DEPARTMENT OF HEALTH AND HUMAN SERVICES

Fiscal Year
2013

Indian Health Service

Justification of Estimates for Appropriations Committees

I am pleased to present the Indian Health Service (IHS) fiscal year (FY) 2013 Congressional Justification. This budget request provides support for the President's and Secretary's priority initiatives and reflects the goals and objectives of the Department. The IHS budget represents extensive consultation with Tribes, and exemplifies the continued IHS and Tribal partnership on budget priorities that are included in the FY 2013 budget request.

For FY 2013, performance measurement and reporting at the IHS includes a comprehensive set of evaluation measures and outcomes. The Agency's budget offers outcome-based information that enables the IHS to share with stakeholders its progress toward achieving the four Agency priorities:

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

Implementation of performance management improvements has allowed the Agency to create a consistent framework for linking IHS-wide goals with program priorities and to more efficiently target resources to meet the needs of American Indians and Alaska Natives. The Agency 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 achievements and to strive for continued improvement.

The IHS FY 2013 budget request represents our efforts to sustain the Agency's valuable programs and maintain the performance improvements we have seen in recent years. It also provides for continued improvements in administration and more effective oversight of clinical, staff, and financial resources. These elements are essential to meeting the health care needs of American Indian and Alaska Native people.

/Yvette Roubideaux/

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2013 Performance Budget Submission to Congress

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

INDIAN HEALTH SERVICE

Approved: /Yvette Roubideaux/

Date: 01/27/2012

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AGENCY OVERVIEW

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

The IHS provides comprehensive primary health care and disease prevention services to approximately 2.1 million American Indians and Alaska Natives through a network of over 650 hospitals, clinics, and health stations on or near Indian reservations. Facilities are predominantly located in a rural primary care setting and 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 565 federally recognized Tribes. The IHS has approximately 15,700 employees, including 2,700 nurses, 900 physicians, 400 engineers, 600 pharmacists, 300 dentists, and 300 sanitarians.

United States Government and Indian Nations

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

Indian Health Service and Its Partnership with Tribes

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

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 care. The recently enacted Patient Protection and Affordable Care Act builds upon these laws by including provisions to modernize and update the IHS and expands the current health insurance system to further improve the quality of health care and make it more accessible and affordable for American Indians and Alaska Natives.

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

Agency Priorities

In 2009, IHS established four agency priorities to lead, manage, improve and support the delivery of health care services to American Indians and Alaska Natives:

1. Renew and strengthen our partnership with Tribes;
2. Bring reform to the IHS;
3. Improve the quality of and access to care; and
4. Make all our work accountable, transparent, fair and inclusive.

These priorities guide the work of agency staff and their partnerships with external stakeholders, including Tribes. The priorities emphasize the goal to change and improve the IHS, and significant improvements have been accomplished to date under each of the priorities. The priorities have served as a common language to communicate about agency activities, improvements and accomplishments among agency staff, patients and Tribes. The IHS budget request includes narratives that highlight how its programs and services advance progress on agency priorities and ensure a consistent focus on change and improvement in all IHS activities.

Overview of Indian Health Service Budget Request

Tribal Consultation – Tribal consultation is fundamental to the IHS budget process, and at its core are the priorities and recommendations developed by Tribes through an annual budget formulation process. The IHS budget request incorporates Tribal priorities and recommendations.

Summary of Request – The FY 2013 President's Budget request for IHS is $4.422 billion, an increase of $115.9 million over the FY 2012 enacted level. The request includes funds to support activities identified by the Tribes as budget priorities including increasing resources for the Contract Health Services program; funding contract support costs shortfall; addressing essential health information technology activities; and providing routine facility maintenance. Overall, the budget request addresses the need to sustain the Indian health system, expand access to care, and continue to improve oversight and accountability in key administrative areas. Specifically, this request includes the following:

CURRENT SERVICES (+$85.6 million)

Federal Commissioned Officer Pay Costs (+$2.4 million)
The budget request projects a 1.7 percent pay raise for Commissioned Officers.

Inflation for Contract Health Services (+$34.0 million)
Inflationary costs help maintain the current level of services and offset the rising cost in providing health care. The $34 million is the calculated need to address a 3.6 percent medical inflation rate for the Contract Health Services program.

Staffing and Operating Costs for New Facilities (+$49.2 million)
This request will fund the staffing and operating costs for six newly constructed Health Centers scheduled to open in FY 2013, including three Joint Venture projects. In addition, the request will complete the funding requirements to staff and operate two Joint Venture projects scheduled to open in FY 2012.

PROGRAM INCREASES / DECREASES (+$30.3 million)

Contract Health Services (+$20 million)
The increase will provide additional health care services for the AI/AN population by purchasing approximately 848 inpatient admissions, 31,705 outpatient visits and 1,116 one-way transportation services. Contract Health Services (CHS) funds are necessary to purchase health care services where direct IHS and Tribal health care is non-existent or unavailable and supplemental funds are needed to provide comprehensive care.

Health Information Technology (HIT) – ICD-10 and Electronic Dental Record (+$6 million)
The largest portion of the Agency's major IT investments is its HIT systems, which are a critical and necessary component for the delivery of patient care services at the numerous IHS and Tribal hospitals and ambulatory clinics, and Urban Indian Health Programs serving 2.1 million American Indians and Alaska Natives. The HIT systems capture patient and performance data for statistical reporting and decision-making, and comprise the billing and collection system for third party reimbursements. The $6 million HIT increase will support mandatory ICD-10 (International Classification of Diseases) implementation and provide $1 million in support for the Electronic Dental Record (EDR) program. These increases for HIT and EDR will allow

Indian Health Service, Tribally managed, and urban Indian Health (I/T/U) programs to improve billing for third party revenues, address the accuracy of medical records and health information systems, improve patient safety overall and improve the quality of and access to care across the Indian health care system.

Direct Operations (+$1.1 million)
The increase will be used to: (a) maintain improvements and reforms made to-date and to continue enhancements in the IHS' capacity for providing comprehensive oversight and accountability in key administrative areas such as: Human resources, property, financial management, performance management and CHS program improvements developed through CHS consultation recommendations on improving business practices related to CHS and third party reimbursements; (b) address recent Congressional oversight and reports issued by the General Accountability Office and the Office of Inspector General which recommended improvements in management of IHS programs such as the CHS program (c) address unfunded mandates for national initiatives associated with privacy requirements, facilities, and personnel security; and (d) improve responsiveness to external authorities such as OMB and Congress including, but not limited to, reforms related to oversight recommendations and the implementation and continuing accountability for new permanent authorities of the reauthorization of the IHCIA.

Contract Support Costs (+$5 million)
The increase will be applied to the Contract Support Costs (CSC) shortfall associated with ongoing contracts and compacts with Tribes and Tribal Organizations under the Indian Self Determination and Educational Assistance Act (ISDEAA).

Maintenance and Improvement (+$1.7 million)
The increase will be used to provide routine maintenance funding for Federal and Tribal healthcare facilities.

