**+$3,416**

Note: Allocation amounts are estimates.

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

INDIAN HEALTH PROFESSIONS

(Dollars in Thousands)

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$48,342	$48,342	$49,345	+$1,003
FTE*	22	22	23	+1

* 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 2017 Authorization.....Permanent

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

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

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

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

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

While the IHP programs have seen successes, we continue to strive to improve our performance and identify areas of risk. Placement of new scholars within 90 days of completing their training continues to be a challenge. The use of online manuals, e-Newsletters, emails, and referral of graduates to recruiters have all been used to facilitate the 90 day scholar placement. In FY 2015, 45.4 percent of scholars had a hire letter within 90 days (target was 78 percent). Failure to meet this goal was primarily due to nursing scholars not completing their licensing boards and finding positions within the 90 day period. The Scholarship program continues to look for new ways to assist our scholars in meeting this requirement. Assuring scholars and loan repayment recipients meet their service obligation is another critical component of the IHP programs. Annual employment verification through personnel rosters and certification by tribal employers assist in this process. Scholarship program and LRP databases allow staff to identify when health professionals are expected to complete their service obligation and allow for timely follow-up.

Loan Repayment Program (Section 108): The LRP is an invaluable tool for recruiting and retaining healthcare professionals by offering health care professionals the opportunity to reduce their student loan debts through service to Indian health programs with critical staffing needs. Applicants agree to serve two years at an Indian health program in exchange for up to $20,000 per year in loan repayment funding and up to an additional $5,000 per year to offset tax liability. Loan repayment recipients can extend their initial two-year contract on an annual basis until their original approved educational loan debt is paid. In FY 2015, a total of 1,211 health professionals were receiving IHS loan repayment. This included 437 new two-year contracts, 395 one-year extension contracts and 379 health professionals starting the second year of their FY 2014 two-year contract.

Applicants who apply for funding and do not receive it, are identified as either "matched unfunded" or "unmatched unfunded." The "matched unfunded" applicants are health professionals employed in an Indian health program. The "unmatched unfunded" applicants are health professionals that either decline a job offer because they did not receive loan repayment funding or those unable to find a suitable assignment meeting their personal or professional needs. In FY 2015, there were 200 "matched unfunded" applicants (including 6 physicians, 10 behavioral health providers, 3 dentists, 7 optometrists, 36 nurses and 63 pharmacists) and 413 "unmatched unfunded" health professionals (including 17 physicians, 53 behavioral health providers, 23 dentists, and 147 nurses). The inability to fund these 613 health professional applicants is a significant challenge for the recruitment efforts of the agency. It is estimated that an additional $30.39 million would be needed to fund the 613 unfunded health professional applicants from FY 2015. A more detailed breakout of loan repayment awards in FY 2015 by discipline is included in a table at the end of the narrative.

Scholarship Program (Sections 103 and 104) – Section 103 scholarships include the preparatory and pre-graduate scholarship programs that prepare students for health professions training programs. Graduate students and junior- and senior-level undergraduate students are given priority for funding for programs under Section 103, unless the section specifies otherwise. Section 104 includes the Health Professions Scholarship program, which provides financial support consisting of tuition, fees and a monthly stipend for AI/AN students from federally recognized Tribes enrolled in health profession or allied health profession programs. Students accepting funding for programs under Section 104 incur a service obligation and payback requirement. In FY 2015, there were 990 new online scholarship applications submitted to the IHS Scholarship program. After evaluating the application for completeness and eligibility, a total of 289 of these new scholarship applications were considered eligible for funding. The IHS Scholarship program was able to fund 149 new awards. An additional $3.3 million in scholarship

funding would have been needed to fund all qualified scholarship applicants. The IHS Scholarship program also reviewed applications from previously awarded scholars that were continuing their education. A total of 185 continuation awards were funded in FY 2015. A detailed breakout of scholarships awarded by discipline in FY 2015 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. System upgrades to date have allowed for easier tracking of scholars throughout the application and award process, while in school and during post graduate training, and while fulfilling their service commitment. Additional enhancements, when completed, will provide annual reports on retention of scholarship recipients employed by IHS beyond the obligated service period.

Extern Program (Section 105) - Section 105 of the IHCIA, is designed to give IHS scholars and other health professions students the opportunity to gain clinical experience with IHS and Tribal health professionals in their chosen discipline. This program is open to IHS scholars and non-scholars. Students are employed up to 120 days annually, with most students working during the summer months. In FY 2015, the Extern Program funded a total of 124 student externs. A total of 120 students were health professions students, and 25 (20%) were American Indian/Alaska Native. A more detailed breakout of extern awards in FY 2015 by discipline is included in a table at the end of the narrative.

FUNDING HISTORY

Fiscal Year	Amount
2012 Enacted	$40,596,000
2013 Enacted	$38,467,000
2014 Final	$28,466,000
2015 Enacted	$48,342,000
2016 Enacted	$48,342,000

BUDGET REQUEST

The FY 2017 budget request for the Indian Health Professions program of $49,345,000 is an increase of $1,003,000 above the FY 2016 Enacted level.

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

Current Services Increase of +$1,003,000 includes:

- Pay Costs +$18,000 – to cover pay raises for federal and Tribal employees, of which about 90 percent are working at the service unit level providing health care and related services.

- Inflation +$985,000 – needed to cover inflationary costs to provide health care services.

The FY 2017 budget request also includes legislative proposals for tax relief and half-time service for the IHS Scholarship and LRP recipients similar to the NHSC Scholarship and LRP and to allow IHS discretionary use of all Title 38 Personnel Authorities similar to the Department of Veterans Affairs. The proposals, if enacted, could immensely help current recruitment and retention activities.

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

Sec	Title	FY 2015 Final	FY 2016 Enacted	FY 2017 Pres. Budget	FY 2017 +/- FY 2016	Expected Performance*
103	Health Professions Preparatory and Pre-Graduate Scholarships	$3,687,137	$3,687,137	$3,687,137	0	52 continuing and 37 new student agreements
104	Health Professions Scholarship	$10,034,760	$10,034,760	$10,534,760	0	182 continuing and 52 new student contracts
105	Extern Program	$1,115,357	$1,115,357	$1,115,357	0	135 temporary clinical assignments
108	Loan Repayment Program	$30,022,607	$30,022,607	$30,525,607	0	374 contract extensions and 465 new contracts.
112	Quentin N. Burdick American Indians Into Nursing Program	$1,669,697	$1,669,697	$1,669,697	0	4 grants
114	Indians into Medicine (INMED) Program	$1,097,364	$1,097,364	$1,097,364	0	3 grants
217	American Indians Into Psychology Program	$715,078	$715,078	$715,078	0	3 grants
	TOTAL	**$48,342,000**	**$48,342,000**	**$49,345,000**	**0**	

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

Performance Discussion

The IHS performance goal is to place scholars within 90 days from when they complete their health profession degree or training. The 90 day placement percentage was not met due mostly to nursing graduates. Many nursing graduates are unable to take the nursing exam until 45-60 days after graduation. The graduates are unable to be considered for positions until they are licensed. For many it takes 120-150 days or longer post-graduation to secure a position. The IHS hiring reforms and improved tracking of placements should result in improved performance and meeting the objective.

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

OUTPUTS / OUTCOMES

Measure	**Year and Most Recent Result / Target for Recent Result / (Summary of Result)**	**FY 2016 Target***	**FY 2017 Target**	**FY 2017 Target +/- FY 2016 Target**
42 Scholarships: Proportion of Health Scholarship recipients placed in Indian health settings within 90 days of graduation. (Outcome)	FY 2015: 45.4 % Target: 78 % (Target Not Met)	78 %	78 %	Maintain
IHP-1 Number of scholarship awards under section 103 (Output)	FY 2015: 83 Awards Target:85 Awards (Target Not Met)	89 Awards	89 Awards	Maintain
IHP-2 Number of scholarship awards under section 104 (Output)	FY 2015: 251 Awards Target: 228 Awards (Target Exceeded)	223 Awards	223 Awards	Maintain
IHP-3 Number of externs under section 105 (Output)	FY 2015: 124 Externs Target: 135 Externs (Target Not Met but Improved)	135 Externs	135 Externs	Maintain
IHP-4 Number of new 2 year contract awarded loan repayments under section 108 (Output)**	FY 2015: 437 contracts Target: 243 contracts (Target Exceeded)	465 contracts	465 contracts	Maintain
IHP-5 Number of continuing 1 year loan repayment contract extensions under section 108 (Output)	FY 2015: 395 contract extensions Target: 260 contract extensions (Target Exceeded)	360 contract extensions	360 contract extensions	Maintain
IHP-6 Total number of new awards funded in previous fiscal year under section 108 (Outcome)	FY 2015: 379 awards Target: 180 awards (Target Exceeded)	360 awards	360 awards	Maintain

***** FY 2016 "Targets" include estimates based on complete FY 2014 funding cycle data and additional Loan Repayment Program funding received in the FY 2015 budget.

** The "Number of Loan Repayments – Total" includes New Awards, Contract Extensions and Continuation Awards.

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

CFDA No. 93.970 - Health Professions Recruitment Program for Indians			
	FY 2015 Enacted	FY 2016 President's Budget	FY 2017 OMB Higher Level
***Quentin N. Burdick American Indians Into Nursing Program (Section 112) – CFDA No. 93.970**			
Number of Awards	4	4	4
Average Award	$414,924	$414,924	$414,924
Range of Awards	$414,924	$414,924	$414,924
Indians Into Medicine Program (Section 114) – CFDA No. 93.970			
Number of Awards	3	3	3
Average Award	$356,083	$356,083	$356,083
Range of Awards	$170,000 - $728,250	$170,000 - $691,837	$170,000 - $691,837
American Indians Into Psychology Program (Section 217) – CFDA No. 93.970			
Number of Awards	3	3	3
Average Award	$238,359	$238,359	$238,359
Range of Awards	$200,000-$253,000	$238,259	$238,359

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

Scholarship Program Awards – In FY 2015, students in the following disciplines received IHS Scholarship Program funding:

Section 103 Pre-professional - 31 students				
Pre-Clinical Psychology	3		Pre-Pharmacy	10
Pre-Nursing	16		Pre-Social Work	2
Section 103 Pre-graduate – 52 students				
Pre-Dentistry	10		Pre-Optometry	2
Pre-Medicine	40			
Section 104 Health Professions - 251 students				
Chemical Dependency Counseling	3		Pharmacy	36
Clinical Psychology	10		Physical Therapy	13
Dentistry	36		Physician Assistant	12
Health Records	5		Physician, Allopathic	28
Medical Technology	3		Physician, Osteopathic	9
Nurse Midwife	3		Podiatry	1
Nurse Practitioner	15		Respiratory Therapy	1
Nurse, Associate Degree	12		Sanitarian	1
Nurse, Baccalaureate Degree	31		Social Work	16
Nurse, Masters Degree	2		Ultrasonography	1
Optometry	11		X-Ray Technology	2

Loan Repayment Program Awards – In FY 2015, the IHS LRP made awards to the following disciplines:

Awards by Profession	Total Awards	New Awards	Contract Extensions	Matched Not Awarded
Behavioral Health	53	34	19	10
Dental*	103	54	49	3

Awards by Profession	Total Awards	New Awards	Contract Extensions	Matched Not Awarded
Nurse	193	171	22	36
Optometrists	44	13	31	7
Pharmacists	178	23	155	63
Physician Assistants/ Advanced Practice Nurses	83	56	27	20
Physicians	85	42	43	6
Podiatrists	13	4	9	1
Rehabilitative Services	39	16	23	12
Other Professions	41	24	17	42
TOTAL	**832**	**437**	**395**	**200**

***** Includes Dentists, Dental Hygienists, and Dental Assistants.

Other Professions	Total Awards	Matched Not Awarded	By Pay System	Awards
Acupuncturist	1	0	Tribal Employees	436
Certified Professional Coder	2	0	Civil Service	266
Dietetics/Nutrition	8	10	Commissioned Corps	116
Engineering	4	5	Urban Health Employees	14
Medical Laboratory Scientist	5	8		
Medical Technology	6	6		
Naturopathic Medicine	1	0		
Respiratory Therapist	1	0		
Sanitarian	3	2		
Other	10	11		
TOTAL	**41**	**42**	**Total**	**832**

Extern Program Awards – In FY 2015, the IHS Extern Program funded summer or winter externships for the following disciplines:

Preparatory and Pre-Graduate Externs FY 2015

Discipline	Externs		Discipline	Externs
Pre-Medical Technology	2		Pre-Medicine	1
Pre-Pharmacy	1		**Total**	**4**

Health Professions Externs FY 2015

Discipline	Externs		Discipline	Externs
Clinical Psychology	2		Physician	2
Dentist	8		Physical Therapy	1
Engineering	10		Podiatry	1
Environmental Health	1		Sanitarian	6
Medical Technology	2		Social Work	2
Nurse	29		X-Ray Technology	2
Optometry	3		**Total**	**120**
Pharmacy	51			

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

TRIBAL MANAGEMENT GRANT PROGRAM

(Dollars in Thousands)

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$2,442	$2,442	$2,488	+$46
FTE*	0	0	0	0

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

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

FY 2017 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. Under the authority of the ISDEAA, the program was established to assist all federally-recognized Indian Tribes and Tribally-sanctioned Tribal organizations (T/TO) to plan, prepare, or decide to assume all or part of existing Indian Health Service (IHS) programs, functions, services, and activities (PFSA) and to further develop and enhance their health program management capability and capacity. The TMG program provides discretionary competitive grants to T/TO, to establish goals and performance measures for current health programs, assess current management capacity to determine if new components are appropriate, analyze programs to determine if T/TO management is practicable, and develop and enhance infrastructure systems to manage or organize PFSA. The nature of the TMG program allows T/TO the option to enter or not enter into ISDEAA contracts/compact agreements which are equal expressions of self-determination. If a Title I Tribe exercises their right of self-determination by assuming operations and management of programs, then they will be prepared to compact services under Title V Self Governance.

The TMG program has established four 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 eligible Direct Service and Title I Federally-recognized Indian Tribes or Tribal organizations. The fourth priority includes eligible Title V Self Governance Federally-recognized Indian Tribes or Tribal organizations.

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

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

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

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

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

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

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

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

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

Throughout the program's history, staff continue to build upon and identify best practices. In FY 2017, TMG will continue to strengthen program policies and procedures and expand on what works well for T/TOs. Based on the results of training and technical assistance sessions, the TMG program will continue to implement and improve upon training and technical assistance

efforts.

FUNDING HISTORY

Fiscal Year	Amount
2012 Enacted	$2,577,000
2013 Enacted	$2,442,000
2014 Final	$1,442,000
2015 Enacted	$2,442,000
2016 Enacted	$2,442,000

BUDGET REQUEST

The FY 2017 budget request for the Tribal Management Grant program of $2,488,000 is an increase of $46,000 above the FY 2016 Enacted level.

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

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

Current Services Increase of +$46,000 includes:

- Inflation +$46,000 – to cover inflationary costs of providing health care services.

PERFORMANCE DISCUSSION

Performance was less in 2015 due to applications not meeting grant criteria – 14 applications were received and 50% met the TMG criteria and were awarded. Several applications were received after the deadline and could not be considered. One Tribe applied for the Self-Governance Cooperative Agreement management grant which was intended for the TMG and could not be considered. FY 2016 and 2017 targets will remain unchanged and additional outreach education efforts will be implemented to meet target goals.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
TMG-1 Planning	FY 2015: 0 planning grants	2 planning	2 planning	Maintain

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
Grants (Output)	Target: 2 planning grants (Target Not Met)	grants	grants	
TMG-2 Health Management Structure (HMS) grants (Output)	FY 2015: 7 HMS grants Target: 26 HMS grants (Target Not Met)	26 HMS grants	26 HMS grants	Maintain

GRANTS AWARDS

FY 2015 funding was distributed to Tribes for individual grant awards as follows: 88 percent of the available funding was distributed for grant awards that focused on Health Management Structure; 8 percent of funding was distributed for planning grants; and 4 percent of funding was distributed for Evaluation studies. Estimate percentages for FYs 2015, 2016 and 2017 will likely remain the same.

CFDA No. 93.228 – CFDA Tribal Management Grant			
	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards[1]	$1,442,000 13 Noncompeting Continuations and 3 New	$2,442,000 10 Noncompeting Continuations and 17 New	$2,442,000 10 Noncompeting Continuations and 17 New
Average Award	$90,125	$95,444	$95,444
Range of Awards	$50,000 - $150,000	$50,000 - $150,000	$50,000 - $150,000

[1] Includes partial awards

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

(Dollars in Thousands)

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$68,065	$72,338	$69,620	-$2,718
FTE*	261	261	264	+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 2017 Authorization.....Permanent

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

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

The IHS Headquarters provides overall program direction, authorities and oversight for the 12 IHS Areas and 170 Service Units; formulates policy and distributes resources; provides technical expertise to all components of the Indian health care system, which includes IHS direct, Tribally operated programs, and urban Indian health programs (I/T/U); maintains national statistics and public health surveillance; identifies trends; and projects future needs. The IHS Headquarters actively works with HHS to formulate and implement national health care priorities, goals, and objectives for AI/ANs within the framework of its mission. The IHS Headquarters works with HHS to formulate the annual budget and necessary legislative proposals. In addition, it responds to congressional inquiries and interacts with other governmental entities to enhance and support health care services for AI/ANs.

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

Service Units and I/T/U staff. They ensure the delivery of quality health care through the 170 Service Units and participate in the development and demonstration of alternative means and improvement techniques of health services management and delivery to promote the optimal provision of health services to Indian people through the Indian health system.

The Direct Operations budget is critical to continue making progress in addressing the agency priority to improve the IHS. One example of improvement is implementation of the Affordable Care Act (ACA) and the Indian Health Care Improvement Act (IHCIA) within the IHS. In FY 2015, implementation focused on helping IHS beneficiaries during the Health Insurance Marketplace open enrollment period, continuing to help Tribal members who can enroll monthly throughout the entire year as a special benefit of the ACA, helping with Medicaid and CHIP enrollment throughout the year, and helping Tribal members and those eligible for IHS with the application for an exemption or waiver from the tax penalty. IHS and its Tribal partners have continued outreach, education, and enrollment activities as well as focusing on enhanced business office and health care delivery system improvements necessary to fully implement ACA and IHCIA provisions in the IHS. IHS recently worked on guidance for the business office, local contracting with Qualified Health Plans from the Marketplace, and training on how to incorporate the new plans and their requirements into the IHS Purchased/Referred Care program. As the ACA is implemented, IHS' ability to show that it is improving and providing quality care will help encourage its current patients to continue using its facilities, even if they take advantage of the health coverage options offered by the ACA. This could mean more third-party resources that will help improve access to services for all patients served at IHS facilities.

Another example of agency improvement is refining Human Resource Management and Servicing systems. The FY 2015 performance goal for IHS executives across the IHS was to have an IHS average overall hiring time of fewer than 80 days. The focus of improvements in the hiring process is ensuring a high quality of applicants on selection certificates and expediting on-boarding through expanded direct hiring authorities. In addition, the agency has made improvements in utilization of pay systems for more competitive salaries because historically it has been difficult for IHS to recruit and retain healthcare personnel due to remote locations and noncompetitive salaries. IHS continues the collaborative work with the Health Resources and Services Administration, which has resulted in approval of 659 IHS, Tribal and Urban Indian (I/T/U) health care delivery sites for placement of National Health Service Corps health care providers and the number of placements has increased to 421 providers as of December 2015. The progress was made possible by collaboratively developing a process for a pre-approved method for site eligibility. Finally, the IHS is implementing a Veterans Hiring Initiative (VHI), announced in FY 2014, to increase the number of veterans employed at the IHS. The goal is to increase the percent of new hires who are veterans from 6 percent to 9 percent in 2 years. The IHS Initiative includes a marketing campaign to IHS and Tribal facilities about participation in the VHI; development of a pilot program to hire qualified veterans with Intermediate Care Technician experience; partnering with the Department of Labor Employment and Training Service Office on veteran employment opportunities; and collaborating with the HHS Veterans Outreach lead on coordinating activities with the Department of Veterans Affairs in the "VA for Vets" program. The Initiative is also involved in other activities locally and regionally.

One important performance goal for IHS is 100 percent of all IHS-operated health care facilities achieve or maintain accreditation or certification by a national health care organization. This has been a major challenge; for example, when a Centers for Medicare and Medicaid Services (CMS) survey in 2015 identified a specific facility lost accreditation, and another facility was at risk of losing accreditation, IHS acted immediately by putting a corrective action plan in place. IHS deployed staff from headquarters and several health care providers to help at one hospital and

suspended the emergency room services at the other hospital. The IHS is also taking a system-wide approach to accreditation or certification with funding support from CMS through the development of an IHS Quality Consortium which is working on directives to federal health care sites to implement consistent accreditation or certification practices. The accreditation or certification performance measure is critical to IHS operations and is one of the six performance measures IHS contributes to in the HHS Strategic Plan. In total, IHS has six representative performance measures for which progress is tracked in meeting defined targets and reported and monitored as part of the HHS Annual Performance Plan and Report which details performance progress for the HHS. The Direct Operations budget request will help provide the oversight needed to measure, track and report performance outcomes.

FUNDING HISTORY

Fiscal Year	Amount
2012 Enacted	$71,653,000
2013 Enacted	$67,894,000
2014 Final	$65,894,000
2015 Final	$68,065,000
2016 Enacted	$72,338,000

BUDGET REQUEST

The FY 2017 budget request for Direct Operations of $69,620,000 is a decrease of $2,718,000 below the FY 2016 Enacted level.

Base Funding of $68,338,000 – Funding is necessary for Direct Operations to continue to fund system-wide administrative, management and oversight priorities at the discretion of the IHS Director that include:

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

all 12 Areas and provided a report to the SCIA summarizing each Area's Assessment including Findings and Actions. IHS will continue to implement and monitor improvements and corrective actions related to the findings of the Area reviews, internal and external reviews.

Current Services Increases of +$1,282,000 includes:

- Pay Costs +$641,000 – needed to cover pay raises for Federal employees, which improve the ability of the agency to retain high performing employees. A funding increase is necessary to mitigate the impact of higher payroll costs on base budgets as the result of pay raises.

- Inflation +$641,000 – needed to cover inflationary costs to provide health care services.

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

	FY 2015 Final	FY 2016 Enacted	FY 2017 Pres. Budget
Headquarters (58.7%)	$39,960,277	$42,462,406	$40,866,940
Title I Contracts (non-add)	*1,739,477*	*1,746,438*	*1,779,201*
Title V Compacts (non-add)	*6,438,100*	*6,463,865*	*6,585,126*
Area Offices (12) (41.3%)	28,105,523	29,875,594	28,753,060
Title I Contracts (non-add)	*538,548*	*540,703*	*550,847*
Title V Compacts (non-add)	*8,539,222*	*8,573,396*	*8,734,230*
BA	**$68,065,000**	**$72,338,000**	**$69,620,000**

AREA ALLOCATION

Direct Operations
(dollars in thousands)

DISCRETIONARY	FY 2015 Final			FY 2016 Enacted			FY 2017 President's Budget			FY '17 +/- FY '16
SERVICES	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$3,307	$1,365	$4,672	$3,592	$1,374	$4,966	$3,381	$1,398	$4,779	-$187
Albuquerque	916	378	1,294	995	380	1,375	936	387	1,324	-52
Bemidji	983	406	1,388	1,067	408	1,476	1,005	416	1,420	-55
Billings	1,570	648	2,219	1,706	652	2,358	1,605	664	2,269	-89
California	1,037	428	1,465	1,127	431	1,557	1,060	439	1,499	-59
Great Plains	1,715	708	2,422	1,862	712	2,574	1,753	725	2,478	-97
Nashville	1,268	523	1,791	1,377	527	1,903	1,296	536	1,832	-72
Navajo	2,153	889	3,042	2,339	894	3,233	2,201	911	3,112	-121
Oklahoma	2,510	1,036	3,547	2,727	1,043	3,769	2,566	1,062	3,628	-142
Phoenix	2,146	886	3,033	2,331	892	3,223	2,194	908	3,102	-121
Portland	1,809	747	2,556	1,965	751	2,717	1,849	765	2,614	-102
Tucson	478	197	675	519	198	717	488	202	690	-27
Headquarters	28,284	11,677	39,960	30,721	11,748	42,469	28,914	11,960	40,873	-1,596
Total, Direct Ops	**$48,176**	**$19,889**	**$68,065**	**$52,328**	**$20,010**	**$72,338**	**$49,249**	**$20,371**	**$69,620**	**-$2,718**

Note: Allocation amounts are estimates.