Health Care Facilities Construction (-$3.6 million)
The FY 2013 request represents a decrease of $3.6 million from the FY 2012 appropriated base level for Health Care Facilities Construction. The funding will be used to continue construction on health facility construction projects already underway.

FY 2013 Performance Overview

Priority Setting - To help the IHS undertake its mission and strategic goals, four priorities (as referenced under the Introduction and Mission section) were established by the IHS Director to guide the Agency's work and to address areas that key stakeholders are most interested in for improvement. The priorities were communicated widely to IHS employees at all organizational levels for feedback as well as to the Agency's delivery partners who responded with input and support for implementation.

The IHS has managed agency performance since 2005 through an agency performance plan, updated annually, that cascades performance goals and objectives and performance-related metrics agency wide. To focus performance on agency priorities, IHS recently strengthened its performance management process. In FY 2010, the Agency performance plan was fully aligned to the Agency priorities and measures were cascaded from senior executive performance plans to managers to supervisors and into employee plans, so that the performance of all employees relates to their job duties in the context of the priorities. Along with the four priorities, a fifth

critical program objective on improving customer service was added to the Agency performance plan in FY 2011. The four priorities will remain the same through FY 2013.

IHS Priorities, Broad Goals and Objectives, and the HHS Strategic Plan - Each agency priority and broad program performance objective aligns to and directly contributes to the Department's goals and priorities established in the HHS Strategic Plan for Fiscal Years 2010-2015 and the Secretary's top priorities and approved budget. Specifically, all four Agency priorities align to the HHS Strategic Plan Goal 1, Strengthen Health Care, and to several of the Goal's objectives. The IHS quality and access to care priority area also aligns to Goal 5, Strengthen the Nation's Health and Human Service Infrastructure and Workforce. The transparency and accountability priority area also aligns to Goal 4, Increase Efficiency, Transparency, and Accountability of HHS programs. Therefore, the IHS shares in the Secretary's future-oriented priority setting, definition of success, and action planning through its agency priorities and the Agency program performance plan. The IHS has two performance measures, tribal consultation and depression screening, in the HHS Strategic Plan.

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

Internal Agency Review - Agency leadership periodically reviews progress in meeting the Agency performance plan measures and holds regular discussions with senior executives. Accountability for each performance plan element is clearly communicated at the start of the performance cycle and progress reviews are conducted at least biannually. Discussions about progress on the Agency priorities are part of regular leadership meetings, such as the Headquarters monthly general staff meetings, the bi-monthly teleconference with IHS executives, quarterly Area Directors' meetings, and frequent senior staff meetings. Cascading performance plan elements to employees holds them accountable for performing the work duties, holds supervisors accountable for the quality of the work, and holds managers and executives responsible for performance results and for taking corrective actions. The connection between performance measures and employee accountability contributes to the Agency leadership decision making on how and when to adjust targets or to take corrective actions to address obstacles that could prevent achieving the desired results.

HHS FY 2011 Quarterly Performance Review - The IHS participated in the quarterly performance review process started by HHS in FY 2011. The reviews included quarterly reporting and at least one face-to-face meeting annually to provide an opportunity for Agency leaders and HHS leaders to discuss performance around priorities drawn from the Agency's internal key performance goals that link to the goals and objectives in the HHS Strategic Plan. In addition, the IHS Director provides monthly reports to the HHS Secretary, which includes progress on the agency priorities.

As part of the HHS quarterly review process, the IHS reported on three performance goals 1) to implement three recommendations from tribes to improve the tribal consultation process each year; 2) to increase the percentage of Indian health program facilities that are eligible for participation in the National Health Service Corps (NHSC) by 10 percent in FY 2011; and 3) to decrease the average hiring time by 30 days each year for the next two years from the 140-day average to reach the Office of Personnel Management goal of 80 days within two years. Before the HHS quarterly review, IHS leadership internally discussed the quarterly progress in reaching targets for each performance goal as well as any challenges that face the agency in reaching the targets and how the agency will manage them. All three of these measures were included in the FY 2011 Agency performance plan and two of the three measures (tribal consultation and depression screening) are HHS Strategic Plan performance measures.

Leadership focus on the three quarterly performance goals produced notable accomplishments in FY 2011. At the end of December 2011, the IHS had implemented seven recommendations from tribes to improve the tribal consultation process and four of the seven were implemented in FY 2011. The IHS and the Health Resources and Services Administration worked collaboratively to pre-approve all Indian health system sites for participation in the NHSC, a result that far exceeded the 10 percent increase target. Site eligibility places Indian health program facilities on the lists of pre-qualified facilities for NHSC placements sent to NHSC loan repayment and scholarship recipients. The collaborative work resulted in approval of 490 IHS, Tribal, and urban Indian health programs for placement of the NHSC health care providers, and the number of placements has increased to 221 providers in FY 2011. To improve hiring time, the IHS has made available Agency-wide, standardized positions descriptions in nine different job series that the Agency recruits for and has improved the effectiveness of the on-line application process by proscribing complete applications through a Special General Memorandum issued by the Director. The IHS reduced its average overall hiring time from 140 days to 81 days by the end of FY 2011.

Performance Measures and Analysis

HHS Performance Plan Measures. The IHS has six performance measures approved by HHS for inclusion within the HHS Performance Plan for FY 2013. The measures and their FY 2013 targets are: 1) 100 percent of hospitals and outpatient clinics operated by the IHS maintain accreditation; 2) 30.2 percent of American Indian and Alaska Native patients with diagnosed diabetes achieve ideal glycemic control 3) 51.9 percent of adults 18 and older are screened for depression in IHS-funded clinical facilities; 4) to implement at least three recommendations from tribes annually to improve the tribal consultation process; 5) 33.2 percent of American Indian and Alaska Native patients, 22 years and older, with Coronary Heart Disease are assessed for five cardiovascular disease risk factors; and 6) American Indian and Alaska Native patients, aged 19-35 months, receive childhood immunizations. These measures are included in the set of measures within the HHS Performance Plan to meet the formal reporting requirements for the GPRA. All of the measures align to the HHS Strategic Plan for Fiscal Years 2010-2015.

Agency Performance Accomplishments

Historically, the IHS has succeeded in substantially improving the health status of the AI/AN population, primarily by focusing on preventive and primary care services and developing a community-based public health system. However, the AI/AN population still suffers disproportionately from a number of economic and health problems including alcohol abuse, cervical cancer and diabetes.

Despite complex, ongoing challenges, the agency has made significant progress on some important indicators of health and clinical care. End stage renal disease or diabetic kidney disease is a significant and growing problem in Indian communities. Early identification of at-risk patients with diabetes may help prevent or delay the need for costly care such as dialysis or renal transplant. Nephropathy (kidney disease) assessment is therefore an essential component of care for patients with diabetes. The agency has been measuring nephropathy assessment rates since it began reporting Government Performance and Results Act rates in FY 2002.
The nephropathy assessment rate increased from 35 percent to 55 percent between FY 2002 and FY 2006, and after the new, more stringent standards of care were adopted, reached 56.5 percent in FY 2011. Such efforts support the President's stated goals of investing in prevention, wellness, and improving the quality of care.

Significant progress was also made in improving the pneumococcal vaccination rate for non-institutionalized adults over 65 years of age from 64 percent in FY 2002 to 85.5 percent in FY 2011. The improvement and maintenance of pneumococcal vaccination rates is important because studies have shown that AI/AN people are at high risk for this disease; the 2004-2006 AI/AN death rate from pneumonia and influenza was 1.3 times greater than the 2005 U.S. all-races death rate. Pneumococcal vaccination is a low-cost medical intervention that has been shown to prevent serious health complications among the elderly. This effort supports the President's stated goals of investing in prevention, wellness, and improving the quality of care.

This approach demonstrates our commitment to targeting measures via performance management. One concern is that certain screening rates (e.g., behavioral health assessments done in the primary care setting) may be easier to improve, compared to cost-intensive health interventions requiring medications and follow-up care. It is worth noting that the Agency's leadership is targeting all clinical measures in the Agency performance plan. Furthermore, there are a number of additional factors that make the achievement of the proposed performance targets in the Agency performance plan challenging. These include:

- High vacancy rates for many provider groups may have significant negative impacts on the ability to achieve performance targets as well as impacting patient access to care;
- The continued growth in the prevalence and incidence of diabetes in the AI/AN population and its associated co-morbidities and costs greatly impact the resources available for care; and,
- Incidental improvements in data collection that have previously contributed to annual performance improvements are now reaching a plateau, as providers are now familiar with screening requirements and data capture improvements have improved.

In light of these issues, the proposed performance targets in the budget request are ambitious, but given the Agency's mission and priorities, are essential to continue needed improvements.

The IHS remains committed to improving efficiency and effectiveness through the appropriate use of technology and sharing of best practices. The Clinical Reporting System (CRS) software provides the capability for local programs to identify patients requiring preventive screenings and/or care for a chronic condition. The nationally deployed Integrated Care (iCare) application, a more sophisticated case and population management tool, is also used by local programs to track patient care. There is active networking to share information and material on successful programs, as well as technical assistance to identify ways to improve clinical business processes. The IHS hosts "best practices" conferences and WebEx presentations which offer training opportunities to providers and serve to integrate medical standards of care with improved agency performance.

IHS performance improvement requires a concerted effort by all members of the Indian health system. This includes all clinic-based, hospital-based and community-based programs, as well as federal, tribal, and urban programs, working together to improve agency performance on the comprehensive set of existing performance measures. The IHS will continue to strive for success, and selectively evaluate interventions/methods to achieve additional outcomes and productivity gains to address the persistent health disparities facing the AI/AN population.

FY 2013 Budget by HHS Strategic Goal

(Dollars in Thousands)

INDIAN HEALTH SERVICE

HHS Strategic Goals	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request
1. Strengthen Health Care	**$3,669,469**	**$3,878,531**	**$3,962,552**
1.A Make coverage more secure for those who have insurance and extend affordable coverage to the uninsured.			
1.B Improve health care quality and patient safety.	$963,424	$984,244	$987,797
1.C Emphasize primary & preventative care linked with community prevention.			
1.D Reduce growth of health care costs while promoting high-value, effective care.			
1.E Ensure access to quality, culturally competent care for vulnerable populations.	$2,706,045	$2,894,287	$2,974,755
1.F Promote the adoption and meaningful use of health information technology.			
2. Advance Scientific Knowledge and Innovation			
2.A Accelerate the process of scientific discovery to improve patient care.			
2.B Foster innovation at HHS to create shared solutions.			
2.C Invest in the regulatory sciences to improve food & medical product safety.			
2.D Increase our understanding of what works in public health and human services.			
3. Advance the Health, Safety and Well-Being of the American People	**$1,320,279**	**$1,356,777**	**$1,377,616**
3.A Promote the safety, well-being, resilience, and healthy development of children and youth.			
3.B Promote economic & social well-being for individuals, families and communities.	$95,665	$79,582	$79,582
3.C Improve the accessibility and quality of supportive services for people with disabilities and older adults.			
3.D Promote prevention and wellness.	$940,588	$980,804	$997,131
3.E Reduce the occurrence of infectious diseases.	$283,682	$296,032	$300,538
3.F Protect Americans' health and safety during emergencies, and foster resilience in response to emergencies.	$343	$358	$364
4. Increase Efficiency, Transparency and Accountability of HHS Programs	**$13,533**	**$4,703**	**$14,059**
4.A Ensure program integrity and responsible stewardship of resources			
4.B Fight fraud and work to eliminate improper payments.			
4.C Use HHS data to improve American health and well-being of the American people.			
4.D Improve HHS environmental, energy, and economic performance to promote sustainability.	$13,533	$4,703	$14,059
5. Strengthen the Nation's Health and Human Service Infrastructure and Workforce	**$136,954**	**$145,733**	**$147,467**
5.A Invest in HHS workforce to meet America's health and human service needs today & tomorrow.			
5. B Ensure that the Nation's healthcare workforce meets increased demands.	$132,268	$141,055	$142,788
5.C Enhance the ability of the public health workforce to improve health at home and abroad.			
5.D Strengthen the Nation's human service workforce.			
5.E Improve national, State & local surveillance and epidemiology capacity.	$4,686	$4,679	$4,679
TOTAL	**$5,140,234**	**$5,385,744**	**$5,501,693**

Discretionary All Purpose Table
Indian Health Service
(Dollars in Thousands)

Jan 24, 2012

Program	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request
SERVICES			
Hospitals & Health Clinics	1,762,865	1,810,966	1,849,310
Dental Services	152,634	159,440	166,297
Mental Health	72,786	75,589	78,131
Alcohol & Substance Abuse	194,409	194,297	195,378
Contract Health Services	779,927	843,575	897,562
Total, Clinical Services	2,962,621	3,083,867	3,186,678
Public Health Nursing	63,943	66,632	69,868
Health Education	16,649	17,057	17,450
Community Health Reps.	61,505	61,407	61,531
Immunization AK	1,930	1,927	1,927
Total, Preventive Health	144,027	147,023	150,776
Urban Health	43,053	42,984	42,988
Indian Health Professions	40,661	40,596	40,598
Tribal Management Grants	2,581	2,577	2,577
Direct Operations	68,583	71,653	72,867
Self-Governance	6,054	6,044	6,044
Contract Support Costs	397,693	471,437	476,446
Total, Other Services	558,625	635,291	641,520
TOTAL, SERVICES	3,665,273	3,866,181	3,978,974
FACILITIES			
Maintenance & Improvement	53,807	53,721	55,470
Sanitation Facilities Construction	95,665	79,582	79,582
Health Care Facilities Construction	39,156	85,048	81,489
Facilities & Environmental Health Support	192,701	199,413	204,379
Equipment	22,618	22,582	22,582
TOTAL, FACILITIES	403,947	440,346	443,502
TOTAL, BUDGET AUTHORITY	**4,069,220**	**4,306,527**	**4,422,476**
COLLECTIONS			
Medicare	196,941	198,848	198,848
Medicaid	636,779	641,863	641,863
Subtotal, M / M	*833,720*	*840,711*	*840,711*
Private Insurance	81,006	81,006	81,006
Total, M / M / PI	*914,726*	*921,717*	*921,717*
Quarters	6,288	7,500	7,500
TOTAL, COLLECTIONS	921,014	929,217	929,217
Special Diabetes Program for Indians	150,000	150,000	150,000
TOTAL, DIABETES	150,000	150,000	150,000
TOTAL, PROGRAM LEVEL	**$5,140,234**	**$5,385,744**	**$5,501,693**