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

(Dollars in Thousands)

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$5,727	$5,735	$5,837	+$102
FTE*	13	13	15	+2

* 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 2017 Authorization.....Permanent

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

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

Since 1993, the IHS, in cooperation with Tribal representatives, developed formula methodologies for identification of Tribal shares for all Indian Tribes. Tribal shares are those program and administrative funds that Tribes are eligible to assume through self-determination contracts and self-governance compacts.[2] Today Indian Tribes and Tribal organizations currently administer over one-half of IHS resources through ISDEAA self-determination contracts and self-governance compacts.

The IHS Tribal Self-Governance program has grown dramatically since the initial 14 compacts and funding agreements were signed in 1994. As of September 2015, the IHS negotiated a total of 87 self-governance compacts and 112 funding agreements with Indian Tribes and Tribal organizations. In FY 2016, approximately $1.8 billion, of the total IHS budget appropriation, will be transferred to Tribes and Tribal Organizations to support 92 ISDEAA self-governance compacts and 117 funding agreements.[3]

[1] *Available at* http://www.whitehouse.gov/sites/default/files/omb/memoranda/2010/m10-33.pdf
[2] The ISDEAA provides two mechanisms for Tribes and Tribal organizations to assume responsibility for health care formerly provided by the Federal government. The IHS Tribal Self-Governance Program is authorized under Title V of the Act. Tribes may also contract with the IHS through self-determination contracts and annual funding agreements authorized under Title I of the Act.
[3] For FY 2016, the IHS estimates an additional five Tribes entering into Title V ISDEAA compacts and funding agreements. This estimate corresponds to the number of Self-Governance Negotiation Cooperative Agreements available each fiscal year. Eligibility requirements for these agreements mirror the statutory requirements that Tribes must meet to participate in the IHS Tribal Self-Governance Program (25 U.S.C. § 458aaa–2; 42 C.F.R. Part 137, Subpart C). For this pool, an average estimate of $5 million per Tribe is used to project estimates for Tribes entering into a Title V ISDEAA compacts and funding agreements, inclusive of both Tribal shares and contract support costs.

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

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

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

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

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

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

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

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

- Maintaining, and improving the OTSG Financial Management (OTSG FM) system containing Tribal compacts, funding agreements, amendment and payment documents. The OTSG FM provides 24/7 access to Tribes and IHS staff. It also meets Federal Funding Accountability and Transparency Act requirements and reports Title V compact and funding agreement amounts to the HHS Tracking Accountability in Government Grants System;
- Coordinating and reporting IHS Tribal Consultation activities with Tribes, HHS, and other federal agencies in accordance with law, executive orders, and policy; and
- Publishing and disseminating self-governance information nationally to Tribes and Tribal organizations.

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

FUNDING HISTORY

Fiscal Year	Amount
2012 Enacted	$6,044,000
2013 Enacted	$5,727,000
2014 Final	$4,227,000
2015 Enacted	$5,727,000
2016 Enacted	$5,735,000

BUDGET REQUEST

The FY 2017 budget request for the Tribal Self-Governance Program of $5,837,000 is an increase of $102,000 above the FY 2016 Enacted level.

FY 2016 Base Funding of $5,735,000 – The base funding is necessary to support further implementation of the IHS Tribal Self-Governance program, to continue funding for Planning and Negotiation Cooperative Agreements to assist Indian Tribes to prepare and enter into the IHS Tribal Self-Governance program, to continue to fund performance projects, and to fund Tribal shares needs in IHS Areas and Headquarters for any Indian Tribes that have decided to participate in the IHS Tribal Self-Governance program**.**

Current Services Increase of +$102,000 includes:

- Pay Costs +$20,000 – to cover pay raises for Federal employees which improve the ability of the agency to support Tribes entering into Self-Governance.

- Inflation +$82,000 – to cover inflationary costs of providing health care services.

PERFORMANCE DISSCUSSION

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

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

OUTPUTS / OUTCOMES

Measure	**Year and Most Recent Result / Target for Recent Result / (Summary of Result)**	**FY 2016 Target**	**FY 2017 Target**	**FY 2017 Target +/- FY 2016 Target**
TOHP-1 Percentage of TOHP clinical user population included in GPRA data. (Outcome)	FY 2015: 58.6 % Target: 55.3 % (Target Exceeded)	57.7 %	58.6 %	+0.9 %
TOHP-SP Implement recommendations from Tribes annually to improve the Tribal consultation process. (Output)	FY 2015: 9 recommendations Target: 3 recommendations (Target Exceeded)	3 recommendations	3 recommendations	Maintain

GRANT AWARDS

CFDA No. 93.444 – Tribal Self-Governance Program: Planning and Negotiation Cooperative Agreement			
	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Planning Cooperative Agreements			
Number of Awards	5	5	5
Award Amount	$120,000	$120,000	$120,000
Negotiation Cooperative Agreements			
Number of Awards	5	5	5
Award Amount	$48,000	$48,000	$48,000

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

PUBLIC AND PRIVATE COLLECTIONS

(Dollars in Thousands)

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Medicare:				
Federal	$183,462	$184,408	$184,408	$0
Tribal[1]	6,986	6,986	6,986	0
Tribal[2]	57,244	57,244	57,244	0
Subtotal:	247,692	248,638	248,638	0
Medicaid:				
Federal	$644,781	$659,185	$659,185	$0
Tribal[1]	22,217	22,517	22,517	0
Tribal[2]	124,203	125,903	125,903	0
Subtotal:	791,201	807,605	807,605	0
M/M Total:	**$1,038,893**	**$1,056,243**	**$1,056,243**	**$0**
Private Insurance	$104,272	$109,272	$109,272	$0
VA Reimbursements[3]	$7,530	$28,062	$28,062	$0
TOTAL:	**$1,150,695**	**$1,193,577**	**$1,193,577**	**$0**
FTE[4]	6,244	6,244	6,244	0

[1] Represents CMS tribal collection estimates as last provided.
[2] Represents estimates of tribal collections due to direct billing between FY 2002 – FY 2015.
[3]The FY 2016 and FY 2017 collections reflect the revised agreed upon estimates with VA staff; these estimates more accurately reflect current trends and future expectations. The VA and IHS will continue to work together to re-evaluate future growth estimates based on FY 2015 and FY 2016 actual collections.
[4] FTE numbers reflect only federal staff and do not include increases in tribal staff.

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

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

In fiscal year (FY) 2015, $1.151 billion was collected from third party insurers, of which an estimated $828 million was Federal M&M collections and $104.3 million, or 9.1 percent was from private insurers. The FY 2017 estimates above are based on the FY 2015 actual collections, current M&M rates available and published in the Federal Register on April 7, 2015 for the 2015 calendar year (CY), increased Medicaid enrollment estimated related to the Affordable Care Act (ACA) for FY 2015 through FY 2017 and agreement with VA staff on reimbursement estimates from the VA.

Collections support HHS strategic goal 1 – "Strengthen Health Care" Public and private collections represent a significant portion of IHS and Tribal health care delivery budgets and are critical to support the IHS priority to improve the quality of and access to care.

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

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

During FY 2016 and FY 2017, IHS will continue the development of a third party interface with the Unified Financial Management System and enhance systems, reports, and processes to meet legislative requirements for IHS operated facilities. The IHS will also work on initiatives such as the Electronic Health Record (EHR) and implementing ICD-10 codes. The IHS will continue to strengthen its business office policies and management practices, including internal controls, patient benefits coordination, provider documentation training, certified procedural coding training, electronic claims processing and debt management. Priority activities include continued development of third party billing and accounts receivable software to improve effectiveness and to ensure system integration with its business processes, compliance with M&M regulations, and industry standards and changes in operational processes. Improvements for IHS operated facilities are coordinated with concurrent enhancements in Purchased and Referred Care business practices related to alternate resources.

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

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

IHS continues to provide resources and education related to the changes under the ACA. Areas have developed and shared their Area Business Plan Templates with Tribes in the Areas and continue to monitor implementation progress. IHS anticipates that in-network contracting with

qualified health plans in the Marketplace may work for many facilities and is working with CMS to identify ways to encourage and monitor implementation. In FY 2015, IHS continued to implement, train, and participate in the Medicare Payment Reform efforts by CMS. This included increasing awareness, implementation, training, and monitoring of Physician Quality Reporting Systems (PQRS) and Value Based Modifier (VBM) Payment Incentives and Adjustments. IHS continues to monitor ACA implementation progress, provides technical assistance, and works with CMS to resolve issues related to AI/ANs and ACA implementation.

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

In December 2012, IHS and the Department of Veterans Affairs (VA) signed the VA/IHS National Reimbursement Agreement that facilitates reimbursement by the VA to the IHS and Tribal facilities for direct health care services provided to eligible AI/AN veterans. This was a significant step forward in ensuring implementation of Section 405 of the IHCIA[1]. The agreement represents a positive partnership to support improved coordination of care between IHS federal facilities and the VA and paves the way for future agreements negotiated between VA and tribal health programs. IHS will continue to work directly with the VA to implement billing practices to ensure IHS receives proper payment for care provided at IHS and Tribal facilities to AI/AN veterans. Monitoring, auditing, and compliance with the agreement will become a focus for FY 2015 through FY 2017. Implementation plans have been developed to bill the VA and collect at all IHS federal sites serving eligible Veterans. Currently, 100 percent of federal sites are billing the VA for services. Tribal health programs currently have 89 agreements with the VA.

Annually, IHS trains health care facility staff in areas related to coding, third party billing and other aspects of the revenue cycle. Area I/T/U staff are highly encouraged to participate in annual CMS trainings. IHS hosts a Partnerships conference to provide the most current information related to finance, information technology, Purchased/Referred Care, and business office functions; special emphasis is also provided for the specific management needs of Tribes and urban programs. In 2015, IHS completed an update of its Third Party Revenue Accounts Management and Internal Controls Policy and is currently preparing a training plan and a schedule of trainings for staff across the country. As part of the transition to ICD-10, the IHS developed an online ICD-10 module for the purpose of identifying issues in the revenue cycle that may be caused by the implementation of ICD-10.

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

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

FY 2016 - 2017 Collections Estimates

Medicare and Medicaid (M&M) The FY 2017 President's Budget request continues the FY 2016 estimated level which has been revised to $1.056 billion.

The FY 2016 M&M estimate includes an increase of $17.350 million over the revised FY 2015 level and this includes $10 million which is anticipated from increased Medicaid enrollment related to current and future ACA implementation and $7.350 million related to the impact of the CY 2015 rate increases.

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

Medicaid – The FY 2017 President's Budget request continues the FY 2016 estimated level which has been revised to $807.605 million.

The FY 2016 revised Medicaid collection estimate includes increases over FY 2015 of $10 million to continue progress in Medicaid expansion during FY 2016 and $6.404 million due to the impact of the CY 2015 rates increases published in the Federal Register on April 7, 2015.

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

Medicare – The FY 2017 President's Budget request continues the FY 2016 estimated level which has been revised to $248.638 million.

The FY 2016 revised level includes an increase of $.946 million over the FY 2015 revised level due to the effect of the CY 2015 Medicare rate increases.

Private Insurance – The FY 2017 President's Budget request totals $109.272 million, the same level as the FY 2016 estimate. The FY 2016 estimate includes an increase of $5 million over the FY 2015 level of $104.272 million as we continue implementation of ACA and expect increases in private insurance coverage among AI/AN populations.

In addition to the premium subsidies that the general American public receives to purchase insurance, the ACA includes special benefits for AI/ANs. The ACA has specific cost sharing exemptions for members of federally recognized tribes and individuals may choose to enroll in private insurance plans that the IHS can bill. While health insurance subsidies will continue in FY 2016 and FY 2017, the purchase of health insurance is voluntary for many AI/ANs. I/T/U delivery of health care is not contingent on the purchase of health insurance and our patients will continue to have access to health care offered in I/T/U facilities regardless of their insurance status.

VA/IHS National Reimbursement Agreement – The FY 2017 President's Budget request totals $28.062 million, the same as the FY 2016 estimated level.

FY 2015 actual Federal collections as reported by the Treasury Department are $7,530. However total collections in FY 2015 are $16.076 million.

The FY 2016 and FY 2017 request reflects the IHS and VA agreement on reimbursement estimates of $28.062 million. Estimates are based on the assumption that the number of AI/AN Veterans who are dually eligible for IHS and VA services will increase to approximately 18,000 by the end of FY 2016. The $28.062 million level includes an estimate of the VA payments that the VA expects will be made to IHS and Tribal facilities during FY 2016.

IHS and VA have agreed to continue to monitor actual reimbursements and will update estimates based on FY 2015 and FY 2016 actual collections. Estimating the true level of FY 2016 through FY 2017 collections is primarily impacted by the actual number of eligible AI/AN Veterans using IHS services and their individual eligibility for VA benefits. IHS continues to work with the VA in identifying the actual number of AI/ANs with VA benefits eligibility and, of those, how many receive direct care from IHS. IHS and the VA continue to work in partnership to identify and resolve billing and reimbursement issues and provide sites with on-going support and training. Currently, all IHS sites have signed implementation plans and have the ability to bill the VA for Veterans Services.

The following table shows third party collections estimated distributions:

(Dollars in Thousands)

Type of Obligation	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Personnel Benefits & Compensation	$421,699	$426,861	$433,050
Travel & Transportation	6,281	6,481	6,408
Non-Patient Transportation	3,761	3,885	3,842
Comm./Util./Rent	21,817	22,415	22,153
Printing & Reproduction	340	349	345
Other Contractual Services	237,674	244.790	241,918
Supplies	199,255	205,157	202,730
Equipment	15,080	15,524	15,337
Land & Structures	7,332	7,547	7,453
Grants	18,810	19,377	19,154
Insurance / Indemnities	466	479	475
Interest/Dividends	0	0	0
Subtotal	$932,515	$952,865	$952,865
Tribal Collections (est.)	210,650	212,650	212,650
Sub-Total Collections	**1,143,165**	**1,165,515**	**1,165,515**
VA	7,530	28,062	28,062
Total, Collections	**$1,150,695**	**$1,193,577**	**$1,193,577**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service Services:
75-0344-0-1-551

CONTRACT SUPPORT COSTS

(Dollars in Thousands)

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$662,970	$717,970	$800,000	+$82,030
FTE	0	0	0	0

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

FY 2017 Authorization.....Permanent

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

PROGRAM DESCRIPTION and ACCOMPLISHMENTS

The 1975 Indian Self-Determination and Education Assistance Act (ISDEAA), Public Law 93-638, provides Indian Tribes and Tribal organizations (T/TO) the authority to contract with the Federal government to operate programs serving eligible persons and to receive not less than the amount of program funding that the Secretary would have otherwise provided for the direct operation of the program. The 1988 amendments to the Act identified Contract Support Costs (CSC) be paid in addition to the program amount. CSC are defined as reasonable costs for administrative activities that T/TO must carry out but that the Secretary either did not carry out in her direct operation of the program or provided from resources other than those under contract.
In FY 2015 more than $2.7 billion of the IHS appropriations was administered by T/TO through ISDEAA contracts and compacts.

Elements of CSC include:

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

The IHS CSC policy was established in 1992 and revised in 2007[1] to provide guidance in the administration of CSC. As a result of recent significant changes related to CSC, IHS is in the process of working on reviewing and updating the IHS CSC policy to reflect necessary changes. The IHS's business process includes assurance of full CSC need payment to each T/TO that is consistent with the ISDEAA and IHS CSC Policy.

For FY 2015, IHS is working with each T/TO to close out their contracts and compacts by determining and paying full CSC need. For FY 2016, IHS continues to work on ensuring

[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.

each Tribe is paid its full CSC need and revising its budget execution processes necessary to implement CSC as a separate discretionary indefinite account.

IHS continues to make progress in resolving Contract Disputes Act claims for CSC owed for past funding years. As of January 19, 2016, the IHS has extended settlement offers on 1,295 claims and settled 1,096 claims for a value of approximately $754 million from the Judgment Fund. This is a significant accomplishment when compared to the three CSC claims that were settled between the Supreme Court's June 2012 decision in *Salazar v. Ramah Navajo Chapter* and November 2013.

FUNDING HISTORY

Fiscal Year	Amount
2012 Enacted	$471,437,000
2013 Enacted	$447,788,000
2014 Final	$612,484,000
2015 Final	$662,970,000
2016 Enacted	$717,970,000

BUDGET REQUEST

The FY 2017 budget request for Contract Support Costs continues the indefinite discretionary appropriation established in FY 2016, with an estimated funding level of $800,000,000 which is an increase of $82,030,000 above the FY 2016 Enacted level. This request reflects the estimated amount needed to fully fund CSC associated with this budget request, based on information available as of this budget submission. In FY 2018 and beyond, the Administration proposes to reclassify contract support costs as a mandatory, three-year appropriation with sufficient increases year over year to fully fund the estimated need for the program, for both the IHS and the Bureau of Indian Affairs and is consistent with tribal consultation.

Performance Impact: Over the past couple years, IHS has implemented a CSC calculation tool that is used to standardize the calculation of each T/TO CSC. Having a uniform tool allows the Agency to review and assure that T/TO are paid their full CSC need. In addition to the implementation of the tool, IHS includes a review and approval process for each negotiation, this step assures consistency and fair application for each T/TO. IHS has also implemented a reconciliation process to 1) address the T/TO full need throughout the year and 2) monitor CSC funds in real time and provides quarterly reports to account for and allocate additional CSC funds to each IHS Area to pay Tribes their additional need throughout the year.

Mandatory: Specifications for FY 2018 Budget Proposal.

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

(Dollars in Millions)

	FY 2018	FY 2019	FY 2020	3-Year Mandatory
CSC	$925	$1,100	$1,300	$3,325

2) Funding is no year and is therefore available to be carried over in future years. For instance, if CSC was to reach $900 million in FY 2018, the remaining $25 million would

be carried over into FY 2019. Under this scenario, $1,125 million ($1,100 million plus the $25 million carried forward) would be available for CSC in FY 2019.

3) New CSC estimates will be provided as part of the reauthorization process.

In addition to amounts already dedicated to program administration, a small amount of CSC can be used for program management and integrity, for example, 2 percent.

AREA ALLOCATION

Contract Support Costs

(dollars in thousands)

DISCRETIONARY	FY 2015 Final			FY 2016 Enacted			FY 2017 President's Budget			FY '17 +/- FY '16
SERVICES	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$0	$218,441	$218,441	$0	$236,563	$236,563	$0	$263,591	$263,591	$27,028
Albuquerque	0	20,933	20,933	0	22,670	22,670	0	25,260	25,260	2,590
Bemidji	0	38,973	38,973	0	42,206	42,206	0	47,028	47,028	4,822
Billings	0	12,258	12,258	0	13,275	13,275	0	14,792	14,792	1,517
California	0	62,106	62,106	0	67,258	67,258	0	74,942	74,942	7,684
Great Plains	0	21,891	21,891	0	23,707	23,707	0	26,416	26,416	2,709
Nashville	0	24,658	24,658	0	26,703	26,703	0	29,754	29,754	3,051
Navajo	0	63,047	63,047	0	68,277	68,277	0	76,078	76,078	7,801
Oklahoma	0	103,142	103,142	0	111,699	111,699	0	124,460	124,460	12,762
Phoenix	0	34,441	34,441	0	37,298	37,298	0	41,559	41,559	4,261
Portland	0	60,402	60,402	0	65,413	65,413	0	72,886	72,886	7,474
Tucson	0	2,679	2,679	0	2,902	2,902	0	3,233	3,233	332
Headquarters	0	0	0	0	0	0	0	0	0	0
Total, CSC	**$0**	**$662,970**	**$662,970**	**$0**	**$717,970**	**$717,970**	**$0**	**$800,000**	**$800,000**	**+$82,030**

Note: Allocation amounts are estimates.

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

(Dollars in Thousands)

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$53,614	$73,614	$76,981	+$3,367
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 2017 Authorization.....Permanent

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

PROGRAM DESCRIPTION and ACCOMPLISHMENTS

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

Maintaining reliable and efficient buildings is an increasing challenge as existing health care facilities age and additional space is added into the real property inventory. The average age for IHS-owned health care facilities is 36 years, whereas the average age, including recapitalization of private-sector hospital plants, is 9 to 10 years.[1] Many IHS and Tribal health care facilities are operating at or beyond capacity, and their designs are not efficient in the context of modern health care delivery. In addition, as existing health care facilities continue to age, the operational and maintenance costs increase.

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

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

reporting Tribal health care facilities as of October 1, 2015 is $473 million. Approximately 4 percent of the current replacement value - $177 million annually - is necessary to fully 'sustain' the facilities and fund a project pool for restoration/modernization/improvement projects to support program requirements. Also, an aggressive new construction program is essential to reduce the backlog. When IHS replaces an older, obsolete hospital or clinic with a new facility, all deficiencies associated with the old facility are removed from the backlog.

M&I Funds Allocation Method

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

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

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

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

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

FUNDING HISTORY

Fiscal Year	Amount
2012 Enacted	$53,721,000
2013 Enacted	$50,919,000
2014 Final	$53,614,000
2015 Final	$53,614,000
2016 Enacted	$73,614,000

BUDGET REQUEST

The FY 2017 budget request for the Maintenance and Improvement program, of $76,981,000, is an increase of $3,367,000 above the FY 2016 Enacted level.

[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.

FY 2017 Funding Increases to Base Funding of $3,367,000 would provide funding for:

- Inflation +$1,872,000 – to cover inflationary costs associated with maintenance and improvement, e.g., the purchase of supplies and materials.

- Population Growth +$978,000 – to address the impact of the additional services need arising from the growing AI/AN population. The growth rate is projected to be 1.8 percent in FY 2017 based on State births and deaths data.

Program Increase +$517,000 - to provide additional funding in addressing the most critical needs on the maintenance backlog at existing Federal and Tribal health care facilities. Funds will be distributed using the M&I allocation methodology.

The FY 2017 President's Budget of $76,981,000 provides funding in the following allocation categories:

- Approximately $65.5 million for routine maintenance to sustain the condition of federal and Tribal healthcare facilities buildings. These funds will support facilities activities that are generally classified as those needed for 'sustainment' of existing facilities and provided to the IHS Area Offices and to Tribes for daily maintenance activities and local projects to maintain the current state of health care facilities. The investment strategy allowed by the FY 2017 President's Budget fully funds the minimum amount calculated by the facility sustainment algorithm used by IHS, but when compared to the recommendation from the Buidling Research Board, this well below the lower end of the 2-4 percent required to maintain the facilities in their current condition for health delivery[3]

- Approximately $8 million would be available for major Area and Tribal M&I projects to reduce the BEMAR deficiencies and to improve healthcare facilities to meet changing healthcare delivery needs. The $3,367,000 increase under the FY 2017 President's Budget would be allocated to the project pool for the Areas and Tribes to manage. At this level, the M&I pool can address small elements of the backlog of work to address the old and antiquated facilities plant infrastructure (e.g., mechanical and electrical BEMAR) and program enhancements. Without restoration and modernization projects to support program requirements, potentially major equipment failure could occur (e.g., boiler failure) closing the building and suspending all services.