INDIAN HEALTH SERVICE
FY 2013 Budget Request
Detail of Changes
(Dollars in Thousands)

Jan 23 2012

Sub Sub Activity	FY 2011 Enacted	FY 2012 Enacted	Current Svcs: Federal Pay Costs CO	Current Svcs: Med 3.6%	Current Svcs: Staffing for New Facilities	Curr Svcs Subtotal	PROGRAM Expansion: CHS	PROGRAM Expansion: Health IT ICD-10, EDR	PROGRAM Expansion: Direct Opers	PROGRAM Expansion: Contract Support Costs	PROGRAM Expansion: Maint. & Improv.	PROGRAM Expansion: Hlth Care Fac. Constr.	Prog. Expans. Subtotal	FY 2013 Budget Request
SERVICES														
Hospitals & Health Clinics	1,762,865	1,810,966	1,383	0	31,961	33,344	0	5,000	0	0	0	0	5,000	1,849,310
Dental Services	152,634	159,440	268	0	5,589	5,857	0	1,000	0	0	0	0	1,000	166,297
Mental Health	72,786	75,589	29	0	2,513	2,542	0	0	0	0	0	0	0	78,131
Alcohol & Substance Abuse	194,409	194,297	27	0	1,054	1,081	0	0	0	0	0	0	0	195,378
Contract Health Services	779,927	843,575	0	33,987	0	33,987	20,000	0	0	0	0	0	20,000	897,562
Total, Clinical Services	2,962,621	3,083,867	1,707	33,987	41,117	76,811	20,000	6,000	0	0	0	0	26,000	3,186,678
Public Health Nursing	63,943	66,632	84	0	3,152	3,236	0	0	0	0	0	0	0	69,868
Health Education	16,649	17,057	2	0	391	393	0	0	0	0	0	0	0	17,450
Comm. Health Reps	61,505	61,407	4	0	120	124	0	0	0	0	0	0	0	61,531
Immunization AK	1,930	1,927	0	0	0	0	0	0	0	0	0	0	0	1,927
Total, Preventive Health	144,027	147,023	90	0	3,663	3,754	0	0	0	0	0	0	0	150,776
Urban Health	43,053	42,984	4	0	0	4	0	0	0	0	0	0	0	42,988
Indian Health Professions	40,661	40,596	2	0	0	2	0	0	0	0	0	0	0	40,598
Tribal Management	2,581	2,577	0	0	0	0	0	0	0	0	0	0	0	2,577
Direct Operations	68,583	71,653	99	0	0	99	0	0	1,115	0	0	0	1,115	72,867
Self-Governance	6,054	6,044	0	0	0	0	0	0	0	0	0	0	0	6,044
Contract Support Cost	397,693	471,437	0	0	0	0	0	0	0	5,009	0	0	5,009	476,446
Total, Other Services	558,625	635,291	105	0	0	105	0	0	1,115	5,009	0	0	6,124	641,520
Total, Services	3,665,273	3,866,181	1,902	33,987	44,780	80,671	20,000	6,000	1,115	5,009	0	0	32,124	3,978,974
FACILITIES														
Maintenance & Improvement	53,807	53,721	0	0	0	0	0	0	0	0	1,749	0	1,749	55,470
Sanitation Facilities Constr.	95,665	79,582	0	0	0	0	0	0	0	0	0	0	0	79,582
Health Care Fac. Constr.	39,156	85,048	0	0	0	0	0	0	0	0	0	(3,559)	(3,559)	81,489
Facil. & Envir. Hlth Supp.	192,701	199,413	510	0	4,456	4,966	0	0	0	0	0	0	0	204,379
Equipment	22,618	22,582	0	0	0	0	0	0	0	0	0	0	0	22,582
Total, Facilities	403,947	440,346	510	0	4,456	4,966	0	0	0	0	1,749	(3,559)	(1,810)	443,502
TOTAL, IHS	4,069,220	4,306,527	2,412	33,987	49,236	85,637	20,000	6,000	1,115	5,009	1,749	(3,559)	30,314	4,422,476

Statement of Personnel Resources
INDIAN HEALTH SERVICE

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request
Direct:			
Hospitals & Health Clinics	6,265	6,358	6,455
Dental Health	692	697	704
Mental Health	219	223	225
Alcohol & Substance Abuse	178	178	178
Contract Health Services	0	0	0
Total, Clinical Services	7,354	7,456	7,562
Public Health Nursing	253	256	261
Health Education	27	29	30
Community Health Reps	7	7	7
Immunization, AK	0	0	0
Total, Preventive Health	287	292	298
Urban Health	5	5	5
Indian Health Professions	21	21	21
Tribal Management	0	0	0
Direct Operations	312	324	343
Self Governance	12	12	12
Contract Support Costs	0	0	0
Total, SERVICES	7,991	8,110	8,241
Maint. & Improvement	0	0	0
Sanitation Facilities	136	136	136
Hlth Care Facs Construction	0	0	0
Facil. & Envir. Hlth Support	1,029	1,039	1,044
Equipment	0	0	0
Total, FACILITIES	1,165	1,175	1,180
Total, Direct FTE	9,156	9,285	9,421
Reimbursable:			
Buybacks	1,743	1,743	1,743
Medicare	738	738	738
Medicaid	3,308	3,308	3,308
Private Insurance	515	515	515
Quarters	25	25	25
Total, Reimbursable FTE	6,329	6,329	6,329
Trust Funds (Gift)	23	23	23
Health Reform non -add:	0	0	0
TOTAL FTE	**15,508**	**15,637**	**15,773**
Total, Civilian FTE	**13,744**	**13,539**	**13,670**
Total, Military FTE	**2,061**	**2,098**	**2,103**

Indian Health Service

Breakdown of Program Level

(Dollars in Thousands)