- Approximately $3 million would be available for environmental compliance projects. The IHS places a high priority on the implementation of the Greening the Government Executive Orders and meeting Federal, State, and local legal/regulatory environmental requirements, including allocating funding to address findings and recommendations from environmental audits. Many IHS and Tribal facilities were constructed before the existence of current environmental laws and regulations. Since IHS is required to comply with current Federal, State, and local environmental regulations, the use of environmental assessments to identify and evaluate potential environmental hazards is important. These assessments form the basis of IHS facilities environmental remediation activities. The IHS has currently identified approximately $10.9 million in environmental compliance tasks and included them in the BEMAR database. Further, a portion of this funding may be used to implement renewable energy technologies (e.g., photovoltaic arrays, wind turbines, geothermal systems, etc.) and

[3] Ibid.

other sustainability projects at existing facilities. Executive Order 13693 *Planning for Federal Sustainability in the Next Decade* requires that by FY 2025, not less than 25 percent of building electric and thermal energy be produced from renewable and alternative sources.

- Approximately $500,000 for demolition projects. The IHS has approximately 180 Federally-owned buildings that are vacant, excess, or obsolete which are no longer needed. Many of these buildings are safety and security hazards. Demolition of some of these buildings, in concert with transferring others, reduces hazards and liability. Demolition Funds may be augmented with environmental compliance funds as available for demolition of the Federal buildings to the extent that the proposed action reduces hazards, environmental concerns, or liability to the Indian Health Service.

  Additionally, the Tribal recommendations from *The National Tribal Budget Formulation Workgroup's Recommendations on the Indian Health Service FY 2017 Budget* cited the critical need to increase M&I funding.

OUTPUTS / OUTCOMES – The Outcomes for this program are measured through BEMAR, i.e., progress in addressing maintenance needs and facility deficiencies.

GRANT AWARDS – This program has no grant awards.

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

(Dollars in Thousands)

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$79,423	$99,423	$103,036	+$3,613
FTE**	161	161	161	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; 42 U.S .C 2004a, Indian Sanitation Facilities Act; 25 U.S.C. 1632, Indian Health Care Improvement Act (IHCIA), as amended 2010

FY 2017 Authorization..... Permanent

Allocation Method .....Needs-based priority system for construction project fund allocation and implemented through P.L. 86-121 Memorandum of Agreements, P.L. 93-638 Self-Determination Contracts and Self-Governance Construction Project Agreements.

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

Sanitation Facilities Construction (SFC) is an integral component of IHS disease prevention activities. IHS has carried out the program since 1959 using funds appropriated for SFC to provide potable water and waste disposal facilities for American Indian and Alaska Native (AI/AN) people and communities. As a result, infant mortality rates and mortality rates for gastroenteritis and other environmentally-related diseases have been reduced by about 80 percent since 1973. Research supported by the Centers for Disease Control and Prevention state populations in regions with lower proportion of homes and absent of water service, reflect significantly higher hospitalization rates for pneumonia, influenza, and respiratory syncytial virus[1]. Researchers associate the increasing illnesses with the restricted access to clean water for hand washing and hygiene. The absence of clean water to sanitation facilities for tribal households exacerbate concern for the Indian Health Service Clinical Health Care program; further decreasing the quality of life for American Indians and Alaska Natives. The SFC Program works collaboratively with tribes to assure all communities and homes are provided with safe and adequate water supply systems and sanitary sewage disposal systems as soon as possible.

The Indian Health Care Improvement Act requires IHS to identify the universe of sanitation facilities needs for existing AI/AN homes by documenting deficiencies and proposing projects to address their needs. These projects provide new and existing homes with first time services such as water wells, onsite waste water systems or connecting homes to community water, and waste water facilities. The universe of need includes upgrading existing water supply and waste disposal facilities.

Projects that provide sanitation facilities to existing homes are selected for funding in priority order each year from the Sanitation Deficiency System (SDS). The SDS is an inventory of the sanitation

[1] Thomas W. Hennessy, Troy Ritter, Robert C. Holman, Dana L. Bruden, Krista L. Yorita, Lisa Bulkow, James E. Cheek, Rosalyn J. Singleton, and Jeff Smith. The Relationship Between In-Home Water Service and the Risk of Respiratory Tract, Skin, and Gastrointestinal Tract Infections Among Rural Alaska Natives. American Journal of Public Health: November 2008, Vol. 98, No. 11, pp. 2072-2078.

deficiencies of all federally recognized AI/AN communities; the sanitation deficiencies include needed water, sewer, and solid waste facilities for existing AI/AN homes. Project selection is driven by objective evaluation criteria including health impact, existing deficiency level, adequacy of previous service, capital cost, local tribal priority, operations and maintenance capacity of the 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.

The four types of sanitation facilities projects funded through IHS are: (1) projects to serve existing housing; (2) projects to serve new or like-new housing, such as Indian homes being constructed or rehabilitated by the BIA-Home Improvement Program, Tribes, individual homeowners, or other nonprofit organizations; (3) special projects (studies, training, or other needs related to sanitation facilities construction); and (4) emergency projects. Projects that serve new or like-new housing are funded based on a priority classification system. Projects that serve existing housing are annually prioritized with tribal input, then funded in priority order.

SFC projects can be managed by IHS directly or 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 will be served, and construction is performed by either the IHS or the Tribes. Projects start with a Tribal Project Proposal and are funded and implemented through execution of an agreement between a Tribe and IHS. In these agreements, the Tribes also assume ownership responsibilities, including operation and maintenance. The overall SFC goals, reporting requirements, eligibility criteria, project planning, and funding priorities remain the same, regardless of the delivery methods chosen by a Tribe.

In FY 2015, IHS provided service to 15,457 AI/AN homes with an average project duration of 3.9 years. However, as of the end of FY 2015 about 24,200, or 6 percent of all AI/AN homes were without access to adequate sanitation facilities; and, about 188,228 or approximately 47 percent of AI/AN homes were in need of some form of sanitation facilities improvements. Maximum health benefits will be realized by addressing existing sanitation needs identified in the backlog, by providing sanitation facilities for new homes when they are constructed, and continuing technical assistance to support tribal operation and maintenance of these facilities. The individuals who live in homes without adequate sanitation facilities are at a higher risk for gastrointestinal disease, respiratory disease and other chronic diseases[2]. 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. Additionally, in FY 2015, the Environmental Protection Agency (EPA) reported that 88 percent of tribal populations served by community water systems received drinking water that met all applicable health-based standards, compared to over 91 percent of the US population served by community water systems.[3]

The total sanitation facility need in FY 2015, as reported through the SDS, continues to be adjusted and is expected to decrease, but will be still be significantly greater than $2 billion. The reason for this decrease is attributed to the SFC program's focus on improving quality of the data reported through the SDS process for the past few years. This effort focused on ensuring the sanitation facilities needs included in SDS were:

[2]Thomas W. Hennessy, Troy Ritter, Robert C. Holman, Dana L. Bruden, Krista L. Yorita, Lisa Bulkow, James E. Cheek, Rosalyn J. Singleton, and Jeff Smith. The Relationship Between In-Home Water Service and the Risk of Respiratory Tract, Skin, and Gastrointestinal Tract Infections Among Rural Alaska Natives. American Journal of Public Health: November 2008, Vol. 98, No. 11, pp. 2072-2078.
[3]US Environmental Protection Agency. GPRA Summary Report. Accessible through this weblink: https://obipublic11.epa.gov/analytics/saw.dll?PortalPages&PortalPath=/shared/SFDW/_portal/Public&Page=Summary

- Adequately documented
- Reflected an update of current needs
- Included only sanitation facilities fundable by the SFC program

This data quality initiative by the SFC program supports the *HHS Strategic Plan FY 2014 - 2018 Strategic Goal 4: Ensuring Efficiency, Transparency, Accountably and Effectiveness of HHS Programs Objective B: Enhance access to and use of data to improve HHS programs and to support improvements in the health and well-being of the American people.*

The total sanitation facility need reported through SDS from 2005 to 2015 has increased over 80% from $1.86 billion to $3.39 billion. As a result of the SFC program's data quality initiative, the sanitation facility need is not expected to continue trending up. However, the underlaying challenges of construction inflation, population growth, an increasing number of regulations, and failing infrastructure, still significantly influence sanitation facility needs across Indian country. Failing infrastructure is presumably the largest factor, a result of inadequate operations and maintenance. Under the Indian Health Care Improvement Act, the IHS is authorized to provide operation and maintenance assistance for, and emergency repairs to, tribal sanitation facilities, when necessary to avoid a health hazard or to protect the Federal investment in sanitation facilities. In order to quantify inadequate operations and maintenance, IHS, in coordination with other federal agencies and Tribes, is assessing the operational and maintenance costs associated at tribal drinking water and wastewater utilities. Also, the IHS is developing an assessment methodology of how operation and maintenance practices have impacted the life of installed sanitation facilities in Indian country.

Additionally, to ensure appropriate funds are expediently and efficiently utilized to construct sanitation facilities serving Indian-occupied homes, the SFC program will continue to obligate funds to construction projects that are 'ready to fund'; this means they have a well-defined scope, a detailed cost estimate, a completed preliminary design and that known potential risks to project construction, operation and maintenance have been considered and mitigated.

In FY 2017, the program will continue to examine and improve data quality of the reported home and community sanitation facility needs and will continue its focus on maintaining average project duration to less than 4 years.

FUNDING HISTORY

Fiscal Year	Amount
2012 Enacted	$79,582,000
2013 Enacted	$75,431,000
2014 Final	$79,423,000
2015 Final	$79,423,000
2016 Enacted	$99,423,000

BUDGET REQUEST

The FY 2017 budget request for the Sanitation Facilities Construction program of $103,036,000 is an increase of $3,613,000 above the FY 2016 Enacted Level.

FY 2017 Funding Increases to Base Funding of $3,613,000 would provide funding for:

- Inflation +$2,349,000 – to cover inflationary costs associated with the sanitation and facilities program activities.

- Population Growth +$1,264,000 – to fund the additional services need arising from the growing AI/AN population. The growth rate is projected to be 1.8 percent in FY 2017 based on State births and deaths data.

FY 2017 President's Budget of $103,036,000 provides funding in the following allocation categories:

- Approximately $56.836 million will be distributed to the Areas for prioritized projects to serve existing homes, based on a formula that considers, among other factors, the cost of facilities to serve existing homes that: (a) have not received sanitation facilities for the first time, or (b) are served by substandard sanitation facilities (water and/or sewer). Another element of the distribution formula is a weight factor that favors Areas with larger numbers of AI/AN homes without water supply or sewer facilities, or without both.

  From this distribution, up to $5 million may be used for projects to clean up open dump sites on Indian lands pursuant to the Indian Lands Open Dump Cleanup Act of 1994[4], pending coordination with the Environmental Protection Agency on oversight and evaluation of tribal solid waste management programs.

- Approximately $43.200 million will be used to serve new and like-new homes, which are non-HUD homes (HUD homes are served under HUD authorities and appropriations). Some of these funds may also be used for sanitation facilities for individual homes of the disabled or sick, with a physician referral, indicating an immediate medical need for adequate sanitation facilities in their home.[5] As needed, amounts to serve new and like-new homes will be established by Headquarters after reviewing Area proposals. Priority will be given to projects under the BIA Housing Improvement Program (HIP) to serve new and like-new homes with the exception of "Category A" BIA HIP homes which are considered existing homes and will be served with the funds described in the first bullet of this section.

- Up to $3 million may be reserved at IHS Headquarters. Of this amount, $1 million may be distributed to Areas to address water supply and waste disposal emergencies caused by unanticipated situations that require immediate attention to minimize potential threats to public health. The remaining $2 million is for funding special projects. Up to $1 million of this amount may be used to assess and enhance the ability of Tribes to establish effective and sustainable operation and maintenance organizations. Additionally, up to $1 million may be used for improving data collection systems, providing technical assistance, and training for userssupporting a national automated computer-aided drafting contract. Emergency and special funds remaining at the end of the fiscal year may be distributed to Areas to address the SDS priority list of needs.

The IHS appropriated funds for sanitation facilities construction are prohibited by law from being used to provide sanitation facilities for new homes funded with grants by the housing programs of the Department of Housing and Urban Development (HUD). These HUD housing grant programs for new homes should continue to incorporate funding for the sanitation facilities necessary for those homes.

[4] Indian Lands Open Dump Cleanup Act of 1994 Pub. L.103-399, Oct. 22, 1994, 108 Stat. 4164 (25 U.S.C. 3091et seq.)

[5] Indian Health Service. Chapter 5 Eligibility for IHS SFC Program Services and IHS-Funded Projects. Criteria for the Sanitation Facility Construction Program June 1999 ver. 1.02, 3/13/03.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
35 Number of new or like-new and existing AIAN homes provided with sanitations facilities. (Outcome)	FY 2015: 15,457 Target: 15,500 (Target Not Met)	18,710	20,000	+1,290
SFC-3 Percentage of AI/AN homes with sanitation facilities. (Outcome)	FY 2015: 93.9% Target: 91% (Target Exceeded)	92%	Retire after 2016	N/A
SFC-E Track average project duration from the Project Memorandum of Agreement (MOA) execution to construction completion. (Outcome)	FY 2014: 3.9 yrs Target: 4 yrs (Target Exceeded)	3.5 yrs	3.5 yrs	Maintain

GRANT AWARDS – This Program has no grant awards.

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

(Dollars in Thousands)

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$85,048	$105,048	$132,377	+$27,329
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 2017 Authorization.....Permanent

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

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 staff quarters where no suitable housing alternatives are available. The IHS is authorized to construct health care facilities and staff quarters, support Tribal construction of facilities under the Joint Venture Construction Program (JVCP), provide construction funding for Tribal small ambulatory care facilities projects, and provide funding to construct new and replacement dental units.

The construction and modernization of IHS infrastructure through the health care facilities construction program is essential to ensure the IHS commitment to the Department of Health and Human Services Strategic goal 1: to strengthen health care. The health care facilities constructed by the IHS ensure access to quality, culturally competent health 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 care service programs provided in these facilities is on prevention and 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 the Health Facilities Construction Priority System (HFCPS) methodology. The HFCPS ranks proposals using factors reflecting the total amount of space needed, age and condition of the existing health care facility, if any, degree of isolation of the population to be served in the proposed health care facility, and availability of alternate health care resources. The remaining health care facilities projects on the HFCPS list, including those partially funded, total approximately $2.2 billion as of April 2015. The reauthorization of the Indian Health Care Improvement Act (IHCIA) included in the Affordable Care Act in 2010 includes a provision stating 'any project established under the construction priority system in effect on the date of enactment of the Act of 2009 shall not be affected by any change in the construction priority system taking place after that date…'. Total Need for the HCFC Program was approximately $5.9 billion in 2006.

The JVCP allows IHS to enter into agreements with Tribes that construct their own health care facilities. The Tribe provides the resources, whether from their own funds, through financing, grants, contributions, or a combination thereof, for the construction of their health care facility. IHS health care facility construction appropriations are not used for construction of facilities in the JVCP but may be used to equip the health care facility. Tribes apply for the JVCP during a competitive process and the approved projects are entered into agreements with IHS. Based on the date of projected completion of construction by the respective Tribe, the IHS agrees to request a funding increase from Congress for additional staffing and operations consistent with fully executed beneficial occupancy of the health care facility. In the next three years the HCFC Program is working with 6 Tribes/Health Corporations to complete JVCP projects.

The FY 2015 budget completed funding for the Northern California YRTC.

In FY 2015 the following health care facilities were completed:

1. San Carlos Health Center: 179,973 sf and 43 Staff Quarters
2. Mississippi Choctaw Health Center: 152,126 sf (Joint Venture Project)
3. Kayenta Health Center: 179,090 sf and 129 Staff Quarters, operational pending receipt of furniture

In FY 2016 the following health care facility is targeted for completion:

1. Muskogee Creek Nation Eufaula Health Center: 64,164 sf (Joint Venture Project)

FUNDING HISTORY

Fiscal Year	Amount
2012 Enacted	$85,048,000
2013 Enacted	$77,238,000
2014 Enacted	$85,048,000
2015 Enacted	$85,048,000
2016 Enacted	$105,048,000

BUDGET REQUEST

The FY 2017 budget request for the Health Care Facilities Construction of $132,377,000 is an increase of $27,329,000 above the FY 2016 Enacted level.

The FY 2016 Base Funding of $105,048,000 would provide funding for the following Health Care Facilities Construction projects in FY:

- Gila River SE Health Center, Chandler, AZ
- Salt River NE Health Center, Scottsdale, AZ
- Rapid City Health Center, Rapid City, SD
- Dilkon Alternative Rural Health Center, Dilkon, AZ

FY 2017 Funding Increases to Base Funding of $27,329,000 would provide funding for:

- Inflation +$3,886,000 to cover inflationary costs associated with the FEHS program activities.

Program Increases + $23,443,000

- Priority List Projects +$11,443,000 would fund construction projects from the Health Care Facilities Construction Priority List.

- Small Ambulatory Program +10,000,000 would fund 5 to 8 Tribes with grants to construct Small Ambulatory Health clinics.

- Staff Quarters +$12,000,000 would fund the replacement and the addition of new housing quarters in isolated and remote locations for healthcare professionals to enhance recruitment and retention.

FY 2017 Funding of $132,377,000 provides funding for the following Health Care Facilities Construction projects in FY 2017:

- Phoenix Indian Medical Center (PIMC) Northeast Ambulatory Care Center, Scottsdale, AZ to complete construction.
- Whiteriver Hospital, Whiteriver, AZ to begin design.
- Rapid City Health Center, Rapid City, SD to continue construction.
- Dilkon Alternative Rural Health Center, Dilkon, AZ to continue infrastructure activities.
- Small Ambulatory Health Care Facility
- Replacement and New Quarters

PIMC Northeast Health Center, Scottsdale, AZ $52,546,000
These funds will be used to complete construction of the PIMC Northeast Health Center. The proposed new Northeast Health Center will consist of 197,850 GSF outpatient health center and serve a projected user population of 18,596 generating 51,275 primary care provider visits and 124,837 outpatient visits annually. It will be a modern, technologically advanced health care facility with enough space and staff to provide an expanded level of health care services specifically designed to meet the health care needs of the northeast portion of the Phoenix Service Unit. This facility will improve access to medical care as well as improve the collaboration and partnership between the Salt River Pima-Maricopa Indian Community and the IHS. The new health care facility will provide an expanded outpatient department, community health department, and a full array of ancillary and support services.

Whiteriver Hospital, Whiteriver, AZ $15,000,000
These funds will be used to begin design of the proposed 220,000 GSF Whiteriver Hospital project. The existing facility, built in 1979 is sound but too small to support the health care delivery program for the service unit population. The proposed facility will serve a projected user population of 18,533 generating 72,600 primary care provider visits and 91,000 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 Whiteriver Service Unit. This facility will improve access to medical care as well as improve the collaboration and partnership between the local tribes and the IHS. New services will include ICU, general surgery, respiratory therapy, and cardiac rehabilitation.

Rapid City Health Center, Rapid City, SD $27,831,000
These funds will be used to continue construction of the health care facility to replace the Sioux San Hospital with a new 200,000 GSF health center at today's medical standard. This project includes funding for refurbishing historic buildings and mitigation of historic buildings that will be demolished. The proposed new ambulatory health care center will serve a projected user population of 21,544 generating 52,195 primary care provider visits and 104,233 outpatient visits annually. It will be a modern, technologically advanced, facility with enough space and staff to provide an expanded level of health care services specifically designed to meet the health care needs of the Rapid City Service Unit. This facility will improve access to medical care as well as

improve the collaboration and partnership between the Great Plains Tribes and the IHS. The new health care facility will provide an expanded outpatient department, community health department, and a full array of ancillary and support services. This FY 2017 request for Rapid City Health Center is based upon receipt of $29,500,000 in Nonrecurring Expense Fund funding in FY 2016.

Dilkon Alternative Rural Health Center, Dilkon, AZ $15,000,000

These funds will be used to continue infrastructure activities of the alternative rural health center with 8 short stay beds and 109 staff quarters located in Dilkon, Arizona. The proposed new facility will consist of 150,000 GSF outpatient health center and serve a projected user population of 17,195 generating 61,633 primary care provider visits and 123,080 outpatient visits annually. The new facility will provide an expanded outpatient department, community health department, and a full array of ancillary and support services. This FY 2017 request for Dilkon Alternative Rural Health Center is based upon receipt of $20,500,000 in Nonrecurring Expense Fund funding in FY 2016.

Small Ambulatory $10,000,000

This initiative will provide an opportunity for tribes to provide direct health care to their communities. The initiative would provide funds to the Small Ambulatory Health Care Facility Construction GrantsProgram (SAP). By expanding or providing new access to health care, this proposed initiative links to *HHS Initiative; Strategic Goal #1; Strengthen Health Care.* Ensure optimal health is achievable by everyone in this country by having a health care system that keeps people healthy and promoting prevention and wellness that is not delivered strictly through the health care system

The SAP, as authorized by Section 306 of P.L. 94-437, allows for providing of small ambulatory health care facilities. It is anticipated that tribal facilities competing in this program will be smaller than health centers, which do not qualify for the IHS Health Care Facilitities Construction Priority system.. Projects receiving funds would not be competing with those projects being processed under the IHS HCFC priority system, and there would be a separate project list for this program. SAPfunds are intended to supplement tribal or health organizations construction moneys to increase the access to health care for their service area.

This funding allows the IHS to request applications from interested tribes. Projects will be selected from applications meeting the program requirements as set forth in IHCIA section 305. Funds will be provided for the construction, expansion or modernization of non-IHS owned small tribal ambulatory health care facilities located apart from a hospital. At this level, the HCFC program could assist up to 20 communities to advance their access to health care.

New and Replacement Quarters $12,000,000

Many of the 2,700 quarters across the IHS health delivery system are more than 40 years old and in need of major renovation or total replacement. Additionally, in a number of locations the amount of housing units is insufficient.. The identified unmet need, of housing units in isolated, remote locations is a significant barrier to the recruitment and retention of quality healthcare professionals across Indian Country. The greatest need is in the Great Plains, Navajo and Alaska Areas; $12.0 million is being requested in FY 2017 to initiate the replacement and addition of quality housing for healthcare professionals in these three Areas. The amount distributed to each Area will be based on each Area's internal priority list that will be completed by mid-FY2016.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
36 Health Care Facility Construction: Number of health care facilities construction projects completed. (Outcome)	FY 2015: 2 projects[1] Target: 2 projects (Target Met)	1 project[2]	1 project[3]	Maintain
HCFC-E 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. (Outcome)	FY 2015: 2 Target: 2 (Target Met)	1	1	Maintain

GRANT AWARDS – Program has no grant awards.

[1]The health care facilities completed in FY 2015 were San Carlos, Arizona and Kayenta, Arizona.

[2]The health care facility scheduled to be completed in FY 2016 is Southern California YRTC.

[3]The health care facility scheduled to be completed in FY 2017 is the Northern California YRTC.

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

FACILITIES AND ENVIRONMENTAL HEALTH SUPPORT

(Dollars in Thousands)

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$219,612	$222,610	$233,858	+$11,248
FTE	1,088	1,089	1,090	+1

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

Dollars in Thousands)

Detail Breakout of FEHS Activity	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$219,612	$222,610	$233,858	+$11,248
Facilities Support	*$130,941*	*$133,129*	*$140,625*	*+$7,496*
Environmental Health Support	*$72,551*	*$73,202*	*$76,375*	*+$3,173*
Office of Environmental Health and Engineering Support	*$16,120*	*$16,279*	*$16,858*	*+$579*
FTE	1,088	1,089	1,090	+1
Facilities Support	*579*	*580*	*581*	*+1*
Environmental Health Support	*445*	*445*	*445*	*0*
Office of Environmental Health and Engineering Support	*64*	*64*	*64*	*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 2017 Authorization.....Permanent

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

SUMMARY OF PROGRAMS

Facilities and Environmental Health Support (FEHS) programs provide and support an extensive array of real property, health care facilities and staff quarters construction, maintenance and operation services, as well as community and institutional environmental health, injury prevention, and sanitation facilities construction services. The programs directly and indirectly support all of the Indian Health Service (IHS) facilities performance measures and improved access to quality health services. The programs and staff at the IHS Headquarters, Area Office, and Service Unit levels work collaboratively with Tribes and other agencies to promote and provide access to improvements in public health through surveillance, education, intervention activities, construction of sanitation facilities and health care facilities. These activities are aligned in sub-activities: Facilities Support, Environmental Health Support, and Office of Environmental Health and Engineering Support.

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

FUNDING HISTORY

Fiscal Year	Amount
2012 Enacted	$199,413,000
2013 Enacted	$193,578,000
2014 Enacted	$211,051,000
2015 Enacted	$219,612,000
2016 Enacted	$222,610,000

BUDGET REQUEST

The FY 2017 budget request for the Facilities and Environmental Health Support program of $233,858,000 is an increase of $11,248 above the FY 2016 Enacted Level.

FY 2017 Funding Increases to Base Funding of $11,248,000 would provide funding for:

- Pay Costs +$2,440,000 – to cover pay raises for Federal and Tribal employees.

- Inflation +$2,922,000 – to cover inflationary costs associated with the FEHS program activities.

- Population Growth +$2,491,000 – to fund the additional services need arising from the growing AI/AN population. The growth rate is projected to be 1.8 percent in FY 2017 based on State births and deaths data.

- Staffing/Operating Cost Requirements for Newly Constructed Facilities +$3,395,000 – Facility and Environmental Health Support funds are requested for 2 new and expanded healthcare facilities and 1 youth treatment facility that are planned to complete construction and/or fully open in FY 2017. One of the 3 facilities is a Joint Venture Construction Program (JVCP) project where the Tribe is fulfilling its responsibility under the JVCP agreements to fund the construction and equipment for the health care facility and IHS is fulfilling its responsibility to request staffing and operating funds from Congress. Funding these facilities allows IHS to expand provision of health care capacity to address critical health care needs.

Staffing and Operating Costs for New/Replacement Facility	Amount	Tribal Pos./FTE
Muskogee (Creek) Nation Eufaula Health Center (JV), Eufaula, OK	$1,087,000	6
Northern California Youth Treatment Center, Davis, CA	$339,000	3
Flandreau Health Center, Flandreau, SD	$680,000	4
Choctaw National Regional Medical Center, Durant, OK	$1,289,000	5
Grand Total:	**$3,395,000**	**18**

FY 2017 Base Funding of $233,858,000 provides funding in the following allocation categories:

FACILITIES SUPPORT – Program Description and Accomplishments

Facilities Support (FS) provides funding for Area and Service Unit staff for facilities-related management activities, operation and maintenance of real property and building systems, medical equipment technical support, and planning and construction management support for new and replacement health facilities projects. The sub-activity directly supports the Agency's priorities including: (1) renewing and strengthening our partnership with Tribes; (2) improving the quality of and access to care; and (3) making all our work accountable, transparent, fair and inclusive.

The IHS owns approximately 10,435,000 square feet of facilities (totaling 2,144 buildings) and 1,830 acres of federal and trust land. The nature of space varies from sophisticated medical centers to residential units and utility plants. Facilities range in age from less than one year to more than 160 years, with an average age greater than 36 years. A professional and fully-staffed workforce is essential to ensure effective and efficient operations. Typical staff functions funded may include:

- Facilities engineers and maintenance staff responsible for ensuring that building systems are operated properly, facilities and grounds are maintained adequately, utilities are managed appropriately, environmental compliance requirements are met, and buildings are safe;
- Specialized clinical engineers and technicians who maintain and service medical equipment;
- Realty staff that manages the real property requirements and quarters; and
- Facilities planning and construction-monitoring that assist in the planning and construction of projects.

In addition, FS provides funding for related Area and Service Unit operating costs, such as utilities, building operation supplies, facilities-related personal property, and biomedical equipment repair and maintenance.

During the period FY 2003 through FY 2015, total utility costs have increased 38.9 percent from $15.7 million to $21.8 million and total utility costs per Gross Square Feet (GSF) increased 68.1 percent from $2.32/GSF to $3.90/GSF. IHS has made conscious efforts to help stem the growth in utility costs to ensure appropriations are sufficient to fund these needs. For example, IHS reduced the energy related utility consumption for IHS managed facilities from 199,649 British Thermal Units per Square Foot (BTU/SF) in 2003 to 148,469 BTU/SF in 2015, a 25.6 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, the Energy Independence and Security Act of 2007, and Executive Order 13693, *Planning for Federal Sustainability in the Next Decade*.

ENVIRONMENTAL HEALTH SUPPORT – Program Description and Accomplishments

The Environmental Health Support Account (EHSA) 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. In accordance with congressional direction, these funds are distributed to the Areas based upon the workload and need associated with the two programs noted below.

Two programs are funded by EHS:

- Sanitation Facilities Construction Program (SFC) – Under this program in FY 2015, staff manage and/or provided professional engineering services to construct 395 sanitation projects

with a total cost of over $146 M 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) –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, correctional facilities, 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 environmental health issues. One EHS focus area is food safety. There are over 6,700 food service establishments in Tribal communities which may be a part of community facilities or Tribally-owned enterprises such as restaurants, casinos, and hotels. Environmental health staff conduct risk assessments in these establishments to keep the public safe from foodborne illness. In addition to food safety, other national priority areas include: children's environments, healthy homes, vector borne and communicable disease, and safe drinking water. The EHS program aligns with many of the goals and objectives described in the HHS Strategic Plan. The program includes the specialty areas of injury prevention and institutional environmental health.

The IHS **Injury Prevention Program** has been instrumental in reducing the injury mortality rate of AI/ANs by 58 percent since it moved from an "education only" focus to a public health approach in the 1970's. The Injury Prevention Program has developed effective strategies and initiatives to reduce the devastating burden of injuries experienced by AI/ANs. Although progress has been made, unintentional injuries are still the biggest killer of young 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

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

adverse health effects in health care and other community facilities and supports health care accreditation which improves the quality of care. Maintaining accreditation ensures that IHS continues to have access to third-party funding. The IHS IEH Program 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. EHS supports more than 1,200 active WebCident user accounts. Users include all IHS hospitals, health centers, health stations, youth regional treatment centers, and many Tribal healthcare facilities. The IEH program provides technical support to local safety programs which help protect more than 15,000 employees, contractors, and students working in IHS facilities. The IHS total occupational injury case rate has dropped from 4.35 injuries/100 employees in 2004 to 2.34 injuries/100 employees in 2014.

Tribal Health Programs: Area, District, and Service Unit environmental health personnel work with Tribes/Tribal organizations to encourage maximum participation in planning health services delivery programs. They provide training and technical assistance to the Tribal officials who carry out administrative/management responsibilities associated with operation of federally supported programs.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
EHS-1 Injury Intervention: Occupant protection restraint use (Output)	FY 2015: 100 %[3] Target: 100 % (Target Met)	Retire after 2015	Retire after 2015	Maintain
EHS-2 Environmental Surveillance: Identification and control of environmental health risk factors (Output)	FY 2015: 100 %[4] Target: 100 % (Target Met)	Retire after 2015	Retire after 2015	Maintain
EHS-3 Injury Intervention: Occupant protection restraint use (Outcome)	FY 2016 Set Baseline	Baseline	TBD	Maintain
EHS-4 Environmental Surveillance (Outcome)	FY 2016 Set Baseline	Baseline	TBD	Maintain

Performance Discussion

Injury Intervention: In FY 2015, the Division of Environmental Health Services reported on methods that were used to share successful injury intervention strategies that were effective in increase seatbelt usage rates. Of the 8 IHS Areas participating in the measure, 7 (87.5%) reported

[3] FY 2015 was the final year of a 5 year performance measure cycle. The FY 2015 target was that all Areas reporting effective strategies to improve seat belt usage would share success stories with other Tribal and IHS programs.

[4] FY 2015 was the final year of a 5 year performance measure cycle. The FY 2015 target was that all Area reporting effective strategies for reducing food safety risk would share success stories with other Tribal and IHS programs.

that successful intervention strategies were shared with other Tribal and IHS programs. A variety of effective strategies were used to increase seatbelt rates, including supporting the development of tribal seatbelt laws, enhancing enforcement activities, and community awareness and education. Methods of sharing effective strategies included:

- Presentations to Tribal councils, communities, elders, and schools to reinforce awareness and encourage the continuance of the interventions to increase seat belt use.
- Reports and information with other Tribal Programs to support efforts to apply for injury prevention grants and other funding opportunities.
- Letters, reports, and presentations/discussions at Tribal consultation and Tribal council meetings.
- Reports and presentations to police departments.
- Local radio and newspaper public service announcements.
- Encouraging law enforcement officials to share results with Tribal Council.
- Presentations at local, state, and national venues. For example, via poster presentation at national conferences on highway safety priorities (such as the Lifesavers Conference).
- Formally recognize successful Tribal partners through certificates, newsletter articles, and IHS Director's Award nominations.

The FY 2016 target expands the implementation of the effective strategies identified in the FY2011-FY2015 performance measure to other Tribal communities. This marks the end of the five-year injury intervention performance cycle. In the 2016-2020 performance cycle, Areas will identify targeted communities from which a national baseline measure of seatbelt use will be developed. For the FY 2017 target, Areas will implement comprehensive interventions using at least three effective strategies to increase seatbelt usage rate in targeted Tribal communities.

Environmental Surveillance: In FY 2015, the Division of Environmental Health Services reported on methods that were used to share environmental surveillance intervention strategies that were effective in reducing food risk factors. Of the 11 IHS Areas participating in the measure, 8 (72.7%) reported successful intervention strategies that were shared with other Tribal and IHS programs.

A variety of effective strategies were used to decrease foodborne illness risk factors including offering food safety training, FDA food safety standardization of environmental health staff, supporting the development of tribal food codes, and working with food service operators to develop corrective action plans to reduce deficiencies. Some examples of methods of sharing effective strategies are provided below:

- Sharing information on the reduction in food borne risk factors with Tribal Health Directors through scheduled meetings or during close-out of environmental health site visits to show how interventions are having an impact.
- Shared via Tribal consultation, presentations, reports, and other discussions with Tribal leaders.
- Internally with EHS program managers and staff through conference calls and meetings.
- Submitting the intervention work for an Indian Health Service National Director’s award.
- Through presentations at health seminars hosted by Tribes.
- Through follow-up surveys focused on providing best practice resources and tools from reputable food safety organizations such as the Food and Drug Administration and the National Restaurant Association (ServSafe).
- Through discussions with food service, Head Start, and child care program leaders and staff.

- Through presentations at Elderly Nutrition Program Pre-Service and Annual Conference training sessions.
- By meeting with Tribal business/enterprise and gaming commission staff to encourage adoption of internal environmental health and food safety programs which include codes, inspections, and training of food handlers.
- A model program was shared with other businesses and Tribes to encourage development of similar food safety programs.

The FY 2016 target focused the implementation of the effective strategies identified in the FY2011-FY2015 performance measure on food service in child care establishments. "Children's Environment" is one of the five DEHS priority areas. This marks the end of the five-year environmental surveillance performance cycle. In the 2016-2020 performance cycle, Areas will identify targeted Tribal Head Start and non-residential day care establishments from which a national baseline of foodborne illness risk factors will be calculated. For the FY 2017 target, Areas will implement and report comprehensive interventions using at least three effective strategies to decrease food risk factor deficiencies at targeted Tribal Head Start and non-residential day care establishments

The FY 2016 EHS performance measures focused on reducing the risk of foodborne illness in children's environments and reducing the risk of motor vehicle-related injuries and deaths through increased use of seatbelts. Barriers that may impact the program's ability to meet these targets include competing local, regional and national priorities, staff turn-over, lapsed vacant positions, and a decentralized approach to program management that can result in non-standardized processes across the country. To help mitigate these barriers, EHS provides ongoing competency development through specialized training programs; strategic planning efforts that support uniform program management; and data management tools to support local staff.

GRANT AWARDS

In 2015, all previous injury prevention cooperative agreements came to an end and a new cycle was awarded. The Injury Prevention Program awarded $1,008,224 in cooperative agreements to fund 23 Tribal programs.

	FY 2015 Enacted	FY 2016 President's Budget	FY 2017 Higher Level
Number of Awards	Part I 7 Part II 16	TBD	TBD
Average Award	Part I $98,318 Part II $20,000	TBD	TBD
Range of Awards	Part I $100,000 Part II $20,000	TBD	TBD

OFFICE OF ENVIRONMENTAL HEALTH AND ENGINEERING SUPPORT
Program Description and Accomplishments:

The IHS Office of Environmental Health and Engineering Support activity (OEHE) provides funds for management activities, personnel, contracts, contractors, and operating costs for the

OEHE Headquarters. Personnel have management responsibility for IHS facilities and environmental health programs, provide direct technical services and support to Area personnel, and perform critical management functions.

Management activities include**:**

- national policy development and implementation
- budget formulation, project review and approval
- congressional report preparation
- quality assurance (e.g., internal control reviews, Federal Managers Financial Integrity Act activities and other oversight)
- technical assistance (e.g., consultation and training)
- long range planning
- meetings (with HHS, Tribes, and other federal agencies)
- and recruitment and retention efforts.

Typical direct support functions are**:**

- OEHE personnel serving as project officers and contracting officer representatives for health care facilities construction projects: reviewing and/or writing technical justification documents, participating in design reviews and site surveys, conducting onsite inspections, and monitoring project funding status.
- positions which 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 staff serving as contracting officer representatives and project officers in support of data systems, cooperative agreements, inter-agency agreements, and community-based projects.

In accordance with appropriation committee direction, OEHE funds personnel and activities to develop, maintain, and utilize data systems to distribute Facilities Appropriation resources to Area offices for facilities and environmental health activities and construction administration and management, based upon workload and need . Also, technical guidance, information, and training are provided throughout the IHS system in support of the Facilities Appropriation.

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
- awarding and monitoring contracts for all aspects of the Facilities Appropriation, including all types of construction contracts and 638 construction project agreements.
- OEHE coordinating construction, environmental health, and real property activities through the 12 Area Offices to ensure program consistency, to ensure the most effective use of resources across IHS, and to support field programs through budget preparation and required reporting, thus ensuring the most effective, accountable use of resources to improve access to quality healthcare services.

The OEHE facilities programs integrate strategic planning, performance, and program integrity into the office's daily business practices. One example is the Sanitation Facilities Construction Strategic planning efforts which have been recognized by OMB. Implementation of this plan has improved project management, reduced project durations and transformed the data system used by IHS and federal partners to manage sanitation programs in Indian country. Another example is the Environmental Health program strategic visioning and the Ten Essential Environmental Health Services as a framework. Implementation of both of these initiatives is ongoing.

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

(Dollars in Thousands)

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$22,537	$22,537	$23,654	$1,117
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 2017 Authorization.....Permanent

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

Equipment funds are used for maintenance, upgrades, replacement, and the purchase of new medical equipment systems at Indian Health Service (IHS) and Tribal 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 health care providers using modern and effective medical equipment/systems to assure the best possible health outcomes. The IHS and tribal health programs manage approximately 90,000 devices consisting of laboratory, medical imaging, patient monitoring, pharmacy, and other biomedical, diagnostic, and patient equipment valued at approximately $500 million. With today's medical devices/systems having an average life expectancy of approximately six years and rapid technological advancements, medical equipment replacement is a continual process making it necessary to replace worn out equipment or provide equipment with newer technology to enhance the speed and accuracy of diagnosis and treatment. To replace the equipment at the end of its six year life would require approximately $84 million per year.

Equipment Funds Allocation Method

The IHS Equipment funds are allocated in three categories: Tribally-constructed health care facilities, TRANSAM and ambulance programs, and new and replacement equipment:

- Tribally-Constructed Health Care Facilities – The IHS provides medical equipment funds to support the initial purchase of equipment for tribally-constructed health care facilities. $5 million is set aside annually for competitive awards to Tribes and Tribal organizations that construct new or expand health care facilities space using non-IHS funding sources. As a result, approximately 500,000 patients will be treated with newly purchased medical equipment.

- TRANSAM and Ambulance Programs – Equipment funds are also used to acquire new and like-new excess medical equipment from the Department of Defense (DoD) or other sources through the TRANSAM (i.e., Transfer of DoD Excess Medical and Other Supplies to Native Americans) Program and to procure ambulances for IHS and Tribal emergency medical services programs. Currently, IHS budgets $500,000 for Ambulances and $500,000 for the TRANSAM Program from the Equipment budget.[1] Under the TRANSAM Program, excess equipment and supplies, at an annual estimated value of $5 million, are acquired for distribution to federal and Tribal sites.

- New and Replacement Equipment – The balance of the equipment funds, approximately $17.7 million, are allocated to IHS and Tribal health care facilities to maintain existing and purchase new medical equipment, including the replacement of existing equipment used in diagnosing and treatment of illnesses. The funding allocation is formula based.

FUNDING HISTORY

Fiscal Year	Amount
2012 Enacted	$22,582,000
2013 Enacted	$21,404,000
2014 Final	$22,537,000
2015 Final	$22,537,000
2016 Enacted	$22,537,000

BUDGET REQUEST

The FY 2017 budget request for the Equipment program of $23,654,000 is $1,117,000 above the FY 2016 Enacted Level.

FY 2017 Funding Increases to Base Funding of $1,117,000 would provide funding for:

- Inflation +$858,000 – to cover inflationary costs of equipment.

- Population Growth +$259,000 – to fund the additional services need arising from the growing AI/AN population. The growth rate is projected to be 1.8 percent in FY 2017 based on State births and deaths data.

The FY 2017 President's Budget of $23,654,000 provides funding in the following allocation categories:

- Approximately $17.7 million for new and routine replacement medical equipment to over 1,500 federally and tribally-operated healthcare facilities;
- $5 million for new medical equipment in tribally-constructed health care facilities;
- $500,000 for the TRANSAM program; and
- $500,000 for the ambulance program.

These funds will be used for maintenance, upgrades, replacement, and the purchase of new medical equipment systems at Indian Health Service (IHS) and Tribal healthcare facilities and to replenish the pool that replaces old equipment with upgraded technologies. The additional

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

$1,117,000 will be used to offset a portion of the increased program need resulting from expanded program space and inflationary increases.

OUTPUTS / OUTCOMES - This program measures outcomes through its inventory of medical equipment.

GRANT AWARDS – This program has no grant awards.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Facilities: 75-0391-0-1-551
PERSONNEL QUARTERS / QUARTERS RETURN FUNDS

(Dollars in Thousands)

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$8,000	$8,500	$8,500	$0
FTE**	29	29	29	0

Quarters funds are not BA but are rents collected for quarters which are returned to the service unit for maintenance and operation costs. They fall under the Program Level Authority.
** FTE numbers reflect 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; Public Law 98-473, Sec. 320, as amended

FY 2017 Authorization.....Permanent

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

When available housing is limited in the area of Indian Health Service (IHS) health care facilities, staff quarters are provided to assist with recruitment and retention of health care providers. The operation, maintenance, and improvement costs of the staff quarters are funded with Quarters Return (QR) funds, i.e., the rent collected from tenants residing in the quarters. The use of the funds includes maintenance personnel services, security guard services, repairs to housing units and associated grounds, purchase of materials, supplies, and household appliances/equipment (e.g., stoves, water heaters, furnaces, etc.). In certain situations, Maintenance and Improvement Program funds may be used, in conjunction with QR funds, to ensure adequate quarters' maintenance. For example, this may be necessary in locations with few quarters where QR funds are insuffient to pay for all required maintenance costs.

FUNDING HISTORY

Fiscal Year	Amount
2012 Enacted	$7,500,000
2013 Enacted	$8,000,000
2014 Final	$8,000,000
2015 Final	$8,000,000
2016 Enacted	$8,500,000

BUDGET REQUEST

The FY 2017 Quarters budget for rent collections of $8,500,000 is the same as the FY 2016 Enacted level for anticipated rental collections. Rental rates are established in accordance with OMB Circular A-45 and adjusted annually based on the national Consumer Price Index.

FY 2017 Quarters Budget for Anticipated Rent Collections of $8,500,000 provides funding for the following:

The operation, management, and general maintenance of quarters, including maintenance personnel services, repairs to housing units and associated grounds, purchase of materials, supplies, and household appliances/equipment (e.g., stoves, water heaters, furnaces, etc.).

OUTPUTS / OUTCOMES - This program measures outcomes through the inventory of staff quarters.

GRANT AWARDS – This program has no grant awards.

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

SPECIAL DIABETES PROGRAM FOR INDIANS

(Dollars in Thousands)

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$150,000	$150,000	$150,000	0
FTE*	0	0	0	0

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

Authorizing Legislation ..... 111 Stat. 574, 1997 Balanced Budget Act (P.L. 105-33), Consolidated Appropriation Act 2001 and amendment to Section 330C (c)(2)(c) Public Health Service Act through Senate Bill 2499 (passed the Senate 12/18/07) to extend funding through FY 2009, the Medicare Improvements for Patients and Providers Act of 2008 (P.L. 110-275) Title III Special Diabetes Program for Indians (SDPI) to extend funding through FY 2011, the H.R. 4994 Medicare and Medicaid Extenders Act of 2010 to extend SDPI funding through FY 2013,the American Taxpayer Relief Act of 2012 (P.L. 112-240) to extend funding through FY 2014, the Protecting Access to Medicare Act of 2014 (PL 113-93; H.R. 4302) to extend funding through FY 2015. H.R. 2 – The Medicare Access and CHIP Reauthorization Act of 2015 authorized SDPI for FY 2016 and FY 2017. The program authorization is set to expire after FY 2017.

FY 2017 Authorization..... Expires FY 2017

Allocation Method ..... Grants and Contracts

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The Special Diabetes Program for Indians (SDPI) grant program provides funding for diabetes treatment and prevention to approximately 301 Indian Health Service (IHS), Tribal and Urban (I/T/U) Indian health grant programs. Funds for SDPI were first authorized in FY 1998; as such, FY 2016 is the 19th year of the SDPI. SDPI operates with a budget of $150 million per year that is currently authorized through FY 2017. The IHS Office of Clinical and Preventive Services (OCPS) Division of Diabetes Treatment and Prevention (DDTP) provides leadership, programmatic, administrative, and technical oversight to the SDPI grant program.

The mission of the DDTP is to develop, document, and sustain public health efforts to prevent and control diabetes in American Indians and Alaska Natives (AI/ANs) by promoting collaborative strategies through its extensive diabetes network. The diabetes network consists of a national program office, Area Diabetes Consultants in each of the 12 IHS Areas, and approximately 301 SDPI grants and sub-grants at I/T/U sites across the country.

Target Population: American Indians and Alaska Natives

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

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

Allocation Method

In the Balanced Budget Act of 1997, Congress instructed the IHS to use SDPI funds to "establish grants for the prevention and treatment of diabetes" to address the growing problem of diabetes in AI/ANs. The entities eligible to receive these grants were I/T/Us. In accordance with legislative intent, the IHS distributes this funding to approximately 301 I/T/U sites annually through a process that includes Tribal consultation, development of a formula for distribution of funds, and a formal grant application and administrative process.