Jan 11, 2012

Sub Sub Activity	2011 Enacted Budget Authority	Private Insurance Collections	Medicare/ Medicaid	Personnel Quarters	Total Program Level	2012 Enacted Budget Authority	Private Insurance Collections	Medicare/ Medicaid	Personnel Quarters	Total Program Level
SERVICES:										
Hospitals & Health Clinics	1,762,865	81,006	833,720 [2/]	0	2,677,591	1,810,966	81,006	840,711 [2/]	0	2,732,683
Dental Health	152,634	0	0	0	152,634	159,440	0	0	0	159,440
Mental Health	72,786	0	0	0	72,786	75,589	0	0	0	75,589
Alcohol & Substance Abuse	194,409	0	0	0	194,409	194,297	0	0	0	194,297
Contract Health Services	779,927	0	0		779,927	843,575	0	0	0	843,575
Total, Clinical Services	2,962,621	81,006	833,720	0	3,877,347	3,083,867	81,006	840,711	0	4,005,584
Public Health Nursing	63,943	0	0	0	63,943	66,632	0	0	0	66,632
Health Education	16,649	0	0	0	16,649	17,057	0	0	0	17,057
Comm. Health Reps.	61,505	0	0	0	61,505	61,407	0	0	0	61,407
Immunization AK	1,930	0	0	0	1,930	1,927	0	0	0	1,927
Total, Preventive Health	144,027	0	0	0	144,027	147,023	0	0	0	147,023
Urban Health	43,053	0	0	0	43,053	42,984	0	0	0	42,984
Indian Health Professions	40,661	0	0	0	40,661	40,596	0	0	0	40,596
Tribal Management	2,581	0	0	0	2,581	2,577	0	0	0	2,577
Direct Operations	68,583	0	0	0	68,583	71,653	0	0	0	71,653
Self-Governance	6,054	0	0	0	6,054	6,044	0	0	0	6,044
Contract Support Costs	397,693	0	0	0	397,693	471,437	0	0	0	471,437
Total, Other Services	558,625	0	0	0	558,625	635,291	0	0	0	635,291
TOTAL, SERVICES	3,665,273	81,006	833,720	0	4,579,999	3,866,181	81,006	840,711	0	4,787,898
FACILITIES:										
Maintenance & Improvement	53,807	0	0	6,288	60,095	53,721	0	0	7,500	61,221
Sanitation Facilities Construction	95,665	0	0	0	95,665	79,582	0	0	0	79,582
Health Care Facs. Constr.	39,156	0	0	0	39,156	85,048	0	0	0	85,048
Facil. & Envir. Health Support	192,701	0	0	0	192,701	199,413	0	0	0	199,413
Equipment	22,618	0	0	0	22,618	22,582	0	0	0	22,582
TOTAL, FACILITIES	403,947	0	0	6,288	410,235	440,346	0	0	7,500	447,846
TOTAL, IHS	4,069,220	81,006	833,720	6,288	4,990,234	4,306,527	81,006	840,711	7,500	5,235,744
Special Diabetes Program for Indians [1/]	150,000	0	0	0	150,000	150,000	0	0	0	150,000
GRAND TOTAL	4,219,220	81,006	833,720	6,288	5,140,234	4,456,527	81,006	840,711	7,500	5,385,744

[1/] The Special Diabetes Program for Indians is reauthorized for a total of $150,000,000 in FY 2011 and FY 2012.

[2/] Includes $29,203,000 in Medicaid/Medicare for CMS estimates of tribal collections as well as $181,277,000 in FY 2011 and FY 2012 for tribal direct collection estimates, which began in FY 2002.

Indian Health Service

Breakdown of Program Level

(Dollars in Thousands)

Jan 11, 2012

Sub Sub Activity	2013 Request: Budget Authority	2013 Request: Private Insurance Collections	2013 Request: Medicare/ Medicaid	2013 Request: Personnel Quarters	2013 Request: Total Program Level	Increase/Decrease of 2013 Over 2012: Budget Authority	Increase/Decrease of 2013 Over 2012: Private Insurance Collections	Increase/Decrease of 2013 Over 2012: Medicare/ Medicaid	Increase/Decrease of 2013 Over 2012: Personnel Quarters	Increase/Decrease of 2013 Over 2012: Total Program Level
SERVICES:										
Hospitals & Health Clinics	1,849,310	81,006	840,711 [2/]	0	2,771,027	38,344	0	0	0	38,344
Dental Health	166,297	0	0	0	166,297	6,857	0	0	0	6,857
Mental Health	78,131	0	0	0	78,131	2,542	0	0	0	2,542
Alcohol & Substance Abuse	195,378	0	0	0	195,378	1,081	0	0	0	1,081
Contract Health Services	897,562	0	0	0	897,562	53,987	0	0	0	53,987
Total, Clinical Services	3,186,678	81,006	840,711	0	4,108,395	102,811	0	0	0	102,811
Public Health Nursing	69,868	0	0	0	69,868	3,236	0	0	0	3,236
Health Education	17,450	0	0	0	17,450	393	0	0	0	393
Comm. Health Reps.	61,531	0	0	0	61,531	124	0	0	0	124
Immunization AK	1,927	0	0	0	1,927	0	0	0	0	0
Total, Preventive Health	150,776	0	0	0	150,776	3,753	0	0	0	3,753
Urban Health	42,988	0	0	0	42,988	4	0	0	0	4
Indian Health Professions	40,598	0	0	0	40,598	2	0	0	0	2
Tribal Management	2,577	0	0	0	2,577	0	0	0	0	0
Direct Operations	72,867	0	0	0	72,867	1,214	0	0	0	1,214
Self-Governance	6,044	0	0	0	6,044	0	0	0	0	0
Contract Support Costs	476,446	0	0	0	476,446	5,009	0	0	0	5,009
TOTAL, SERVICES	3,978,974	81,006	840,711	0	4,900,691	112,793	0	0	0	112,793
FACILITIES:										
Maintenance & Improvement	55,470	0	0	7,500	62,970	1,749	0	0	0	1,749
Sanitation Facilities Construction	79,582	0	0	0	79,582	0	0	0	0	0
Health Care Facs. Constr.	81,489	0	0	0	81,489	(3,559)	0	0	0	(3,559)
Facil. & Envir. Health Support	204,379	0	0	0	204,379	4,966	0	0	0	4,966
Equipment	22,582	0	0	0	22,582	0	0	0	0	0
TOTAL, FACILITIES	443,502	0	0	7,500	451,002	3,156	0	0	0	3,156
TOTAL, IHS	4,422,476	81,006	840,711	7,500	5,351,693	115,949	0	0	0	115,949
Special Diabetes Program for Indians [1/]	150,000	0	0	0	150,000	0	0	0	0	0
GRAND TOTAL	4,572,476	81,006	840,711	7,500	5,501,693	115,949	0	0	0	115,949

[1/] The Special Diabetes Program for Indians authorization is set to expire in FY 2013.

[2/] Includes $29,203,000 in Medicaid/Medicare for CMS estimates of tribal collections as well as $181,277,000 for tribal direct collection estimates, which began in FY 2002.

INDIAN HEALTH SERVICE

STAFFING AND OPERATING COSTS FOR NEW / EXPANDED FACILITIES -- Estimates

FY 2013 Request

(Dollars in Thousands)

	Ardmore, OK Chickasaw Nation Health Clinic Joint Venture (Part II)		Vinita, OK Cherokee Nation Health Center Joint Venture (Part II)		Tishomingo, OK Chickasaw Nation Health Clinic Joint Venture		Wasilla, AK Southcentral Foundation Valley Primary Care Ctr Joint Venture		Fairbanks, AK Tanana Chief Conference Interior Health Center Joint Venture		Nome, AK Norton Sound Regional Hospital (Replacement)		TOTAL	
Opening Date (cal. yr):	Oct 2012		Oct 2012		Feb 2013		Oct 2012		Dec 2012		Oct 2012			
Percent Funded incl this request:	100%		100%		67%		50%		35%		50%			
Sub Sub Activity	Pos	Amount	Pos	Amount	Pos	Amount	Pos	Amount	Pos	Amount	Pos	Amount	Pos	AMOUNT
Hospitals & Health Clinics	55	$5,388	17	$1,638	32	$3,181	62	$8,631	40	$5,517	59	$7,606	265	$31,961
Dental Health	12	$1,143	5	$508	5	$513	13	$1,593	7	$882	8	$950	50	$5,589
Mental Health	6	$559	1	$94	4	$376	7	$841	3	$343	3	$300	24	$2,513
Alcohol & Substance Abuse	3	$273	1	$91	2	$183	3	$285	1	$126	1	$96	11	$1,054
Total, Clinical Services	76	$7,363	24	$2,331	43	$4,253	85	$11,350	51	$6,868	71	$8,952	350	$41,117
Public Health Nursing	6	$720	1	$121	4	$486	7	$969	2	$356	4	$500	24	$3,152
Health Education	1	$91	0	$0	1	$61	1	$114	1	$77	1	$48	5	$391
Comm. Health Representatives	0	$0	2	$120	0	$0	0	$0	0	$0	0	$0	2	$120
Total, Preventive Health	7	$811	3	$241	5	$547	8	$1,083	3	$433	5	$548	31	$3,663
Total, Services	83	$8,174	27	$2,572	48	$4,800	93	$12,433	54	$7,301	76	$9,500	381	$44,780
Facilities Support	4	$774	1	$220	3	$541	4	$1,029	2	$582	3	$855	17	$4,001
Environmental Health Support									1	$191	2	$264	3	$455
Total, FEHS	4	$774	1	$220	3	$541	4	$1,029	3	$773	5	$1,119	20	$4,456
Total, Facilities	4	$774	1	$220	3	$541	4	$1,029	3	$773	5	$1,119	20	$4,456
Grand Total [1]	**87**	**$8,948**	**28**	**$2,792**	**51**	**$5,341**	**97**	**$13,462**	**57**	**$8,074**	**81**	**$10,619**	**401**	**$49,236**

[1] Includes utilities

FY 2011 Crosswalk
Budget Authority
Enacted Distribution
(Dollars in Thousands)

Sub Activity	Federal Health Administration								Tribal Health Administration								FY 2011 Enacted
	Clinical Services	Urban Health	Preventive Health	Indian Health Professions	Federal Administration	Self-Governance	Facilities	TOTAL Federal Health Admini-stration	Clinical Services	Preventive Health	Urban Health	Management Training	Self-Governance	Contract Support	Facilities	TOTAL Tribal Health Admini-stration	
SERVICES																	
Hospitals & Health Clinics	838,498	0	0	0	0	0	0	838,498	924,367	0	0	0	0	0	0	924,367	1,762,865
Dental Health	79,485	0	0	0	0	0	0	79,485	73,149	0	0	0	0	0	0	73,149	152,634
Mental Health	30,106	0	0	0	0	0	0	30,106	42,680	0	0	0	0	0	0	42,680	72,786
Alcohol & Substance Abuse	29,529	0	0	0	0	0	0	29,529	164,880	0	0	0	0	0	0	164,880	194,409
Contract Health Services	372,786	0	0	0	0	0	0	372,786	407,141	0	0	0	0	0	0	407,141	779,927
Subtotal (CS)	1,350,404	0	0	0	0	0	0	1,350,404	1,612,217	0	0	0	0	0	0	1,612,217	2,962,621
Public Health Nursing	0	0	32,092	0	0	0	0	32,092	0	31,851	0	0	0	0	0	31,851	63,943
Health Education	0	0	4,232	0	0	0	0	4,232	0	12,417	0	0	0	0	0	12,417	16,649
Community Health Repr.	0	0	1,477	0	0	0	0	1,477	0	60,028	0	0	0	0	0	60,028	61,505
Immunization AK	0	0	0	0	0	0	0	0	0	1,930	0	0	0	0	0	1,930	1,930
Subtotal (PH)	0	0	37,801	0	0	0	0	37,801	0	106,226	0	0	0	0	0	106,226	144,027
Urban Health Project	0	15,828	0	0	0	0	0	15,828	0	0	27,225	0	0	0	0	27,225	43,053
Indian Health Professions	0	0	0	40,661	0	0	0	40,661	0	0	0	0	0	0	0	0	40,661
Tribal Management	0	0	0	191	0	0	0	191	0	0	0	2,390	0	0	0	2,390	2,581
Direct Operations	0	0	0	0	50,359	0	0	50,359	0	0	0	18,224	0	0	0	18,224	68,583
Self-Governance	0	0	0	0	0	3,228	0	3,228	0	0	0	0	2,826	0	0	2,826	6,054
Contract Support Costs	0	0	0	0	0	0	0	0	0	0	0	0	0	397,693	0	397,693	397,693
Subtotal (OS)	0	15,828	0	40,852	50,359	3,228	0	110,267	0	0	27,225	20,614	2,826	397,693	0	448,358	558,625
Total, Services	1,350,404	15,828	37,801	40,852	50,359	3,228	0	1,498,472	1,612,217	106,226	27,225	20,614	2,826	397,693	0	2,166,801	3,665,273
FACILITIES																	
Maintenance & Improvement	0	0	0	0	0	0	18,992	18,992	0	0	0	0	0	0	34,815	34,815	53,807
Sanitation Facilities Constr.	0	0	0	0	0	0	33,483	33,483	0	0	0	0	0	0	62,182	62,182	95,665
Health Care Facs. Constr.	0	0	0	0	0	0	3,000	3,000	0	0	0	0	0	0	36,156	36,156	39,156
Facs. & Env. Health Sup	0	0	0	0	0	0	129,076	129,076	0	0	0	0	0	0	63,625	63,625	192,701
Equipment	0	0	0	0	0	0	5,893	5,893	0	0	0	0	0	0	16,725	16,725	22,618
Total, Facilities	0	0	0	0	0	0	190,445	190,444	0	0	0	0	0	0	213,503	213,503	403,947
TOTAL, IHS	1,350,404	15,828	37,801	40,852	50,359	3,228	190,445	1,688,916	1,612,217	106,226	27,225	20,614	2,826	397,693	213,503	2,380,304	4,069,220

FY 2012 Crosswalk
Budget Authority
Enacted Distribution
(Dollars in Thousands)