Strategy

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

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

SDPI: Two Major Components

As directed by Congress and Tribal consultation, the SDPI consists of two major components: (1) SDPI Grant Program; and (2) Diabetes data and program delivery infrastructure.

1. SDPI Grant Program

[1] Centers for Disease Control and Prevention (CDC). *National Diabetes Statistics Report: Estimates of Diabetes and Its Burden in the United States, 2014.* Atlanta, GA: U.S. Department of Health and Human Services; 2014. *Available at*:http://www.cdc.gov/diabetes/data/statistics/2014statisticsreport.html

[2] Lee ET, Howard BV, Savage PJ, et al. Diabetes and impaired glucose tolerance in three American Indian populations aged 45-74 years: the Strong Heart Study. *Diabetes Care*. 1995;18:599-610.

The SDPI grant program (formerly called the SDPI Community-Directed grant program) will provide $138.7 million per year in grants and technical assistance for local diabetes treatment and prevention services at I/T/U health programs in 35 states. Each of the communities served by the SDPI grant program is unique in that its diabetes treatment and prevention needs and priorities are defined locally. Based on these local needs and priorities the SDPI grant programs implement proven interventions to address the diabetes epidemic.

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 SDPI grant application process used throughout AI/AN communities. Grant programs are required to document the use of one Diabetes Best Practice,[3] corresponding evaluation measures, and progress in achieving program objectives in order to enhance accountability. Grantees receive training on how to collect, evaluate, and improve their data collection and use it to improve their outcome results.

Impact of the SDPI Grant Programs

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

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

Clinical Diabetes Outcomes During SDPI

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

- *Improving Blood Sugar Control*
  Blood sugar control among AI/ANs with diabetes served by the IHS has improved over time. The average blood sugar level (as measured by the A1C test) decreased from 9.0 percent in 1996 to 8.1 percent in 2015, nearing the A1C goal for most patients of less than 8 percent.
- *Improving Blood Lipid Levels*
  Average LDL cholesterol (i.e., "bad" cholesterol) declined from 118 mg/dL in 1998 to 93.6 mg/dL in 2015, surpassing the goal of less than 100 mg/dL.

2. Diabetes Data and Program Delivery Infrastructure

The IHS has used funding from the SDPI to strengthen the diabetes data infrastructure of the Indian health system by improving diabetes surveillance and evaluation capabilities. SDPI

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

supports the development and implementation of the IHS Electronic Health Record, and the IHS Diabetes Management System in all 12 IHS Areas.

Facilities associated with SDPI programs participate in the annual IHS Diabetes Care and Outcomes Audit. The Diabetes Audit is the cornerstone of the IHS DDTP diabetes care surveillance system, tracking annual performance on diabetes care and health outcome measures. Data collection for the Diabetes Audit follows a standardized protocol to ensure statistical integrity and comparability of measures over time. The 2015 Diabetes Audit included a review of 116,743 patient charts at 333 I/T/U health facilities. The Diabetes Audit enables IHS and the SDPI programs to monitor and evaluate yearly performance at the local, regional, and national levels. DDTP provides diabetes training through multiple online and webinar formats. DDTP receives evaluations on all trainings provided to guide improvements for future sessions.

Key Performance/Accomplishments

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

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

Reporting

In addition to internal monitoring of the SDPI Grant Program, the DDTP has completed four SDPI Reports to Congress to document the progress made since 1998. The SDPI Reports to Congress are as follows:

- January 2000 Interim Report to Congress on SDPI;
- December 2004 Interim Report to Congress on SDPI;
- 2007 SDPI Report to Congress: On the Path To A Healthier Future;
- 2011 SDPI Report to Congress: Making Progress Toward A Healthier Future; and
- A new SDPI Report to Congress is under HHS review with an anticipated release during FY 2016.

BUDGET REQUEST

The U.S. Senate passed a two-year renewal of the SDPI. The renewal was contained in the larger bill called: "H.R. 2 – The Medicare Access and CHIP Reauthorization Act of 2015." This followed action by the U.S. House of Representatives on March 26, 2015, which also passed the legislation. The President signed the legislation into law on April 16, 2015. The program will now expire on September 30, 2017. The FY 2017 budget request for the SDPI is $150,000,000 annually. The distribution of funding for FY 2016 has been changed by the IHS Principal Deputy Director following Tribal consultation and is illustrated below:

Special Diabetes Program for Indians – Total Yearly Costs

CATEGORY	Percentage of the total	(Dollars in Millions)
Original Community-Directed Grants – now called SDPI Grant Programs (272 Tribal and IHS grants, sub-grants, and technical assistance in FY 2017)	**86.8%**	**$130.2**
Administration of SDPI grants (includes program support funds to IHS Areas, Tribal Leaders Diabetes Committee, DDTP, Grants Management, evaluation support contracts, etc.)	**4%**	**6.1**
Urban Indian Health Program SDPI Grant Programs ($8.5M allocated to 29 grants and technical assistance in FY 2017)	**5.7%**	**8.5**
Funds to strengthen the Data Infrastructure of IHS	**3.5%**	**5.2**
TOTAL:	**100%**	**$150.0**

The final agency decision on the distribution of FY 2017 SDPI funding was based on consultation with Tribes and conferring with Urban Indian Organizations. SDPI activities are being modified accordingly.

Performance Discussion

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

SDPI has contributed substantially to improved clinical outcomes over the duration of the grant program. SDPI provides funds for diabetes clinical care programs across the country, each of which must select an evidenced-based Best Practice[4] on which to focus during the grant year. SDPI also provides funds at the national and Area levels to support and improve provision of care. This support includes clinical training, clinical tools, and performance data feedback to sites via the Diabetes Audit.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/-FY 2016 Target
2 American Indian and Alaska Native patients with diagnosed diabetes achieve Good Glycemic Control	FY 2015: 47.4 % Target: 47.7 % (Target Not Met)	49.5 %	48.4 %	-1.1 %

[4] SDPI Best Practices: Aspirin or Other Antiplatelet Therapy in Cardiovascular Disease, Blood Pressure Control, Chronic Kidney Disease Screening and Monitoring, Dental Exam, Depression Screening, Diabetes-related Education, Eye Exam-Retinopathy Screening, Foot Exam, Glycemic Control, Immunizations: Hepatitis B, Immunizations: Influenza, Immunizations: Pneumococcal, Immunizations: Tetanus/Diphtheria, Lipid Management in Cardiovascular Disease, Nutrition Education, Physical Activity Education, Tobacco Use Screening, and Tuberculosis Screening.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/-FY 2016 Target
(A1c Less than 8.0%). (Outcome)				
2 Tribally Operated Health Programs (Outcome)	FY 2015: 50.3 % Target: 50.3 % (Target Met)	52.5 %	51.4 %	-1.1 %
3 Diabetes: Blood Pressure Control: Proportion of patients with diagnosed diabetes that have achieved blood pressure control (<140/90). (Outcome)	FY 2015: 62.5 % Target: 63.8 % (Target Not Met)	65 %	63.8 %	-1.2 %
3 Tribally Operated Health Programs (Outcome)	FY 2015: 61.2 % Target: 62.7 % (Target Not Met)	64.3 %	62.5 %	-1.8 %
4 Diabetes: Dyslipidemia Assessment: Proportion of patients with diagnosed diabetes assessed for dyslipidemia (LDL cholesterol). (Outcome)	FY 2015: 73.3 % Target: 71.8 % (Target Exceeded)	Retire after 2015	Retire after 2015	Maintain
4 Tribally Operated Health Programs (Outcome)	FY 2015: 72.1 % Target: 70.9 % (Target Exceeded)	Retire after 2015	Retire after 2015	Maintain
50 DM Statin Therapy (Intermediate Outcome)	FY 2016: Result Expected Sep 30, 2016 Target: Set Baseline (Pending)	Baseline	TBD	N/A
50 TOHP DM Statin Therapy (Intermediate Outcome)	FY 2016: Result Expected Sep 30, 2016 Target: Set Baseline (Pending)	Baseline	TBD	N/A

GRANTS AWARDS

The SDPI provides grants for diabetes treatment and prevention services to IHS, Tribal and Urban Indian health programs in 35 states. The SDPI grant programs provide local diabetes treatment and prevention services based on community needs.

Size of Awards

CFDA No. 92.237 / SDPI Community-Directed Grant Programs			
(whole dollars)	FY 2015 Final	FY 2016 Enacted*	FY 2017 President's Budget*
Number of Awards	365 (includes sub-grants)	301 (includes sub-grants)	301 (includes sub-grants)
Average Award	$304,229	$492,927	$492,927
Range of Awards	$12,549 - $6,483,988	$19,394 - $7,155,511	$19,394 - $7,155,511
Total Awards	$111,347,776	$136,047,763	$136,047,736

*Number and amounts of grants awarded in FY 2016 and FY 2017 are different than FY 2015 due to the FY 2016 competitive application process.

FY 2016 Mandatory State/Formula Grants

CFDA No. 92.237 / Special Diabetes Program for Indians Grant Programs
by State and FY 2016 Annual Financial Assistance Awards

State	State Name	FY 98 – FY 15 Total # Grant Programs	FY 16 Total # Grant Programs	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget*	Difference # +/- FY 2016 – FY 2015	Difference $ +/- FY 2016 – FY 2015
AK	Alaska	25	19	$8,927,252	$10,191,326	$10,191,326	-6	+$1,264,074
AL	Alabama	1	1	207,422	276,249	276,249	0	+68,827
AZ	Arizona	33	27	26,284,093	28,338,793	28,338,793	-6	+2,054,700
CA	California	42	39	8,714,164	9,740,219	9,740,219	-3	+1,026,055
CO	Colorado	3	3	728,212	903,625	903,625	0	+175,413
CT	Connecticut	2	2	195,466	232,550	232,550	0	+37,084
FL	Florida	2	2	526,853	479,662	479,662	0	-47,191
IA	Iowa	1	1	254,197	304,592	304,592	0	+50,395
ID	Idaho	4	4	760,150	935,841	935,841	0	+175,691
IL	Illinois	1	1	226,282	281,832	281,832	0	+55,550
KS	Kansas	6	5	366,961	937,919	937,919	-1	+570,958
LA	Louisiana	4	4	307,833	367,019	367,019	0	+59,186
MA	Massachusetts	2	2	67,506	168,477	168,477	0	+100,971
ME	Maine	5	5	460,160	543,068	543,068	0	+82,908
MI	Michigan	13	12	2,128,707	2,363,824	2,363,824	-1	+235,117
MN	Minnesota	13	8	3,287,642	3,274,552	3,274,552	-5	-13,090
MS	Mississippi	1	1	1,029,119	1,227,316	1,227,316	0	+198,197
MT	Montana	17	10	5,512,348	5,564,865	5,564,865	-7	+52,517
NE	Nebraska	5	5	1,590,573	1,931,172	1,931,172	0	+340,599
NV	Nevada	14	14	2,941,217	5,203,730	5,203,730	0	+2,262,513
NM	New Mexico	31	29	6,938,491	13,163,620	13,163,620	-2	+6,225,129
NY	New York	4	3	1,176,338	1,310,560	1,310,560	-1	+134,222
NC	North Carolina	1	1	1,184,081	1,340,392	1,340,392	0	+156,311
ND	North Dakota	8	5	2,643,997	3,168,173	3,168,173	-3	+524,176
OK	Oklahoma	34	27	17,649,873	23,460,585	23,460,585	-7	+5,810,712

CFDA No. 92.237 / Special Diabetes Program for Indians Grant Programs by State and FY 2016 Annual Financial Assistance Awards								
State	State Name	FY 98 – FY 15 Total # Grant Programs	FY 16 Total # Grant Programs	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget*	Difference # +/- FY 2016 – FY 2015	Difference $ +/- FY 2016 – FY 2015
OR	Oregon	14	9	1,799,861	1,832,727	1,832,727	-5	+32,866
RI	Rhode Island	1	1	94,684	112,563	112,563	0	+17,879
SC	South Carolina	1	1	136,424	161,201	161,201	0	+24,777
SD	South Dakota	14	9	5,399,117	6,014,473	6,014,473	-5	+615,626
TN	Tennessee	2	1	79,915	130,002	130,002	-1	+50,087
TX	Texas	4	4	575,946	789,528	789,528	0	+213,582
UT	Utah	7	5	1,449,293	2,051,292	2,051,292	-2	+601,999
WA	Washington	34	27	3,892,836	4,792,337	4,792,337	-7	+899,501
WI	Wisconsin	13	12	3,062,885	3,421,213	3,421,213	-1	+358,328
WY	Wyoming	3	2	747,878	1,032,196	1,032,196	-1	+284,318
	Total States	**365**	**301**	**$111,347,776**	**$136,047,763**	**$136,047,736**	**-64**	**+$24,699,987**
	Indian Tribes**	**286**	**252**	**$92,603,859**	**$111,084,398**	**$111,084,398**	**-**	**-**

* Number and amounts of grants awarded in FY 2016 and FY 2017 will be different from FY 2015 due to the FY 2016 competitive application process.

**This is the number tribes that are primary grantees or sub-grantees.

Mental Health Initiative Investment - Mandatory Proposals

Mandatory Proposals:

1. Tribal Crisis Response Fund

(Total funding $30 million, $15 million per year). The Indian Health Service (IHS) Tribal Behavioral Health Crisis Response Fund provides emergency funding opportunities, outside of grant funding, during behavioral health crises in American Indian and Alaska Native (AI/AN) communities. Tribes have experienced a mass shooting, school violence, and suicide clusters across the country. During these events, limited funding is available to address the mental health needs of AI/AN individuals. Tribes must rely heavily on emergency grant funding from other federal agencies which can be scarcely available. Tribes may also request emergency funds from IHS; however, IHS has limited resources to cover Tribal requests during emergent situations. Despite the limited funding available to Tribes, countless resources are required for a rapid response to mental health crises in AI/AN communities. As part of the President's new $500 million investment in mental health, IHS is seeking an increase to its Mental Health budget to strengthen the service capacity of tribal communities to more effectively respond to mental health crises.

The FY 2017 request includes a proposal for $15 million per year for two years to address AI/AN behavioral health crisis situations. Funds will be used to cover emergency funds requests from Tribes during mental health crises. Tribes would be able to request funds for one or more of the following categories:

- Technical assistance;
- Specialized behavioral health crisis-response staffing;
- Assistance to prevent reoccurrences; and
- Community engagement to connect critical community-based organizations to increase the service capacity of AI/AN communities to develop a sustained response.

One-year budget impact: $15 million
Two-year budget impact: $30 million

2. Behavioral Health Professions Expansion Fund

(Total funding $20 million, $10 million per year). The Indian Health Professions (IHP) program works to increase the number of health professionals providing health care services to AI/AN communities. Within the IHP, the IHS Loan Repayment and Scholarship programs are essential to recruiting and retaining behavioral health providers, among others. These new funds will specifically help expand the number of behavioral health professionals providing high quality health services to AI/AN communities. This investment complements the additional funding proposed for the National Health Service Corps, both of which will significantly add to the behavioral health workforce.

The FY 2017 request incudes a proposal for $10 million per year for two years to increase the number of behavioral health providers. The funds will be used to provide 202 additional loan repayment awards per year to psychiatrists, clinical psychologists, counseling psychologists, chemical dependency/addiction counselors, family and marriage therapy counselors, licensed professional counselors and social workers working in Indian health facilities. Additionally, the funding will support 67 health professions scholars training to be chemical dependency counselors, clinical psychologists, counseling psychologists, psychiatric nurses, and social workers.

One-year budget impact: $10 million
Two-year budget impact: $20 million

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Drug Control Budget
FY 2017

	Budget Authority (in Millions)		
	FY 2015 Final	**FY 2016 Enacted**	**FY 2017 President's Budget**
Drug Resources by Function			
Prevention	18.178	30.044	42.721
Treatment	93.167	84.626	98.209
Total Drug Resources by Function	**$111.345**	**$114.670**	**$140.930**
Drug Resources by Decision Unit			
Alcohol and Substance Abuse	106.853	110.178	136.438
Urban Indian Health Program	4.492	4.492	4.492
Total Drug Resources by Decision Unit	**$111.345**	**$114.670**	**$140.930**
Drug Resources Personnel Summary			
Total FTEs (direct only)	171	171	171
Drug Resources as a Percent of Budget			
Agency Budget	$ 5,913.795	$ 6,111.671	$6,489.097
Drug Resources Percentage	1.88%	1.88%	2.17%

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 2015 and FY 2016, the total drug resources include funds for staffing and operating both the Southern and Northern California Youth Regional Treatment Centers, respectively.

BUDGET SUMMARY

In FY 2017, IHS requests $136.438 million for its drug control activities, that is an increase of $26.26 million over the FY 2016 Enacted level.

Alcohol and Substance Abuse
FY 2017 Request: $233.286 million

The FY 2017 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
FY 2017 Request: $4.5 million
(Flat with FY 2016)

The FY 2017 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 2017, the IHS budget request for its drug control activities supports the Office of National Drug Control Policy's (ONDCP) funding priorities as well as the 2014 National Drug Control Strategy (the *Strategy*). 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 *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 2017, 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 Substance Abuse and Suicide Prevention (SASP) program (formerly known as the Methamphetamine and Suicide Prevention Initiative) is a nationally-coordinated grant program, focusing on providing targeted methamphetamine and suicide prevention and intervention resources to communities in AI/AN communities with the greatest need for these programs. There is mutual development and implementation of the SASP project with Tribes, Tribal programs, and other Federal agencies which now provides support to 118 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 developed by the communities themselves, with a national support network for ongoing program development and evaluation.

Tribal YRTC Pilot Project +$1,800,000 - to fund the Youth Regional Treatment Centers (YRTCs) pilot project. IHS currently funds eleven YRTCs to provide a range of clinical services rooted in a culturally relevant, holistic model of care. These services include clinical evaluation, substance abuse education, group, individual and family psychotherapy, art therapy, adventure-based counseling, life skills, medication management or monitoring, evidence-based/practice-based treatment, aftercare relapse prevention, and limited post-treatment follow-up services. Once American Indian and Alaska Native (AI/AN) youth are discharged home, they are faced with leaving a structured treatment environment to return home where little work has occurred with their families and often times, aftercare services are limited.

The IHS is seeking additional funding to establish a pilot project to fill this gap in services and provide a continuum of care for AI/AN youth after they are discharged home from YRTCs. The goal of the pilot project will be to promote integration of cultural practices with evidence based treatment in aftercare services for AI/AN youth. Funded projects will hire and train clinical staff in evidence-based treatment approaches, such as dialectical behavior therapy, with the incorporation of new staff to provide culturally appropriate interventions and activities. YRTCs will be able to hire staff, such as a cultural teacher or cultural knowledge keeper, tribal elder, and/or peer specialist. Pilot projects will incorporate cultural approaches that are appropriate for their regional or local service area, such as dancing, ceremonial practices, canoe journeys, and traditional teachings.

SASP Expansion – Generation Indigenous (Gen I) +$15,000,000 - to expand SASP under Purpose Area #4 – "Generation Indigenous Initiative Support" to focus on hiring additional staff to improve behavioral health services and prevention programming for AI/AN youth. Strategies to address mental health, alcohol, substance use, and suicide require comprehensive clinical approaches, collaborations, and partnerships with consumers and their families to reduce morbidity and early mortality. The SASP Expansion will support Gen I by removing barriers to behavioral health treatment and provide prevention programming to ensure that comprehensive, culturally appropriate approaches exist for Native children and youth to reach their full potential. The SASP Expansion – Gen I supports the HHS Arc of delivery system reform and finds better ways to deliver care for AI/AN youth.

The IHS is seeking $15,000,000 above the FY 2016 Enacted budget for the Alcohol and Substance Abuse budget to:

- Provide funds to currently funded SASP projects under Purpose Area #4 to hire behavioral health professionals, peer specialists, and other professionals to provide services for AI/AN children, youth, and their families.
- Increase the number of additional Tribes, Tribal organizations, and Urban Indian organizations to participate in SASP Purpose Area #4.

Substance use disorders 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 early intervention with adolescents and youth adults and preventing further progression by recognizing and responding to the sequel of the abuse. IHS promotes expanded health care services, such as mental and behavioral health treatment and prevention, by providing training on substance use disorders to IHS, Tribal, and Urban Indian health programs at annual conferences, meetings, and

webinars. Continuing Medical Education (CMEs) and Continuing Education Units (CEUs) are offered in these training opportunities provided to primary care providers.

IHS continues to support the integration of substance abuse treatment into primary care and emergency services through its activities to implement ONDCP's National Drug Control Strategy. Integrating treatment into healthcare offers opportunities for healthcare providers to identify patients with substance use disorders, provide them with medical advice, help them understand the health risks and consequences, and refer patients with more severe substance use-related problems to treatment.[1] One integration activity is Screening, Brief Intervention, and Referral to Treatment (SBIRT) which is an early intervention and treatment service for people with substance use disorders and those at risk of developing these disorders. IHS is broadly promoting SBIRT as an integral part of a sustainable primary care-based behavioral health program through reimbursement from the Centers for Medicare and Medicaid Services. IHS will be providing training on SBIRT in FY 2016 and has developed guidelines for documentation in the electronic health record.

Another activity is Medication Assisted Treatment (MAT) for opioid addiction which is an approach that uses Food and Drug Administration approved pharmacological treatments, in combination with psychosocial treatments, for patients with opioid use disorders.[2] In FY 2016, IHS will provide the necessary waiver training for physicians to precsribeMAT through its Tele-Behavioral Health Center of Excellence (TBHCE). IHS also works to provide training on proper opioid prescribing through the TBHCE. As of November 2015, more than 1800 IHS, Tribal, and Urban Indian health care providers have received the training. IHS will continue to offer the training on a regular basis in FY 2016 with refresher courses offered every three years.

As competencies and skills increase among IHS, Tribal, and Urban Indian health programs, IHS is considering the most appropriate metric and data sources to assess the impact of training on prescription drug abuse. In FY 2017, IHS will continue education on SBIRT, promote the use of MAT, train providers on proper opioid prescriving, and develop a national prescription drug abuse measure to better assess the impact of prescription drug abuse. The national prescription drug abuse measure was initially planned for rollout in FY 2017 and will now be released in FY 2018. To provide clinical support for providers, the TBHCE recently launched weekly Pain and Addiction consultations. Healthcare providers may receive a no-cost consultation from an expert panel on the most challenging pain and addiction cases.

The IHS provides several training opportunities annually on alcohol and substance abuse issues for its providers. In FY 2015, the TBHCE, in partnership with the University of New Mexico, provided webinar training for 10,551 participants on current and pressing behavioral health issues through a series of webinars, including a concentrated focus on substance use disorders through a weekly Pain and Addiction Series and Addiction Mini-Series. Topics included: Introduction to Addiction; Opioid Dependence; Chronic Pain and Depression; Anxiety and Chronic Pain; Fibromyalgia; Chronic Pain and Neurology; Epidemiology of Chronic Pain; Non-Opioid Pain Medication; Screening for Misuse, Diversion, and Addiction; Buprenorphine; Medication Management; Screening for Opiate Addictions; Methadone - An Introduction; Substance Abuse I & II; Naloxone and MAT for Opioid Dependence.