Sub Activity	Federal Health Administration								Tribal Health Administration								FY 2012 Enacted
	Clinical Services	Urban Health	Preventive Health	Indian Health Professions	Federal Administration	Self-Governance	Facilities	TOTAL Federal Health Admini-stration	Clinical Services	Preventive Health	Urban Health	Management Training	Self-Governance	Contract Support	Facilities	TOTAL Tribal Health Admini-stration	
SERVICES																	
Hospitals & Health Clinics	839,594	0	0	0	0	0	0	839,594	971,372	0	0	0	0	0	0	971,372	1,810,966
Dental Health	79,229	0	0	0	0	0	0	79,229	80,211	0	0	0	0	0	0	80,211	159,440
Mental Health	29,985	0	0	0	0	0	0	29,985	45,604	0	0	0	0	0	0	45,604	75,589
Alcohol & Substance Abuse	29,218	0	0	0	0	0	0	29,218	165,079	0	0	0	0	0	0	165,079	194,297
Contract Health Services	402,504	0	0	0	0	0	0	402,504	441,071	0	0	0	0	0	0	441,071	843,575
Subtotal (CS)	1,380,530	0	0	0	0	0	0	1,380,530	1,703,337	0	0	0	0	0	0	1,703,337	3,083,867
Public Health Nursing	0	0	31,985	0	0	0	0	31,985	0	34,647	0	0	0	0	0	34,647	66,632
Health Education	0	0	4,205	0	0	0	0	4,205	0	12,852	0	0	0	0	0	12,852	17,057
Community Health Repr.	0	0	1,379	0	0	0	0	1,379	0	60,028	0	0	0	0	0	60,028	61,407
Immunization AK	0	0	(3)	0	0	0	0	(3)	0	1,930	0	0	0	0	0	1,930	1,927
Subtotal (PH)	0	0	37,566	0	0	0	0	37,566	0	109,457	0	0	0	0	0	109,457	147,023
Urban Health Project	0	15,759	0	0	0	0	0	15,759	0	0	27,225	0	0	0	0	27,225	42,984
Indian Health Professions	0	0	0	40,596	0	0	0	40,596	0	0	0	0	0	0	0	0	40,596
Tribal Management	0	0	0	187	0	0	0	187	0	0	0	2,390	0	0	0	2,390	2,577
Direct Operations	0	0	0	0	52,582	0	0	52,582	0	0	0	19,071	0	0	0	19,071	71,653
Self-Governance	0	0	0	0	0	3,218	0	3,218	0	0	0	0	2,826	0	0	2,826	6,044
Contract Support Costs	0	0	0	0	0	0	0	0	0	0	0	0	0	471,437	0	471,437	471,437
Subtotal (OS)	0	15,759	0	40,783	52,582	3,218	0	112,342	0	0	27,225	21,461	2,826	471,437	0	522,949	635,291
Total, Services	1,380,530	15,759	37,566	40,783	52,582	3,218	0	1,530,438	1,703,337	109,457	27,225	21,461	2,826	471,437	0	2,335,743	3,866,181
FACILITIES																	
Maintenance & Improvement	0	0	0	0	0	0	18,906	18,906	0	0	0	0	0	0	34,815	34,815	53,721
Sanitation Facilities Constr.	0	0	0	0	0	0	27,854	27,854	0	0	0	0	0	0	51,728	51,728	79,582
Health Care Facs. Constr.	0	0	0	0	0	0	12,979	12,979	0	0	0	0	0	0	72,069	72,069	85,048
Facs. & Env. Health Sup	0	0	0	0	0	0	113,567	113,567	0	0	0	0	0	0	85,846	85,846	199,413
Equipment	0	0	0	0	0	0	5,857	5,857	0	0	0	0	0	0	16,725	16,725	22,582
Total, Facilities	0	0	0	0	0	0	179,164	179,163	0	0	0	0	0	0	261,184	261,184	440,346
TOTAL, IHS	1,380,530	15,759	37,566	40,783	52,582	3,218	179,164	1,709,601	1,703,337	109,457	27,225	21,461	2,826	471,437	261,184	2,596,927	4,306,527

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

Sub Activity	Federal Health Administration: Clinical Services	Urban Health	Preventive Health	Indian Health Professions	Federal Administration	Self-Governance	Facilities	TOTAL Federal Health Administration	Tribal Health Administration: Clinical Services	Preventive Health	Urban Health	Management Training	Self-Governance	Contract Support	Facilities	TOTAL Tribal Health Administration	FY 2013 Estimate
SERVICES																	
Hospitals & Health Clinics	843,357	0	0	0	0	0	0	843,357	1,005,953	0	0	0	0	0	0	1,005,953	1,849,310
Dental Health	80,018	0	0	0	0	0	0	80,018	86,279	0	0	0	0	0	0	86,279	166,297
Mental Health	30,014	0	0	0	0	0	0	30,014	48,117	0	0	0	0	0	0	48,117	78,131
Alcohol & Substance Abuse	29,245	0	0	0	0	0	0	29,245	166,133	0	0	0	0	0	0	166,133	195,378
Contract Health Services	428,310	0	0	0	0	0	0	428,310	469,252	0	0	0	0	0	0	469,252	897,562
Subtotal (CS)	1,410,944	0	0	0	0	0	0	1,410,944	1,775,734	0	0	0	0	0	0	1,775,734	3,186,678
Public Health Nursing	0	0	32,069	0	0	0	0	32,069	0	37,799	0	0	0	0	0	37,799	69,868
Health Education	0	0	4,207	0	0	0	0	4,207	0	13,243	0	0	0	0	0	13,243	17,450
Community Health Repr.	0	0	1,383	0	0	0	0	1,383	0	60,148	0	0	0	0	0	60,148	61,531
Immunization AK	0	0	(3)	0	0	0	0	(3)	0	1,930	0	0	0	0	0	1,930	1,927
Subtotal (PH)	0	0	37,656	0	0	0	0	37,656	0	113,120	0	0	0	0	0	113,120	150,776
Urban Health Project	0	15,763	0	0	0	0	0	15,763	0	0	27,225	0	0	0	0	27,225	42,988
Indian Health Professions	0	0	0	40,598	0	0	0	40,598	0	0	0	0	0	0	0	0	40,598
Tribal Management	0	0	0	187	0	0	0	187	0	0	0	2,390	0	0	0	2,390	2,577
Direct Operations	0	0	0	0	53,499	0	0	53,499	0	0	0	19,368	0	0	0	19,368	72,867
Self-Governance	0	0	0	0	0	3,218	0	3,218	0	0	0	0	2,826	0	0	2,826	6,044
Contract Support Costs	0	0	0	0	0	0	0	0	0	0	0	0	0	476,446	0	476,446	476,446
Subtotal (OS)	0	15,763	0	40,785	53,499	3,218	0	113,265	0	0	27,225	21,758	2,826	476,446	0	528,255	641,520
Total, Services	1,410,944	15,763	37,656	40,785	53,499	3,218	0	1,561,865	1,775,734	113,120	27,225	21,758	2,826	476,446	0	2,417,109	3,978,974
FACILITIES																	
Maintenance & Improvement	0	0	0	0	0	0	19,523	19,523	0	0	0	0	0	0	35,947	35,947	55,470
Sanitation Facilities Constr.	0	0	0	0	0	0	27,854	27,854	0	0	0	0	0	0	51,728	51,728	79,582
Health Care Facs. Constr.	0	0	0	0	0	0	40,000	40,000	0	0	0	0	0	0	41,489	41,489	81,489
Facs. & Env. Health Sup	0	0	0	0	0	0	114,077	114,077	0	0	0	0	0	0	90,302	90,302	204,379
Equipment	0	0	0	0	0	0	5,857	5,857	0	0	0	0	0	0	16,725	16,725	22,582
Total, Facilities	0	0	0	0	0	0	207,312	207,311	0	0	0	0	0	0	236,192	236,192	443,502
TOTAL, IHS	1,410,944	15,763	37,656	40,785	53,499	3,218	207,312	1,769,176	1,775,734	113,120	27,225	21,758	2,826	476,446	236,192	2,653,301	4,422,476