[1] U.S. Office of National Drug Control Policy. Integrating Treatment into Healthcare. *Available at* http://www.whitehouse.gov/ondcp/integrating-treatment-and-healthcare.
[2] U.S. Office of National Drug Control Policy. Medication Assisted Treatment for Opioid Addiction. Available at http://www.whitehouse.gov/sites/default/files/ondcp/recovery/medication_assisted_treatment_9-21-20121.pdf

The TBHCE evaluates models of care delivery, access to care, and sustainability. A toolkit is available for sites to prepare the infrastructure for tele-behavioral health services. Intra-Agency agreements continue between the TBHCE and IHS Billings, Great Plains, Nashville, Navajo, Phoenix, and Tucson Areas. In FY 2015, over 9,773 patient encounters were provided nationally via tele-behavioral health. As IHS promotes the use of MAT programming, future development work includes options to expand tele-health for MAT maintenance.

IHS established a multi-disciplinary workgroup to focus on Prescription Drug Abuse in Indian Country in 2012. The workgroup utilized the published ONDCP epidemic framework to address four main focus areas, including participation with existing state prescription drug monitoring programs (PDMP). IHS has worked with ONDCP, the Bureau of Justice Assistance, and numerous state PDMPs to participate in development of best practice recommendations and begin to report controlled substance dispensing data to state PDMPs. To date, IHS has developed software compatible with five American Society for Automation in Pharmacy formats; deployed reporting capacity in 21 IHS states; and assisted tribal programs with PDMP program deployment. Future development work includes enhanced prescriber utilization of PDMP data through integration with existing interconnects.

In FY 2016, the IHS and Bureau of Indian Affairs (BIA) entered into a formal partnership to reduce deaths from prescription drug and heroin overdoses. . As a result of this partnership, IHS will provide medication and training to law enforcement officers on the proper administration of naloxone. IHS plans to provide training and medication to more than 500 BIA law enforcement officers across the country beginning in FY 2016.

FY 2017 Changes (no change): IHS will continue to serve AI/ANs impacted by substance abuse and dependence through its YRTCs and other IHS, Tribal, and Urban Indian operated substance abuse treatment and prevention programs.

Indian Health Service		
Selected Measures of Performance	**FY 2015 Target**	**FY 2015 Achieved**
» Alcohol-use screening among appropriate female patients	66.7%	66.6%
» Accreditation rate for Youth Regional Treatment Centers in operation 18 months or more	100%	90%
» Report on number of emergency department patients who receive SUD intervention*	44,112	41,749
Report on number of SUD services in primary care clinics*	114,674	114,570

*Results are preliminary for FY 2015. Final results will be available February 2016.

Information regarding the performance of the drug control efforts of IHS is based on agency GPRA/GPRAMA documents and other information that measures the agency's contribution to the *Strategy*. The table above and accompanying text below represent highlights of IHS's achievements during FY 2014, the latest year for which data are available. The selected performance measures reported in the table provide targets and results from both Tribally-Operated Health Programs and Federally-Administered Health Programs.

As a routine part of women's health, IHS providers screen for alcohol use among women of child-bearing age. In FY 2015, the Alcohol Screening measure was missed by 0.1 percent. However, the overall percentage of female patients screened for alcohol use improved and has consistently improved since 2004. To provide more comprehensive routine screening, IHS will

expand its Alcohol Screening measure to include all patients 12 through 75 years of age in FY 2017 and retire the Alcohol Screening measure for female patients. Additoinally, IHS is planning to report a new SBIRT measure with baseline results in 2017.

The accreditation measure for YRTCs reflects an evaluation of the quality of care associated with accreditation status by either the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities (CARF), state certification, or regional Tribal health authority certification. For youth with substance use disorders, the YRTCs provide invaluable treatment services. The accreditation measure for YRTCs reflects an evaluation of the quality of care by either the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities (CARF), or State licensure. The 100 percent accreditation performance measure was not met in FY 2015 as a result of the accreditation for one federally-operated YRTC. However, an appeal was submitted and subsequent accreditation for the YRTC was issued in FY 2016.

The IHS monitors two program measures on the number of substance use disorder (SUD) encounters provided in emergency departments and primary care clinics. The final results for FY 2015 emergency department and primary care clinics will be available in February 2016. In FY 2017, IHS will include overall SUD encounters provided in all clinical settings across the health system to aid in promoting integrated SUD services. Tracking overall clinical SUD encounters will allow IHS to report on the effectiveness of IHS programs that focus on drug abuse. In FY 2015, the preliminary result for SUD encounters across all IHS clinics was 603,469 encounters. The SUD encounters for primary care clinics and emergency departments will not be discontinued in FY 2017 as previously planned. IHS will report on all three program measures in FY 2017.

Office of Urban Indian Health Programs

Urban Indian Organizations (UIO) are resources to both tribal and urban communities. UIO that offer inpatient and outpatient substance abuse treatment have become reliable referral sites for tribes. In FY 2017 IHS is proposing $4.5 million for the urban ONDCP budget.

AI/AN people who live in urban centers present a unique morbidity and mortality profile. Urban AI/AN populations suffer disproportionately higher mortality from certain causes in sharp contrast to mainstream society. These unique challenges require a targeted response. Existing UIO see their efforts in health education, health promotion, and disease prevention as essential to impacting the behavioral contributors to poor health[3]:

- Alcohol-induced death rates are 2.8 times greater for urban AI/AN people than urban all races.
- Chronic liver disease death rates are 2.1 times greater for urban AI/AN people than urban all races.
- Tuberculosis death rates are 2 times greater for urban AI/AN people than urban all races.
- Accidents and external causes of death rates are 1.4 times greater for urban AI/AN people than urban all races.

Alcohol and drug-related deaths continue to plague urban AI/AN. Alcohol-induced mortality rates for urban AI/AN are markedly higher than for urban all races. All regions,[4] with the exception of eastern seaboard cities in the Nashville Area, show dramatically higher rates for urban AI/AN than for urban all races who live in the same communities: the Billings Area is 4

[3] Indian Health Service, Office of Urban Indian Health Programs, *Urban Needs Assessment Report – Draft*, 2015.
[4] Ibid.

times greater, the Phoenix Area is 6 times greater, the Tucson Area is 6.7 times greater, and the Aberdeen Area has a 13.4 times greater alcohol-induced rate of mortality[5].

Urban AI/AN populations are more likely to engage in health risk behaviors. Urban AI/AN are more likely to report heavy or binge drinking than all-race populations and urban AI/AN are 1.7 times more likely to smoke cigarettes. Urban AI/AN more often view themselves in poor or only fair health status, with 22.6 percent reporting fair/poor health as compared to 14.7 percent of all races reporting as fair/poor.

UIO emphasis on integrating behavioral health, health education, health promotion and disease prevention into primary care offered within a culturally appropriate framework, leads to positive outcomes for urban AI/AN. Urban AI/AN in need of substance abuse treatment commonly exhibit co-occurring disorders. UIO programs have recognized the need for more mental health and substance abuse counselors to adequately address the needs presented by AI/AN with co-occurring disorders. AI/AN need gender- and age-appropriate substance abuse treatment. Stakeholders reported the need for more age- and gender-appropriate resources for substance abuse treatment. While male AI/AN can encounter wait times for treatment admission up to 6 months, treatment options for youths, women, and women with children can be greater than 6 months. Some of the best AI/AN treatment programs for youth, women, and women with children are administered by UIO. Affecting lifestyle changes among urban AI/AN families requires a culturally sensitive approach. The existing UIO have operated culturally appropriate initiatives to reduce health risk factors. UIO continued efforts to target behavioral or lifestyle changes offer the best hope for impacting the major health challenges of the urban AI/AN population.

Fetal alcohol spectrum disorders (FASD) is used to describe a range of effects that can occur in someone whose mother consumed alcohol during pregnancy. FASD includes disorders such as fetal alcohol syndrome (FAS), alcohol-related neuro developmental disorder (ARND), and alcohol-related birth defects (ARBD). Interventions are needed in urban centers to address prevention efforts for urban AI/AN with a FASD. The IHS Policy on Conferring with Urban Indian Organizations identifies FASD as a provision that requires the IHS to confer with UIO "to develop and implement culturally sensitive assessment and diagnostic tools including dysmorphology clinics and multidisciplinary fetal alcohol spectrum disorders clinics for use in Indian communities and urban centers." Heavy drinking during pregnancy can cause significant birth defects, including FAS. FAS is the leading and most preventable cause of intellectual disability. The rates of FAS are higher among AI/ANs than the general population. Screening with intervention has been shown to be effective in reducing alcohol misuse in pregnancy and to reduce the incidence of FAS.

In FY 2016, the IHS and Bureau of Indian Affairs (BIA) entered into a formal partnership to provide naloxone to law enforcement officers. As a result of the memorandum of agreement, IHS will provide the medication and training to law enforcement officers on the proper administration of naloxone. This effort has been implemented to reduce deaths from prescription drug and heroin overdoses and includes the participation of two Urban Indian Organizations, Oklahoma City Indian Clinic, Oklahoma City, OK; and Indian Health Care Resource Center of Tulsa, Tulsa, OK.

[5] Ibid.

FY 2017 BUDGET SUBMISSION
INDIAN HEALTH SERVICE
OBJECT CLASSIFICATION
(Dollars in Thousands)

Object Class	FY 2015 Final	FY 2016 Enacted	FY 2017 Pres. Budget	FY 17 +/- FY 2016
DIRECT OBLIGATIONS				
Personnel Compensation:				
Full-Time Permanent(11.0)……	433,940	439,700	448,342	8,642
Other than Full-Time Permanent(11.3)……	19,670	20,000	20,463	463
Other Personnel Comp.(11.5)……	58,033	58,801	59,880	1,079
Military Personnel Comp (11.7)……	93,056	94,368	96,259	1,891
Special Personal Services Payments (11.8)……	283	284	286	2
Subtotal, Personnel Compensation..…	604,982	613,153	625,230	12,077
Civilian Personnel Benefits(12.1)……	164,052	166,226	169,456	3,230
Military Personnel Benefits (12.2)	39,917	40,469	41,249	780
Benefits to Former Personnel(13.0)……	12,016	12,066	12,129	63
Subtotal, Pay Costs……	**820,967**	**831,914**	**848,064**	**16,150**
Travel(21.0)……	46,880	46,852	49,063	2,211
Transportation of Things(22.0)……	9,255	9,289	9,750	461
Rental Payments to GSA(23.1)……	15,971	15,896	16,630	734
Rental Payments to Others(23.2)……	16,126	15,951	16,523	572
Communications, Utilities and Miscellaneous Charges(23.3……	10,725	11,156	12,052	896
Printing and Reproduction(24.0)……	198	198	203	5
Other Contractual Services:				
Advisory and Assistance Services(25.1)……	6,926	7,025	7,348	323
Other Services(25.2)……	160,941	182,594	238,065	55,471
Purchases from Govt. Accts.(25.3)……	75,420	75,520	78,927	3,407
Operation and Maintenance of Facilities(25.4)….	8,081	22,330	23,877	1,547
Research and Development Contracts(25.5)…….	7	7	7	0
Medical Care(25.6)……	323,868	324,548	341,751	17,203
Operation and Maintenance of Equipment(25.7)..	14,294	24,508	25,789	1,281
Subsistence and Support of Persons(25.8)……	6,685	6,573	6,764	191
Subtotal, Other Contractual Current.....…	**596,222**	**643,105**	**722,528**	**79,423**
Supplies and Materials(26.0)……	106,879	109,267	116,291	7,024
Equipment (31.0)……	35,882	35,612	36,667	1,055
Land & Structures (32.0)……	68,844	89,104	93,118	4,014
Investments & Loans (33.0)……	0	0	0	0
Grants, Subsidies, & Contributions (41.0)……	2,886,860	2,972,067	3,236,107	264,040
Insurance Claims & Indemnities (42.0)……	27,538	27,145	27,984	839
Interest & Dividends (43.0)……	34	33	35	2
**Subtotal Non-Pay Costs.....…… **	**3,821,414**	**3,975,675**	**4,336,951**	**361,276**
Total, Direct Obligations……	**4,642,381**	**4,807,589**	**5,185,015**	**377,426**

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

Object Class	FY 2015 Final	FY 2016 Enacted	FY 2017 Pres. Budget	Increase or Decrease
Personnel Compensation:				
Full-Time Permanent (11.0)	433,940	439,700	448,342	8,642
Other than Full-Time Permanent (11.3)	19,670	20,000	20,463	463
Other Personnel Comp. (11.5)	58,033	58,801	59,880	1,079
Military Personnel Comp. (11.7)	93,056	94,368	96,259	1,891
Special Personnel Services Payments (11.8)	283	284	286	2
Subtotal, Personnel Compensation	604,982	613,153	625,230	12,077
Civilian Personnel Benefits (12.1)	164,052	166,266	169,456	3,190
Military Personnel Benefits (12.2)	39,917	40,469	41,249	780
Benefits to Former Personnel (13.0)	12,016	12,066	12,129	63
Total, Pay Costs	**820,967**	**831,954**	**848,064**	**16,110**
Travel (21.0)	10,979	10,882	11,255	373
Transportation of Things (22.0)	9,255	9,289	9,750	461
Rental Payments to Others (23.2)	16,126	15,951	16,523	572
Communications, Utilities & Misc. Charges (23.3)	10,725	11,156	12,052	896
Printing and Reproduction (24.0)	198	198	203	5
Other Contractual Services:				
Advisory and Assistance Services (25.1)	6,926	7,025	7,348	323
Other Services (25.2)	160,941	182,594	238,065	55,471
Purchases from Govt. Accts. (25.3)	75,420	75,520	78,927	3,407
Operation and Maintenance of Facilities (25.4)	8,081	22,330	23,877	1,547
Operation and Maintenance of Equipment (25.7)	14,294	24,508	25,789	1,281
Subsistence and Support of Persons (25.8)	6,685	6,573	6,764	191
Subtotal, Other Contractual	272,347	318,550	380,770	62,220
Supplies and Materials (26.0)	106,879	109,267	116,291	7,024
Total, Non-Pay Costs	**426,509**	**475,293**	**546,844**	**71,551**
Total Salaries & Expenses	1,247,476	1,307,247	1,394,908	87,661
Direct FTE	8,859	8,875	8,891	16

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

	FY 2015 Final	FY 2016 PB	FY 2017 CJ
Headquarters			
Sub-Total, Headquarters	415	420	425
Area Offices			
Alaska Area Office	383	383	383
Albuquerque Area Office	1,108	1,107	1,108
Bemidji Area Office	618	617	618
Billings Area Office	984	983	984
California Area Office	90	108	113
Great Plains Area Office	2,140	2,139	2,140
Nashville Area Office	197	196	197
Navajo Area Office	3,976	3,974	3,976
Oklahoma City Area Office	1,622	1,622	1,622
Phoenix Area Office	2,582	2,581	2,582
Portland Area Office	507	507	507
Tucson Area Office	481	481	481
Sub-Total, Area Offices	14,688	14,699	14,710
Trust Funds (Gift)	23	23	23
TOTAL FTES	15,126	15,142	15,158

INDIAN HEALTH SERVICE

DETAIL OF PERMANENT POSITIONS

(Dollars in Thousands)

	FY 2015 Final	FY 2016 Enacted	FY 2017 Pres. Budget
Total - ES's	18	18	18
Total - ES Salaries	$3,139	$3,139	$3,139
GS/GM-15	427	428	428
GS/GM-14	405	406	407
GS/GM-13	424	425	425
GS-12	1,074	1,075	1,077
GS-11	1,268	1,269	1,271
GS-10	610	611	611
GS-9	1,293	1,295	1,297
GS-8	374	374	375
GS-7	1,159	1,160	1,162
GS-6	1,428	1,430	1,432
GS-5	2,104	2,107	2,110
GS-4	1,077	1,078	1,080
GS-3	182	182	182
GS-2	23	23	23
Subtotal	11,847	11,863	11,879
Total - GS Salaries	$636,915	$645,362	$657,730
Director Grade CO-06	433	433	433
Senior Grade CO-05	576	576	576
Full Grade CO-04	608	608	608
Senior Assistant Grade CO-03	332	332	332
Assistant Grade CO-02	33	33	33
Junior Grade CO-01	10	10	10
Subtotal	1,992	1,992	1,992
Total - CO Salaries	$132,973	$134,837	$137,688
Ungraded	1,246	1,246	1,246
Total - Ungraded Salaries	$47,940	$48,576	$49,507
Trust Funds (Gift)	23	23	23
Average ES level	ES-02	ES-02	ES-02
Average ES salary	$174	$174	$174
Average GS grade	5.1	5.1	5.1
Average GS salary	$54	$54	$55

INDIAN HEALTH SERVICE

Programs Proposed for Elimination

The Indian Health Service FY 2017 budget request does not include any programs for proposed elimination.

Physicians' Comparability Allowance (PCA)

Indian Health Service

Table 1

		PY 2015 (Actual)	**CY 2016** (Estimates)	**BY 2017*** (Estimates)
1) Number of Physicians Receiving PCAs		7	7	4
2) Number of Physicians with One-Year PCA Agreements		0	0	0
3) Number of Physicians with Multi-Year PCA Agreements		7	7	4
4) Average Annual PCA Physician Pay (without PCA payment)		$152,096	$152,096	$148,719
5) Average Annual PCA Payment		$26,857	$26,857	$27,500
6) Number of Physicians Receiving PCAs by Category (non-add)	Category I Clinical Position	6	6	4
	Category II Research Position			
	Category III Occupational Health			
	Category IV-A Disability Evaluation			
	Category IV-B Health and Medical Admin.	1	1	0

*FY 2017 data will be approved during the FY 2018 Budget cycle.

7) If applicable, list and explain the necessity of any additional physician categories designated by your agency (for categories other than I through IV-B). Provide the number of PCA agreements per additional category for the PY, CY and BY.

Not applicable.

8) Provide the maximum annual PCA amount paid to each category of physician in your agency and explain the reasoning for these amounts by category.

Maximum annual PCA for Category I (Clinical Position) - $30,000. Factors used were board certification, multi-year agreements, shortage specialty, location (remote), and duties.

Maximum annual PCA for Category IV-B (Health and Medical Administration) - $18,000. Factors used were board certification, multi-year agreement, categorical allowance.

9) Explain the recruitment and retention problem(s) for each category of physician in your agency (this should demonstrate that a current need continues to persist).

(*Please include any staffing data to support your explanation, such as number and duration of unfilled positions and number of accessions and separations per fiscal year.)*

Overall, Physician vacancy rates continue in the 20% range due to a shortage of physicians, particularly in primary care specialties. IHS has moved to using Title 38 Physician and Dentist Pay instead of PCA as the only option to compete successfully with private sector salaries. Many of our previous PCA recipients have been converted to Title 38.

10) Explain the degree to which recruitment and retention problems were alleviated in your agency through the use of PCAs in the prior fiscal year.

(*Please include any staffing data to support your explanation, such as number and duration of unfilled positions and number of accessions and separations per fiscal year.)*

IHS is using Title 38 Physician and Dentist Pay authority more than PCA authority at this point in time. In general, PCA does not provide the pay flexibility needed to recruit and retain Physicians.

11) Provide any additional information that may be useful in planning PCA staffing levels and amounts in your agency.

Over the next few years IHS PCA levels should decrease. This is based on knowledge of the physicians' contract dates and management intent. If the recipients predicted to change to T38 PDP are converted then only 3 doctors will be left receiving PCA.

INDIAN HEALTH SERVICE
Summary of Reimbursements, Assessments, and Purchases
FY 2017 Estimates

CJ FY 2017

		FY 2013 Actual	FY 2014 Actual	FY 2015 Estimate	FY 2016 Estimate	FY 2017 Estimate
Type of Funding	**Reimbursement for Services Purchased within HHS**					
SSF	Service & Supply Fund	24,166,950	23,812,836	23,850,178	24,000,000	24,200,000
SSF	HHS Consolidated Acquisition System (HCAS) Operations and Maintenance	2,711,448	2,711,000	2,710,000	2,711,000	2,711,000
SSF	Unified Financial Management System (UFMS) Operations and Maintenance	6,013,562	5,687,000	5,663,000	5,778,000	7,317,000
SSF	UFMS (Governance)	1,105,000	1,106,000	1,106,000	1,129,000	1,149,000
SSF	UFMS (CFRS, FBIS/OBIEE)		1,733,000	1,732,000	1,769,000	2,016,000
	Subtotal SSF	33,996,960	35,049,836	35,061,178	35,387,000	37,393,000
OS TAP	Audit Resolution	33,543	75,000	82,000	436,000	540,000
OS TAP	Web Communications	2,339,000	2,339,000	2,311,000	3,542,000	3,542,000
OS TAP	DATA ACT	0	0	416,662	416,662	416,662
OS TAP	Strategic Sourcing/Planning System	81,000	69,000	91,000	253,530	261,000
OS TAP	Web Crawler	6,000	6,000	9,000	152,000	152,000
OS TAP	Telecommunications Management/WITS	222,121	155,000	275,000	323,000	323,000
OS TAP	Telecommunications Services	132,231	43,000	91,000	91,000	91,000
OS TAP	Small Business Consolidation	179,000	179,000	22,000	194,000	196,000
OS TAP	Tracking Accountability Government Grants System (TAGGS)	256,000	251,000	261,000	307,000	307,000
OS TAP	Departmental Contract Information System (DCIS)	458,000	458,000	507,000	482,000	482,000
OS TAP	Acquisition Integration Modernization (AIM)	227,000	278,000	227,000	239,000	239,000
OS TAP	Commissioned Corps Force Management (CCFM)	7,499,965	7,849,000	7,538,000	8,670,000	8,446,000
OS TAP	Human Resource Centers	1,816,143	2,662,000	2,584,000	3,229,000	3,229,000
OS TAP	OGC Claims	350,000	315,000	322,000	182,000	183,000
OS TAP	(OIS) CSIRC			2,279,000	2,281,000	2,281,000
OS TAP	(OIS) OS IT Security Operations			573,000	572,000	572,000
OS TAP	(OIS) TIC			1,040,000	858,000	834,000
OS TAP	Credit Monitoring (OPM)			263,506	263,506	263,506
OS TAP	Security Clearances (OPM)			144,489	144,489	144,489
	Subtotal Non-PSC	13,600,002	14,679,000	19,036,657	22,636,187	22,502,657
JFA	Office of General Counsel	1,338,648	1,236,668	1,458,332	1,500,000	1,500,000
JFA	OGC Departmental Ethics Program	320,000	320,000	340,000	360,000	360,000
JFA	OGC Ethics Program (IAA)	201,560	207,624	201,560	203,560	203,560
JFA	Legislatively Mandated Initiatives and Emerging Technologies (formerly part of HHS Enterprise) (LMIE)	624,164	535,136	562,866	600,000	600,000
JFA	Regional Health Administrators	308,010	308,010	308,010	310,010	310,010
JFA	National Institute of Health - Health Services Research Library	940,921	608,609	608,609	608,609	608,609
JFA	Office of Global Health Affairs	13,404	13,404	13,404	13,404	13,404
JFA	CFO Financial Statement Audit	537,700	583,000	600,500	650,500	650,500
JFA	Media Monitoring and Analysis	65,125	71,946	74,823	80,000	80,000
	Subtotal JFA Assessments	4,349,532	3,884,397	4,168,104	4,326,083	4,326,083
	Government-wide Administrative Functions					
JFA	Federal Employment Services (USAJOBS)	74,513	71,450	74,513	77,513	77,513
JFA	President's Council on Study of Bioethics	22,800	22,800	22,800	25,800	25,800
	Subtotal, GAF	97,313	94,250	97,313	103,313	103,313
	Grand Total	52,043,807	53,707,483	58,363,252	62,452,583	64,325,053

INDIAN HEALTH SERVICE
FY 2017 CONGRESSIONAL JUSTIFICATION
Significant Items

Contract Support Costs – The recommendation includes $800,000,000 as requested for full funding of estimated contract support costs. Bill language has been added making these funds available until expended and protecting against the use of other appropriations to meet unanticipated shortfalls. The Service is directed to work with Tribes and tribal organizations to ensure that budget estimates continue to be as accurate as possible.

Action taken or to be taken

The Service has focused its primary attention on updating the contract support costs policy, the current policy was last updated in 2007. Recent significant changes related to CSC requires an update to the policy. The policy provides guidance in the overall administration of contract support costs and is necessary to assure consistency.

Over the past couple years, IHS has reviewed its business practices and as a result has implemented the contract support costs calculation tool that is used to standardize the calculation of each T/TO CSC. Having a uniform tool allows the Agency to review and assure that T/TO are paid their full CSC need. In addition to the implementation of the tool, IHS includes a review and approval process for each negotiation, this step assures consistency and fair application for each T/TO. IHS has also implemented a reconciliation process to 1) address the T/TO full need throughout the year and 2) monitor CSC funds in real time throughout the year.

Eligibility. – The Committee recognizes the Federal government's trust responsibility for providing healthcare for American Indians and Alaska Natives. The Committee is aware that the definition of who is an ''Indian'' is inconsistent across various Federal health programs, which has led to confusion, increased paperwork and even differing determinations of health benefits within Indian families themselves. The Committee therefore directs the Department of Health and Human Services, the Indian Health Service, and the Department of the Treasury to work together to establish a consistent definition of an ''Indian'' for purposes of providing health benefits.

Action taken or to be taken

Under the ACA, only members of federally recognized tribes and shareholders in Alaska Native regional or village corporations who purchase coverage through a state or federal Marketplaces are eligible to receive special protections and some exemptions from cost sharing. This definition of Indian is narrower than the definition used by IHS, Medicaid and CHIP, leaving out a significant population of American Indians and Alaska Natives that the ACA was intended to benefit and protect. HHS has determined it does not have the administrative authority to align the inconsistent definitions under the ACA and that a legislative fix is necessary. The definition of Indian used by IHS, Medicaid, and CHIP is found in 42 C.F.R. 447.50 (b) and includes individuals who: (1) are members of a federally recognized Indian tribe who reside in an urban center and meet one of four criteria, (2) are considered by the Secretary of the Interior to be an Indian for any purpose, or (3) are considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for IHS services, including as a California Indian, Eskimo, Aleut, or other Alaska Native. In 2016, the IHS submitted an A-19 proposal to adopt a

consistent statutory definition of "Indian" to use in implementing the Affordable Care Act (ACA).

Urban Indian Health – The recommendation includes $48,157,000for Urban Indian Health, $3,416,000 above the fiscal year 2016 enacted level. The agency is directed to include current services estimates for Urban Indian Health in future budget requests. The Committee notes the agency's failure to report the results of the needs assessment directed by House Report 111–180. Therefore the recommendation includes a reduction to the Service leadership budget, along with bill language requiring a program strategic plan developed in consultation with urban Indians and the National Academy of Public Administration.

Action taken or to be taken

The Indian Health Service (IHS), Office of Urban Indian Health Programs (OUIHP) will develop a strategic plan for the Urban Indian Health Programs who hold Indian Health Care Improvement Act Title V contracts with the Agency. OUIHP has already begun working, internally, with the IHS Division of Acquisition Policy to determine and outline the appropriate steps for contracting and collaborating with the National Academy of Public Administration as a key partner in drafting the strategic plan for approval and implementation. The strategic planning process will be facilitated by OUIHP and developed through the process of conferring with urban Indians, as outlined in the *IHS Policy on Conferring with Urban Indian Organizations*. This activity will be completed and the strategic plan will be published not later than one year after the date of enactment of the bill.

Preventive Dental Care for Children - The Committee received testimony this year about an initiative to increase preventive dental care for children by bringing dentists and hygienists into elementary schools. The Committee recommendation includes $500,000 to begin the initiative and directs the Service to work with the Bureau of Indian Education (BIE) and to consult with Tribes about piloting the initiative in the BIE school system.

Action taken or to be taken

Indian Health Service (IHS) has worked with the Bureau of Indian Education (BIE) providing community outreach and as of January 2016 IHS is working with 86 BIE schools throughout the nation to provide oral health preventive services to AI/AN youth. The IHS utilizes existing resources to provide these services. In 2011 and 2012, the IHS conducted the largest-ever oral health surveillance of 6-9 year-old children to determine the disease burden of this population, and in conducting the screening surveys; the IHS utilized Bureau of Indian Education-operated (BIE) elementary schools. IHS programs throughout the country engage in delivering preventive services such as dental screenings, dental sealants, and fluoride applications to school-age children in both dental clinics and in BIE-operated schools, and the success of these services are measured through three Government Performance and Results Act (GPRA) indicators annually – access to care, dental sealants in 2-15 year-olds, and the number of 1-15 year-olds receiving fluoride applications.

Department of Health & Human Services
Indian Health Service
Number of Service Units and Facilities
Operated by IHS and Tribes, October 1, 2015

Type of Facility	TOTAL	IHS Total	TRIBAL Total	Title I [a]	Title V [b]	Other [c]
Service Units	170	57	113			
Hospitals	45	27	18	3	15	0
Ambulatory	634	100	534	126	402	6
Health Centers	343	59	284	89	195	0
School Health Centers	17	9	8	0	8	0
Health Stations	111	32	79	31	48	0
Alaska Village Clinics	163	0	163	6	151	6

[a] Operated under P.L. 93-638, Self Determination Contracts

[b] Operated under P.L. 106-260, Tribal Self-Governance Amendment of 2000

[c] Operated by a local government, not a tribe, for some Alaska Native villages through a standard procurement contract or also to denote certain Navajo Area contractors

Indian Health Service
Summary of Inpatient Admissions and Outpatient Visits
Federal and Tribal
FY 2014 Data

Direct Care Admissions

	IHS	Tribal	TOTAL
TOTAL	**18,818**	**23,248**	**42,066**
Alaska	*	11,178	11,178
Albuquerque	878	*	878
Bemidji	369	*	369
Billings	645	*	645
California	*	*	0
Great Plains	3,450	*	3,450
Nashville	*	849	849
Navajo	7,685	5,114	12,799
Oklahoma	1,181	6,087	7,268
Phoenix	4,177	20	4,197
Portland	*	*	0
Tucson	433	*	433

* No direct inpatient facilities in FY 2014

Direct Care Outpatient Visits

	IHS	Tribal	TOTAL
TOTAL	**5,258,344**	**8,255,928**	**13,514,272**
Alaska	*	1,657,784	1,657,784
Albuquerque	489,776	114,749	604,525
Bemidji	137,944	737,478	875,422
Billings	501,538	126,638	628,176
California	*	605,129	605,129
Great Plains	1,083,331	128,932	1,212,263
Nashville	19,000	536,784	555,784
Navajo	1,097,061	764,826	1,861,887
Oklahoma	613,877	2,394,170	3,008,047
Phoenix	841,167	537,810	1,378,977
Portland	297,591	567,819	865,410
Tucson	177,059	83,809	260,868

** No IHS facilities in FY 2014

INDIAN HEALTH SERVICE
Immunization Expenditures[1]

	FY 2013 Estimate	FY 2014 Estimate	FY 2015 Estimate	FY 2016 Estimate	FY 2017 Estimate	Increase or Decrease
Infants, <2 yrs	$13,329,165	$21,922,093	$18,793,408	$18,816,007	$18,234,078	- $581,929
Adolescents, 13-17 yrs		$12,412,350	$11,704,995	$11,824,249	$14,184,614	+$2,360,365
HPV vaccine, Female 19-26 yrs	$9,388,432	$6,001,292	$7,389,130	$2,654,568	$7,116,136	+$4,461,568
HPV Vaccine, Males 19-21 yrs		$5,889,641	$6,799,171	$3,136,902	$5,339,282	+$2,202,380
Tdap, 19+ yrs		$6,508,229	$6,977,397	$1,399,293	$4,369,742	+$2,970,449
Hepatitis B for diabetics, 19-59 yrs		$5,752,971	$4,595,452	$4,870,146	$5,400,839	+$530,693
Influenza, 19yrs+	$3,210,800	$25,969,076	$29,225,712	$29,542,047	$25,539,057	-$4,002,990
Zoster vaccine, 60yrs		$494,463	$36,189	$558,050	$598,728	+$40,678
Pneumococcal (PPSV23), 65yrs+		$392,934	$432,156	$179,359	$270,111	+$90,752
Pneumococcal (PCV13), 65yrs+				$4,410,552	$4,790,620	+$380,068
Monitoring	$110,442	$114,528	$118,078	$122,565	$127,100	+$4,535
TOTAL	$26,038,839	$85,457,577	$86,071,688	$77,513,738	$85,970,307	$8,456,569

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 < 19 years of age is covered by the Vaccines for Children (VFC) program, only the costs for vaccine administration, which are not covered by the VFC program, are included for this age group. Vaccine administration fees were based on an average of the CMS Maximum Regional Charges for vaccine administration, multiplied by the number of doses of vaccine routinely recommended for each age group (25 doses for children < 2 yrs; 6 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 2017 estimated costs. In prior years, costs were only included for adults 65+ yrs and for influenza vaccine. In August 2014, the Advisory Committee on Immunization Practices (ACIP) for the first time recommended routine use of 13-valent pneumococcal conjugate vaccine (PCV13) among adults aged ≥65 years; the projected costs for incorporating this additional vaccine are included starting with the FY 2016 expenditures. The assumptions for all calculations are included in the table below.

1. The immunization estimates do not include the Hepatitis B and Haemophilus Immunization program; estimates for these immunizations are included under the Immunization Alaska budget.

Costs for monitoring of immunization coverage were also included, and represent a 3.7 percent increase over the FY 2016 estimate.

- FY 2013 Estimated Costs = FY 2012 cost plus 3.1 percent
- FY 2014 Estimated Costs = FY 2013 cost plus 3.7 percent
- FY 2015 Estimated Costs = FY 2014 cost plus 3.1 percent
- FY 2016 Estimated Costs = FY 2015 cost plus 3.8 percent
- FY 2017 Estimated Costs = FY 2016 cost plus 3.7 percent

For 2017, $85,843,207 is estimated for vaccine costs, and $127,100 for immunization monitoring costs, for a total of $85,970,307 estimated for all immunization expenditures. This represents a $8,456,569 increase over FY 2016 due to redistribution in population age categories and realignment of coverage goals to Healthy People 2020 goals. Calculations for the costs included as part of the 2017 estimated immunization costs were based on the assumptions outlined in the table below:

	Estimated User Pop (FY 2015)	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	41,956	80%	NA	33,565	$0.00	$21.73	25	$543.25	$18,234,078
Adolescents, 13-17 years	135,993	80%	NA	108,794	$0.00	$21.73	6	$130.38	$14,184,614
HPV Females, 19-26	118,178	60%	46%	16,545	$121.64	$21.73	3	$430.11	$7,116,136
HPV Males, 19-21 yrs	38,793	60%	28%	12,414	$121.64	$21.73	3	$430.11	$5,339,282
Tdap, 19+ yrs	1,074,650	90%	81%	96,719	$23.45	$21.73	1	$45.18	$4,369,742
Hepatitis B for diabetics, 19-59 yrs	93,330	60%	21%	36,399	$27.73	$21.73	3	$148.38	$5,400,839
Influenza, 19+ yrs	1,074,650	70%	NA	752,255	$12.22	$21.73	1	$33.95	$25,539,057
Zoster, 60 yrs	14,325	30%	NA	4,298	$117.59	$21.73	1	$139.32	$598,728
Pneumococcal (PPSV23) 65yrs+	135,489	90%	86%	5,420	$28.11	$21.73	1	$49.84	$270,111
Pneumococcal (PCV13) 65yrs+	135,489	30%	NA	40,647	$96.13	$21.73	1	$117.86	$4,790,620
Vaccine Costs									$85,843,207
Monitoring									$127,100
Total Costs									$85,970,307

† Based on Healthy People 2020, where applicable

*Coverage estimates based on most current coverage levels reported by IHS.
HPV estimate is 3 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

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.

FISCAL YEAR 2017 DHHS LEGISLATIVE
PROPOSAL
Indian Health Service

Special Diabetes Program for Indians Permanent Reauthorization

Proposal: Permanent reauthorization for the Special Diabetes Program for Indians (SDPI) at $150 million per year.

Current Law: 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, codified in the Public Health Service Act at 42 U.S.C. § 254c-3, has been reauthorized through September 30, 2017.

Rationale: Reauthorization of the SDPI beyond FY 2017 will be required to continue progress in the prevention and treatment of diabetes in AI/AN communities. Permanent reauthorization allows the programs more continuity and the ability to plan more long term interventions and activities.

The SDPI has provided the funding which has enabled AI/AN programs to implement and sustain quality diabetes treatment and prevention services. As the four SDPI Reports to Congress in FYs 2000, 2004, 2007, and 2011 have demonstrated, substantial improvements in clinical measures and outcomes have been associated with the diabetes prevention and treatment activities implemented with SDPI funding. A 2014 Report to Congress, which documents continued improvements, has been drafted and is undergoing review.

Indian Health Service (IHS) data indicate a slowing in the rise of the prevalence of diabetes in AI/AN people nationally: from 2001-2005, there was a relative increase in age- adjusted diabetes prevalence in AI/AN adults of 2.2% per year on average, while from 2006- 2013, diabetes prevalence increased only 0.8% per year on average[1]. Another positive trend is that rates of obesity in AI/AN children and youth aged 2-19 years remained nearly constant during the same time period[1]. Key clinical outcome measures have continued to improve overall at I/T/U facilities since the inception of the SDPI:

- Improved blood sugar control: Average blood sugar (as measured by the A1C test) in AI/AN patients with diabetes decreased from 9.0 percent in 1996 to 8.1 percent in 2015, nearing the A1C goal for most patients of less than 7 percent[2].
- Improved blood lipid levels: Average LDL cholesterol in AI/AN patients with diabetes decreased 22 percent from 118 mg/dL in 1998 to 94 mg/dL in 2015, well below the target of 100 mg/dL[2].
- Reduced kidney failure: From 2000 to 2011, the rate of new cases of kidney failure due to diabetes leading to dialysis declined 43 percent in AI/AN people. This is a much larger decline than in any other racial group in the U.S[3].

[1] IHS National Data Warehouse
[2] IHS Diabetes Care and Outcomes Audit
[3] United States Renal Data System

The SDPI Grant Program have implemented diabetes prevention and treatment activities that are culturally appropriate, community-driven, and centered on evidence- based best practices. These programs will continue to implement specific prevention and treatment strategies and best practices for AI/AN adults, children and youth.

The SDPI 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[4]. The SDPI DP/HH Initiative grantees helped develop web-based toolkits which will share best practices with other programs. As they have accomplished what they were funded to do, the DP and HH Initiatives will be closing out their grant activities during FY 2016 and FY 2017. In FY 2017, IHS will continue to disseminate the DP and HH Initiative activities to AI/AN communities and health care programs across the country.

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 continue to provide administrative support to ensure their appropriate implementation and evaluation.

Reauthorization is highly supported by the Tribes. In 2015, Tribes submitted testimony to the House Appropriations 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 2017 SDPI funding will be based on tribal consultation and final agency decision; the activities will be modified appropriately.

Budget Impact: (Costs)

SDPI Funding 5 and 10 year Total					
FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	5 Year Total
$150 M	$150 M	$150 M	$150 M	$150 M	$750 M
FY 2022	FY 2023	FY 2024	FY 2025	FY 2026	10 Year Total
$150 M	$150 M	$150 M	$150 M	$150 M	$1.5 B

Effective Date: Upon enactment; beginning FY 2017.

[4] Special Diabetes Program for Indians 2011 Report to Congress

FISCAL YEAR 2016 LEGISLATIVE PROPOSAL
Indian Health Service

Provide Indian Health Service Health Professions Scholarship Program and Health Professions Loan Repayment Program with a Tax Exemption

Proposal: IHS is seeking tax treatment, similar to the treatment provided to recipients of National Health Service Corps (NHSC) and Armed Forces Health Professions scholarships, to allow scholarship funds for qualified tuition and related expenses received under the Indian Health Services Health Professions Scholarships to be excluded from gross income under Section 117(c)(2) of the Internal Revenue Code (IRC) and to allow participants in the IHS Loan Repayment Program to exclude from gross income student loan amounts that are forgiven by the IHS Loan Repayment program under Section 108(f)(4) of the IRC. In addition, IHS is seeking exemption from any Federal Employment Tax (FICA), making the IHS programs comparable to the current NHSC status.

Current Law: Generally, benefits awarded in the form of scholarship awards and loan repayments are regarded as federal taxable income by the IRS under Title 25 of the Internal Revenue Code. However, three federal laws currently provide for the non-taxability of federal scholarship awards and loan repayment programs:

- Section 413 of P.L. 107-16, the Economic Growth and Tax Relief Reconciliation Act of 2001 provides that tuition, fee, and other related cost payments by the National Health Service Corps and F. Edward Hebert Armed Forces Health Professions Scholarships and Financial Assistance Program scholarships are not taxable. This tax exemption was made permanent by Congress in December 2012 but did not include IHS scholarships.

- 26 USC 108(f)(4) provides that funds received through the National Health Service Corps Loan Repayment Program authorized under 338B(g) of the Public Health Service Act or a state loan repayment program described in section 338I of the Public Health Service Act are permanently not subject to federal income tax.

- 26 USC 3401(a)(19) excludes NHSC loan repayment from federal employment tax.

As IHS programs are not included in the exceptions, IHS health professions scholarships and loan repayment awards are taxed under the IRC.

Rationale**:** The IHS, as a rural healthcare provider, has difficulty recruiting healthcare professionals. There are over 1,484 vacancies for healthcare professionals including: physicians, dentists, nurses, pharmacists, physician assistants, and nurse practitioners. The IHS Health Professions Scholarship Program and the Loan Repayment Program play a significant role in the recruitment and retention of the healthcare professionals needed to fill these vacancies.

The IHS Health Professions Scholarship and IHS Loan Forgiveness Program are very similar to other programs that receive preferred tax treatment, and should therefore receive similar tax treatment. Currently, benefits awarded through IHS in the form of loan repayment and scholarships are regarded as federal taxable income to the recipient; however, the same benefits offered under the NHSC are not taxable. This disparate tax treatment of IHS-funded scholarship and loan repayment awards increases the overall tax bracket for the participants and creates a

financial disincentive for those otherwise willing to serve American Indian and Alaska Native patients by working in Indian health facilities.

The ability to exempt scholarship and loan repayment funds from gross income would make this recruitment and retention tool more attractive to potential participants. Thus, the IHS would be better able to increase the number of healthcare providers entering and remaining within the IHS to provide primary healthcare and specialty services.

Budget Impact: To Department of Treasury

Federal Tax Revenue Foregone:

Loan Repayment	$8,086,658
Scholarship	$3,059,727
Total	$11,146,415

Budget impact is the amount of tax revenue withheld from IHS Health Professions Scholarship and Loan Repayment and forwarded to the Internal Revenue Service. This also includes the tax liability owed by the scholarships recipients.

Effective Date: Upon enactment.

Purchased/Referred Care (PRC) Rate: "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

Current Legislation

PRC rate for Nonhospital Services would permit IHS, Tribes, tribal Organizations, or IHS-funded programs operated by Urban Indian organization to pay a capitated rate such as "Medicare-like rates" (MLR) for outpatient services funded through the Purchased/Referred Care (PRC) program. Since 2007, IHS's PRC program has had the authority to pay MLR for PRC authorized in-patient services furnished by Medicare-participating hospitals, and require those hospitals to accept that rate as a condition of participation in Medicare. This legislative proposal would expand these rates, and the condition that Medicare participating providers must accept the rate, to outpatient services, which will reduce the amount of funds IHS and tribal providers would pay for PRC outpatient services. As noted in the GAO's April 2013 report, expanding the MLR cap is a budget-neutral mechanism that will allow IHS and Tribal facilities to save millions of dollars and use those savings to increase the care that IHS provides through the PRC program.

Proposed PRC Rates Regulation Expansion

On December 5, 2014, IHS published a notice of proposed rulemaking which would amend PRC regulations to apply Medicare payment methodologies to all physician and other health care professional services and non-hospital-based services that are authorized by IHS or Tribal PRC programs or purchased by urban Indian organizations. Unlike the legislative proposal, the regulation cannot require that providers participating in Medicare accept the capitated PRC rate from IHS. The IHS sought comments on this proposed rule on how to establish reimbursement that is consistent across federal health care programs, aligns payment with inpatient services, and enables IHS to expand beneficiary access to medical care. IHS also sought comment on whether it should be allowed to negotiate a rate higher than the Medicare methodology. Comments were due by February 4, 2015 and IHS reviewed them and made needed revisions for the potential final rule. The final draft of the final rule was submitted to the Office of Information and Regulatory Affairs within the Office of Management and Budget in December of 2015.

FISCAL YEAR 2017 DHHS LEGISLATIVE PROPOSAL
Indian Health Service

Meet Loan Repayment/Scholarship Service Obligations on a Half-Time Basis

Proposal: Permit both IHS scholarship and loan repayment recipients to fulfill service obligations through half-time clinical practice, under authority similar to that now available to the National Health Service Corps (NHSC) Loan Repayment Program (LRP) and Scholarship Program. Authority similar to Section 331(i) of the Public Health Service Act would allow IHS loan repayment and scholarship recipients to satisfy their service obligations through half-time clinical practice for double the amount of time or to accept half the loan repayment award amount in exchange for a two-year service obligation. This would provide parity with NHSC programs.

Current Law: Sections 104 and 108 of the Indian Health Care Improvement Act require employees who receive IHS scholarships or loan repayments to provide clinical services on a full-time basis. Section 331(i) of the Public Health Service Act was amended by § 10501(n) of the Affordable Care Act to permit certain NHSC loan repayment and scholarship recipients to satisfy their service obligations through half-time clinical practice for double the amount of time or, for NHSC loan repayment recipients, to accept half the loan repayment award amount in exchange for a two-year service obligation.

Section 331(j) of the PHS Act (42 USC 254d(j)) defines "full-time" clinical practice as a minimum of 40 hours per week, for a minimum of 45 weeks per year. It also defines "half-time" as a minimum of 20 hours per week (not to exceed 39 hours per week), for a minimum of 45 weeks per year.

Rationale: The IHS, as a rural healthcare provider, has difficulty in recruiting healthcare professionals. This has been especially significant with the recruitment of physicians and other primary care clinicians. While IHS has not specifically tracked the number of part-time employment applicants, we believe that having the options to permit IHS scholarship and loan repayment health professional employees to fulfill their service obligations through half-time clinical practice for double the amount of time and to offer half the loan repayment award amount in exchange for a two-year service obligation could increase the number of providers interested in serving in the Indian health system. Additional half-time direct care employees could also reduce the number and cost of Purchased/Referred Care program referrals, especially at sites that do not need full time specialty care services.

The NHSC was authorized to establish a demonstration project permitting loan repayment recipients to meet their service obligations through less than full-time clinical service in response to requests from clinicians and sites. The Affordable Care Act replaced this demonstration with permanent authority for two specific kinds of NHSC options (described above under Current

Law). The IHS is equally concerned with the requests from clinicians and prospective candidates for loan repayment awards for half-time service by clinicians. Having similar authority as the NHSC would increase the ability for the IHS to recruit and retain healthcare clinicians to provide primary healthcare and specialty services and otherwise support the IHS and HHS Priorities.

The ability to provide scholarship and loan repayment awards for half-time clinical service would make these recruitment and retention tools more flexible and cost-effective, while at the same time requiring a minimal amount of additional monitoring over a longer period of time.

Budget Impact: None.

Effective Date: Upon enactment.

FISCAL YEAR 2017 LEGISLATIVE PROPOSAL
Indian Health Service

Extension of 100% Federal Medical Assistance Percentage (FMAP) to All Indian Health Programs, including Tribal and Urban Indian Health Programs

Proposal: To extend the 100% Federal medical assistance percentage (FMAP) under the Medicaid program to all Indian health programs for American Indian and Alaska Native (AI/AN) patients, including urban Indian health programs (UIHP) to codify what already exists for tribally-operated health programs.

Current Law: FMAP determines what percentage of a payment for State Medicaid services the Federal government will match. States may pay for Medicaid services not covered by private insurance and the Federal government will reimburse the state for a percentage of its costs.

Currently, the Medicaid statute provides that the 100% FMAP rate applies to state expenditures for Medicaid services "received through an Indian Health Service facility, whether operated by the Indian Health Service or by an Indian tribe or tribal organization." 42 U.S.C. § 1396d(b). This has been construed to extend to "Medicaid services furnished to Medicaid eligible AI/ANs by any tribal facility operating under a 638 agreement" based on a 1996 Memorandum of Understanding between IHS and the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services (CMS)), but excludes urban Indian health programs, though not explicit. Since these authorities are limited to IHS facilities and tribal facilities operated under the Indian Self-Determination and Education Assistance Act (ISDEAA), payments to other providers operating within the IHS system are excluded. For example, payments by the state to clinics operated by urban Indian organizations are paid according to the applicable state match. Nor would payments to non-facility providers be included. Additionally, CMS's longstanding view is that, even at IHS and tribal facilities operated under a 638 contract, 100% FMAP applies only to services for IHS beneficiaries.

Under this proposal, the 100% FMAP would be extended to expenditures for any service furnished by an Indian health program, including the whole scope of the IHS/Tribal/Urban (I/T/U) service delivery network. Specifically, that would include otherwise covered Urban Indian clinic services and non-facility services. The 100% FMAP would not also extend to contractors who provide services through IHS's Purchased/Referred Care Program for which the Indian health program may accept clinical, financial, and legal responsibility.

Rationale: Expanding 100% FMAP to include UIHP as an eligible category for receiving 100% federal reimbursement for Medicaid services provided through urban Indian health facilities will help both the State and the UIHP access more federal dollars to support health care. While these federal dollars would initially do nothing more than supplant existing state contributions for care, in the longer term, the increased FMAP could allow UIHP and non-facility I/T/U providers to

negotiate with the state for higher rates of payment. The higher rates of payment could support the expansion of UIHP service offerings and improve beneficiary care.

Budget Impact: The federal impact on CMS of extending 100% FMAP is estimated to be $2,334,220.

Data is derived from the 2013 UIHP UDS Report. Total urban AIAN patients equals 53,408. 23% of urban AIAN patients (12,284) are currently enrolled in Medicaid. 64% of urban AIAN patients (34,181) are currently uninsured. A large percentage of this category would be Medicaid eligible, especially in the Medicaid expansion States. The average national FMAP rate = 57%. Using the national CMS Medicare FQHC PPS encounter rate for 2014 ($158.85) and carving out 43% (100% - 57%), $68.29 additional dollars per claim would be reimbursed to the State by CMS. $68.29 x 34,181 = $2,334,220, on the high end.

Effective Date: Upon enactment

IHS-2017
July 2015

FISCAL YEAR 2017 LEGISLATIVE PROPOSAL
Indian Health Service

Provide a consistent Definition of "Indian" in the Affordable Care Act

Proposal: Adopt a consistent statutory definition of "Indian" to use in implementing the Affordable Care Act (ACA).

Current Law: The ACA includes several different, although similar, definitions of "Indian." They are not consistent, however, with the definition used for delivery of other federally supported health services to American Indian/Alaska Natives under Medicaid, the Children's Health Insurance Program (CHIP), or the Indian Health Services (IHS). The definition for ACA implementation leaves out a significant population of American Indians and Alaska Natives (AI/ANs) served by IHS and who are eligible for cost-sharing waivers under Medicaid. This inconsistency affects the ACA's waiver of cost sharing, special monthly enrollment periods, and individual responsibility requirements.

Rationale:
The three definitions used in the ACA are inconsistent with IHS eligibility regulations because the definitions only include members of federally recognized Tribes. In other words, under the law, only members of federally recognized tribes and Alaska Native Claims Settlement Act village or corporation shareholders who purchase coverage through a state or federal Marketplace are eligible to receive special protections and some exemptions from cost sharing. This means that descendants (including children), many Urban Indians, and many California Indians are excluded from the ACA Indian specific protections. HHS has created through regulation an exemption from the shared responsibility payment for those eligible for services from an I/T/U that mitigates some of the impact of the different definitions. Implementation of these special provisions is an administrative challenge for HHS since each Marketplace or exemption application requires a thorough review of the eligibility criteria and proper processing of the applications. In addition, educating the public and staff about these differences continue to be an issue. Tribal Leaders continue to voice their concerns to the HHS and Congress and have requested adoption of a uniform and consistent definition of "Indian" so that descendants, Urban Indians and California Indians are not excluded from participating in the benefits, protections, and increased access to health care that the ACA was intended to bring all Americans, including AI/ANs.

HHS has determined it does not have the administrative authority to align the inconsistent definitions under the ACA and that a legislative fix is necessary. Therefore, we propose that the law be changed to use the definition of Indian relied on by Medicaid, CHIP and IHS found at 42 C.F.R. § 447.50[i] for the purpose of implementing the ACA, including for the Marketplace and the specific AI/AN provisions.

Doing so will avoid administrative confusion across programs and will facilitate a streamlined enrollment process. Even more importantly, doing so will advance fulfillment of the federal

government's historical and unique legal relationship with and resulting responsibility toward AI/ANs, promote the ACA's objectives of making health coverage more accessible to the uninsured, and address the alarmingly inadequate access to health services by AI/ANs due to underfunding of the IHS. In addition:

- All American Indian and Alaska Natives eligible for IHS services will be treated equally when receiving health care services and coverage under the ACA.
- This would simplify implementation of the Indian-specific protections for Qualified Health Plans (QHPs) in the Marketplace by using one consistent definition that is verifiable for 2.9 million individuals through an IHS Electronic Health Record (EHR) produced letter for Indian enrollment verification.
- Access to available health programs will be improved and confusion for both American Indians and Alaska Natives and those implementing federal programs will decrease.
- American Indian and Alaska Native national and regional organizations support the implementation of all Indian-specific ACA provisions using the Medicaid definition for all federally funded health programs.
- Outreach and education materials will be improved through clearer messaging and simplification of terms by use of a single Indian definition for Medicaid, CHIP and Marketplace protections.

Budget Impact: A change in the definition of Indian is likely to increase the number of Marketplace enrollees who qualify for cost-sharing reductions (CSRs) and thus result in an increase in the cost of CSRs. At this time, there is no estimate of the number of people currently excluded from the Marketplace by the definition of Indian, or the increased CSR cost that could result from expanding the definition. This may also increase the number of people eligible for advance premium tax credits.

- Some may indicate there will be increased funding needed for cost-sharing reductions and advance premium tax credits because the number of Marketplace enrollees who qualify for both will increase with expanded eligibility, however the cost is likely negligible, because the government has already realized a cost savings due to the fact that we have expanded the individual shared responsibility exemption already to all IHS eligible individuals.
- Both the Federally-Facilitated Marketplace and the State-Based Marketplaces would need modifications and additional IT funding to accommodate new eligibility rules.
- Increased outreach and educational materials would need to be developed to educate American Indians and Alaska Natives.
- CMS would need to work closely with the Internal Revenue Service to assist in making changes to ensure appropriate tax credits are applied to newly eligible American Indians and Alaska Natives.
- OMB has not supported this policy publically despite past HHS requests.
- Please note that State-Based Marketplaces (SBMs) will need to be financially self-sufficient by plan year 2015, and this proposal may increase state costs as they update systems.

Personnel Requirements: New personnel will be required to make the changes described above or existing personnel will be moved from existing tasks.

Effective Date: CMS recommends this A-19 be effective in the next benefit year after enactment. For example, if the statute is amended in 2015, the change would become effective in benefit year 2016. We request this change to avoid beneficiary confusion, and to avoid mid-year operational costs in both plan and financial management.

Other Data: This is a re-proposal. Modifications include an update on HHS's current experience with implementing different definitions of Indian including the administrative challenges in educating our beneficiary population and staff of the differences. There may be additional challenges from a CMS perspective in terms of processing and appropriately identifying which AI/ANs are eligible for special protections.

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[i] COST SHARING

§ 447.50 Premiums and cost sharing: Basis and purpose.

Sections 1902(a)(14), 1916 and 1916A of the Act permit states to require certain beneficiaries to share in the costs of providing medical assistance through premiums and cost sharing. Sections 447.52 through 447.56 specify the standards and conditions under which states may impose such premiums and or cost sharing.

§447.51 Definitions.

As used in this part—

…*Indian* means any individual defined at 25 U.S.C. 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 CFR 136.12. This means the individual:
(1) Is a member of a Federally-recognized Indian tribe;
(2) Resides in an urban center and meets one or more of the following four criteria:

(i) Is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member;

(ii) Is an Eskimo or Aleut or other Alaska Native;

(iii) Is considered by the Secretary of the Interior to be an Indian for any purpose; or

(iv) Is determined to be an Indian under regulations promulgated by the Secretary;

(3) Is considered by the Secretary of the Interior to be an Indian for any purpose; or
(4) Is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.

Indian Health Service
Indian Self Determination

Indian Health Service Philosophy – The Indian Health Service (IHS) implements the Indian Self-Determination and Education Assistance Act (ISDEAA), Public Law (Pub. L. No.) 93-638, as amended, which recognizes the unique legal and political relationship between the United States and American Indian and Alaska Native peoples. Accordingly, the IHS supports Tribal sovereignty: (1) by assisting Tribes in exercising their right to administer the IHS health programs, or portions thereof, and (2) by continuing to directly provide services to Tribes that choose the IHS as their health care provider. A Tribal decision to enter or not enter into ISDEAA agreements are equal expressions of self-determination.

Title I Contracts and Title V Self-Governance Compacts – Titles I and V of the ISDEAA provide Tribes the option to exercise the right to self-determination by assuming control and management of programs previously administered by the federal government. Since 1975, the IHS has entered agreements with Tribes and Tribal organizations to plan, conduct, and administer programs authorized under Section 102 of the Act. Today, over $2.7 billion of the Agency's appropriation is transferred to Tribes and Tribal Organizations through Title I contracts and Title V compacts. Under Title I, there are 234 Tribes and Tribal Organizations operating 275 contracts and 351 annual funding agreements which comprise approximately $980 million. Under Title V, IHS is party to 87 compacts and 113 funding agreements; through which $1.8 billion of the IHS budget is transferred to Tribes and Tribal organizations. Sixty-two percent of federally-recognized Tribes participate in Title V.

IHS and Tribally-Operated Service Unit and Medical Facilities – In recent years, the amount of funding administered under ISDEAA contracts and compacts has nearly doubled, with a corresponding increase in services provided and managed by Tribal programs. Tribes have traditionally assumed operation of community services and have expanded into providing medical care. For example, Tribes operate nearly all of the Community Health Representative Program and community-based alcohol programs. In addition, the number of tribally-operated hospitals has increased to over 40% of the hospitals funded by the IHS. With the increase of ambulatory medical facilities, Tribes continue to expand their provision of health care.

Indian Health Service
Self-Governance Funded Compacts FY 2015
(Dollars in Thousands)

Compacts by State	IHS Services	IHS Facilities	Contract Support Costs (Direct)	Contract Support Costs (Indirect)	Total
ALASKA	**432,098**	**40,511**	**49,031**	**158,434**	**680,074**
Alaska Native Tribal Health Consortium	55,262	17,653	10,847	18,739	102,501
Aleutian Pribilof Islands Association, Inc.	2,025	257	195	1,084	3,561
Arctic Slope Native Association, Ltd	22,402	1,982	3,064	7,499	34,947
Bristol Bay Area Health Corporation	20,681	829	2,200	8,690	32,400
Chickaloon Native Village	56	1	14	12	83
Chugachmiut	3,605	20	209	1,752	5,586
Copper River Native Association	5,380	366	452	1,741	7,939
Council of Athabascan Tribal Governments	1,740	97	93	1,147	3,077
Eastern Aleutian Tribes, Inc.	3,023	26	166	1,663	4,878
Kenaitze Indian Tribe, I.R.A.	11,878	1,042	369	5,261	18,550
Ketchikan Indian Community	5,164	132	512	3,808	9,616
Knik Tribal Council	70	1	10	15	96
Kodiak Area Native Association	6,729	565	424	2,279	9,997
Maniilaq Association	26,131	810	2,629	14,254	43,824
Metlakatla Indian Community	6,039	904	443	1,419	8,805
Mount Sanford Tribal Consortium	767	209	76	212	1,264
Native Village of Eklutna	171	2	6	36	215
Native Village of Eyak	764	19	82	230	1,095
Norton Sound Health Corporation	41,950	3,509	4,043	7,509	57,011
Seldovia Village Tribe	1,785	31	81	794	2,691
Southcentral Foundation	77,161	4,354	9,151	30,229	120,895
SouthEast Alaska Regional Health Consortium	35,881	1,393	3,325	15,518	56,117
Tanana Chiefs Conference	59,245	4,114	5,242	13,328	81,929
Yakutat Tlingit Tribe	304	2	29	124	459
Yukon-Kuskokwim Health Corporation	43,885	2,193	5,369	21,091	72,538
ALABAMA	**3,954**	**112**	**142**	**638**	**4,846**
Poarch Band of Creek Indians	3,954	112	142	638	4,846
ARIZONA	**96,663**	**9,091**	**4,434**	**32,047**	**142,235**
Gila River Indian Community	34,300	5,057	1,648	11,769	52,774
Tuba City Regional Health Care Corporation	40,181	3,083	2,037	14,484	59,785
Winslow Indian Health Care Center, Inc.	22,182	951	749	5,794	29,676
CALIFORNIA	**72,116**	**2,407**	**3,345**	**29,887**	**107,755**
Chapa-De Indian Health Program, Inc.	6,386	151	167	3,598	10,302
Consolidated Tribal Health Project, Inc.	3,907	77	96	1,485	5,565
Feather River Tribal Health, Inc.	5,793	320	152	1,723	7,988
Hoopa Valley Tribe	5,119	112	245	2,293	7,769
Indian Health Council, Inc.	8,388	224	254	3,228	12,094
Karuk Tribe of California	2,957	77	88	1,275	4,397
Northern Valley Indian Health, Inc.	4,044	648	104	1,183	5,979
Redding Rancheria Tribe	6,558	183	535	3,309	10,585
Riverside-San Bernardino County Indian Health,	21,001	377	809	8,611	30,798
Santa Ynez Band of Chumash Mission Indians	1,443	32	27	419	1,921
Southern Indian Health Council, Inc.	4,802	173	721	1,961	7,657
Susanville Indian Rancheria	1,718	33	147	802	2,700

Indian Health Service
Self-Governance Funded Compacts FY 2015
(Dollars in Thousands)

Compacts by State	IHS Services	IHS Facilities	Contract Support Costs (Direct)	Contract Support Costs (Indirect)	Total
CONNECTICUT	**2,383**	**34**	**0**	**523**	**2,940**
Mohegan Tribe of Indians of Connecticut	2,383	34	0	523	2,940
FLORIDA	**8,158**	**417**	**905**	**1,539**	**11,019**
Seminole Tribe of Florida	8,158	417	905	1,539	11,019
IDAHO	**15,530**	**651**	**1,785**	**5,449**	**23,415**
Coeur D'Alene Tribe	6,156	246	1,321	3,244	10,967
Kootenai Tribe of Idaho	629	29	71	198	927
Nez Perce Tribe	8,745	376	393	2,007	11,521
KANSAS	**2,540**	**112**	**19**	**419**	**3,090**
Prairie Band Potawatomi Nation	2,540	112	19	419	3,090
LOUISANA	**1,165**	**81**	**116**	**170**	**1,532**
Chitimacha Tribe of Louisiana	1,165	81	116	170	1,532
MASSACHUSETTS	**687**	**25**	**204**	**277**	**1,193**
Wampanoag Tribe of Gay Head	687	25	204	277	1,193
MAINE	**3,259**	**80**	**158**	**795**	**4,292**
Penobscot Indian Nation	3,259	80	158	795	4,292
MICHIGAN	**24,945**	**765**	**1,988**	**3,303**	**31,001**
Grand Traverse Band of Ottawa and Chippewa I	2,814	161	285	559	3,819
Keweenaw Bay Indian Community	3,315	123	746	888	5,072
Little River Band of Ottawa Indians	2,020	70	230	479	2,799
Sault Ste. Marie Tribe of Chippewa Indians	16,796	411	727	1,377	19,311
MINNESOTA	**19,599**	**521**	**2,601**	**2,424**	**25,145**
Bois Forte Band of Chippewa Indians	2,592	52	369	845	3,858
Fond du Lac Band of Lake Superior Chippewa	11,174	317	1,120	771	13,382
Mille Lacs Band of Ojibwe	4,122	144	1,096	491	5,853
Shakopee Mdewakanton Sioux Community	1,711	8	16	317	2,052
MISSISSIPPI	**28,502**	**1,705**	**1,164**	**3,866**	**35,237**
Mississippi Band of Choctaw Indians	28,502	1,705	1,164	3,866	35,237
MONTANA	**20,582**	**1,365**	**1,703**	**4,392**	**28,042**
Chippewa Cree Tribe of the Rocky Boy's Reserva	10,307	550	1,013	2,384	14,254
Confederated Salish and Kootenai Tribes of the F	10,275	815	690	2,008	13,788
NORTH CAROLINA	**18,988**	**1,407**	**933**	**4,213**	**25,541**
Eastern Band of Cherokee Indians	18,988	1,407	933	4,213	25,541
NEW MEXICO	**12,228**	**159**	**1,240**	**2,088**	**15,715**
Pueblo of Jemez	9,433	123	904	1,644	12,104
Pueblo of Sandia	1,913	32	139	202	2,286
Taos Pueblo	882	4	197	242	1,325
NEVADA	**25,435**	**979**	**2,029**	**5,228**	**33,671**
Duck Valley Shoshone-Paiute Tribes	6,608	467	721	1,470	9,266
Duckwater Shoshone Tribe	1,039	12	188	667	1,906
Ely Shoshone Tribe	1,256	14	58	275	1,603
Las Vegas Paiute Tribe	3,204	40	112	396	3,752
Reno-Sparks Indian Colony	6,495	218	632	1,535	8,880
Washoe Tribe of Nevada and California	4,900	136	221	567	5,824
Yerington Paiute Tribe of Nevada	1,933	92	97	318	2,440
NEW YORK	**7,770**	**433**	**300**	**1,009**	**9,512**
St. Regis Mohawk Tribe	7,770	433	300	1,009	9,512

Indian Health Service
Self-Governance Funded Compacts FY 2015
(Dollars in Thousands)

Compacts by State	IHS Services	IHS Facilities	Contract Support Costs (Direct)	Contract Support Costs (Indirect)	Total
OKLAHOMA	**364,708**	**35,358**	**28,762**	**64,744**	**493,572**
Absentee Shawnee Tribe of Oklahoma	15,508	1,456	1,811	4,511	23,286
Cherokee Nation	124,768	10,804	7,019	15,122	157,713
Chickasaw Nation	80,953	12,162	9,488	17,606	120,209
Choctaw Nation of Oklahoma	59,310	7,508	5,964	14,797	87,579
Citizen Potawatomi Nation	13,547	1,082	1,692	3,886	20,207
Kaw Nation of Oklahoma	1,384	97	194	648	2,323
Kickapoo Tribe of Oklahoma	7,515	105	272	1,454	9,346
Modoc Tribe of Oklahoma	48	0	5	14	67
Muscogee Creek Nation	41,468	1,848	1,759	4,307	49,382
Northeastern Tribal Health System	7,269	62	144	902	8,377
Ponca Tribe of Oklahoma	3,668	75	222	262	4,227
Sac and Fox Nation of Oklahoma	7,372	83	155	809	8,419
Wyandotte Nation	1,898	76	37	426	2,437
OREGON	**28,362**	**1,083**	**2,579**	**9,151**	**41,175**
Confederated Tribes of Grand Ronde	6,555	244	509	2,433	9,741
Confederated Tribes of Siletz Indians of Oregon	7,706	184	702	2,193	10,785
Confederated Tribes of the Coos, Lower Umpqua	1,774	48	280	554	2,656
Confederated Tribes of the Umatilla Reservation	6,723	391	688	2,097	9,899
Coquille Indian Tribe	2,012	73	221	1,101	3,407
Cow Creek Band of Umpqua Tribe of Indians	3,592	143	179	773	4,687
UTAH	**7,530**	**104**	**1,726**	**3,259**	**12,619**
Utah Navajo Health System, Inc.	7,530	104	1,726	3,259	12,619
WASHINGTON	**54,373**	**2,195**	**2,648**	**14,247**	**73,463**
Cowlitz Indian Tribe	3,106	62	22	827	4,017
Jamestown S'Klallam Indian Tribe	1,264	44	86	324	1,718
Kalispel Tribe of Indians	1,081	34	21	76	1,212
Lower Elwha Klallam Tribe	1,822	68	102	414	2,406
Lummi Indian Nation	7,835	530	253	2,173	10,791
Makah Indian Tribe	4,234	217	286	880	5,617
Muckleshoot Tribe	7,145	196	200	0	7,541
Nisqually Indian Tribe	2,251	95	108	575	3,029
Port Gamble S'Klallam Tribe	2,613	124	134	1,341	4,212
Quinault Indian Nation	5,464	334	219	1,585	7,602
Shoalwater Bay Indian Tribe	1,761	16	280	911	2,968
Skokomish Indian Tribe	2,046	57	112	532	2,747
Squaxin Island Indian Tribe	2,681	157	194	1,268	4,300
Suquamish Tribe	1,736	15	145	672	2,568
Swinomish Indian Tribal Community	2,148	66	174	602	2,990
Tulalip Tribes of Washington	7,186	180	312	2,067	9,745
WISCONSIN	**23,918**	**774**	**1,440**	**1,939**	**28,071**
Forest County Potawatomi Community	1,991	57	695	410	3,153
Oneida Tribe of Indians of Wisconsin	19,078	561	295	936	20,870
Stockbridge-Munsee Community	2,849	156	450	593	4,048
Grand Total	**1,275,493**	**100,369**	**109,252**	**350,041**	**1,835,155**

Indian Health Service
FY 2015 Self-Governance Funding
By Area
(Dollars in Thousands)

	Program Tribal Shares	Area Office Tribal Shares	Headquarters Tribal Shares	Contract Support Costs (Direct)	Contract Support Costs (Indirect)	Total
ALASKA	450,737	12,890	8,982	49,031	158,434	680,074
ALBUQUERQUE	10,162	1,900	325	1,240	2,088	15,715
BEMIDJI	66,922	2,156	1,444	6,029	7,666	84,217
BILLINGS	19,337	1,761	849	1,703	4,392	28,042
CALIFORNIA	69,401	3,058	2,064	3,345	29,887	107,755
NASHVILLE	73,170	4,723	1,267	3,922	13,030	96,112
NAVAJO	69,910	2,512	1,609	4,512	23,537	102,080
OKLAHOMA	381,787	10,238	10,693	28,781	65,163	496,662
PHOENIX	62,472	1,697	1,602	3,677	16,997	86,445
PORTLAND	95,811	3,680	2,703	7,012	28,847	138,053
Total, IHS	**1,299,709**	**44,615**	**31,538**	**109,252**	**350,041**	**1,835,155**