INDIAN HEALTH SERVICE

Federal Funds

General and Special Funds:

Indian Health Service

For expenses necessary to carry out the Act of August 5, 1954 (68 Stat. 674), the Indian Self-Determination 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, [$3,872,377,000,] *$3,978,974,000*, 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 [$844,927,000] *$897,562,000* for contract medical care, including $51,500,000 for the Indian Catastrophic Health Emergency Fund, shall remain available until expended: *Provided further*, That of the funding provided for information technology activities and, notwithstanding any other provision of law, $4,000,000 shall be allocated at the discretion of the Director of the Indian Health Service: *Provided further*, That of the funds provided, up to $36,000,000 shall remain available until expended for implementation of the loan repayment program under section 108 of the Indian Health Care Improvement Act: *Provided further*, That the amounts collected by the Federal Government as authorized by section 104 and 108 of the Indian Health Care Improvement Act (25 U.S.C. 1613a and 1616a) during the preceding fiscal year for breach of contracts shall be deposited to the Fund authorized by section 108A of the Act (25 U.S.C. 1616a-1) and shall remain available until expended and, notwithstanding section 108(c) of the Act (25 U.S.C. 1616a-1(c)), funds shall be available to make new awards under the loan repayment and scholarship programs under sections 104 and 108 of the Act (25 U.S.C. 1613a and 1616a): *Provided further*, That notwithstanding any other provision of law, the amounts made available within this account for the methamphetamine and suicide prevention and treatment initiative and for the domestic violence prevention initiative shall be allocated at the discretion of the Director of the Indian Health Service and shall remain available until expended: *Provided further*, That funds provided in this Act may be used for annual contracts and grants that fall within 2 fiscal years, provided the total obligation is recorded in the year the funds are appropriated: *Provided further*, That the amounts collected by the Secretary of Health and Human Services under the authority of title IV of the Indian Health Care Improvement Act shall remain available until expended for the purpose of achieving compliance

with the applicable conditions and requirements of titles XVIII and XIX of the Social Security Act, except for those related to the planning, design, or construction of new facilities: *Provided further*, That funding contained herein for scholarship programs under the Indian Health Care Improvement Act (25 U.S.C. 1613) shall remain available until expended: *Provided further*, That amounts received by tribes and tribal organizations under title IV of the Indian Health Care Improvement Act shall be reported and accounted for and available to the receiving tribes and tribal organizations until expended: *Provided further*, That, notwithstanding any other provision of law, of the amounts provided herein, not to exceed [$472,193,000] *$476,446,000* shall be for payments to tribes and tribal organizations for contract or grant support costs associated with contracts, grants, self-governance compacts, or annual funding agreements between the Indian Health Service and a tribe or tribal organization pursuant to the Indian Self-Determination Act of 1975, as amended, prior to or during fiscal year 2012, of which not to exceed $10,000,000 may be used for contract support costs associated with new or expanded self-determination contracts, grants, self-governance compacts, or annual funding agreements: *Provided further*, That the Bureau of Indian Affairs may collect form the Indian Health Service, tribes and tribal organizations operating health facilities pursuant to Public Law 93-638, such individually identifiable health information relating to disabled children as may be necessary for the purpose of carrying out its functions under the Individuals with Disabilities Education Act (20 U.S.C. 1400, et seq.): *Provided further*, That the Indian Health Care Improvement Fund may be used, as needed, to carry out activities typically funded under the Indian Health Facilities account. *(Department of the Interior, Environment, and Related Agencies Appropriations Act, 2012.)*

Indian Health Facilities

For construction, repair, maintenance, improvement, and equipment of health and related auxiliary facilities, including quarters for personnel; preparation of plans, specifications, and drawings; acquisition of sites, purchase and erection of modular buildings, and purchases of trailers; and for provision of domestic and community sanitation facilities for Indians, as authorized by section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a), the Indian Self-Determination Act, and the Indian Health Care Improvement Act, and for expenses necessary to carry out such Acts and titles II and III of the Public Health Service Act with respect to environmental health and facilities support activities of the Indian Health Service, [$441,052,000,] *$443,502,000*, to remain available until expended: *Provided*, That notwithstanding any other provision of law, funds appropriated for the planning, design, construction, renovation or expansion of health facilities for the benefit of an Indian tribe or tribes may be used to purchase land on which such facilities will be located: *Provided further*, That not

to exceed $500,000 shall be used by the Indian Health Service to purchase TRANSAM equipment from the Department of Defense for distribution to the Indian Health Service and tribal facilities: *Provided further*, That none of the funds appropriated to the Indian Health Service may be used for sanitation facilities constructions for new homes funded with grants by the housing programs of the United States Department of Housing and Urban Development: *Provided further*, That not to exceed $2,700,000 from this account and the "Indian Health Services" account shall be used by the Indian Health Service to obtain ambulances for the Indian Health Service and tribal facilities in conjunction with an existing interagency agreement between the Indian Health Service and the General Services Administration: *Provided further*, That not to exceed $500,000 shall be placed in a Demolition Fund, to remain available until expended, and be used by the Indian Health Service for the demolition of Federal buildings. *(Department of the Interior, Environment, and Related Agencies Appropriations Act, 2012.)*

ADMINISTRATIVE PROVISIONS, INDIAN HEALTH SERVICE

Appropriations provided in this Act to the Indian Health Service shall be available for services as authorized by 5 U.S.C. 3109 at rates not to exceed the per diem rate equivalent to the maximum rate payable for senior-level positions under 5 U.S.C. 5376; hire of passenger motor vehicles and aircraft; purchase of medical equipment; purchase of reprints; purchase, renovation and erection of modular buildings and renovation of existing facilities; payments for telephone service in private residences in the field, when authorized under regulations approved by the Secretary; uniforms or allowances therefor as authorized by 5 U.S.C. 5901-5902; and for expenses of attendance at meetings that relate to the functions or activities of the Indian Health Service: *Provided*, That in accordance with the provisions of the Indian Health Care Improvement Act, non-Indian patients may be extended health care at all tribally administered or Indian Health Service facilities, subject to charges, and the proceeds along with funds recovered under the Federal Medical Care Recovery Act (42 U.S.C. 2651-2653) shall be credited to the account of the facility providing the service and shall be available without fiscal year limitation: *Provided further*, That notwithstanding any other law or regulation, funds transferred from the Department of Housing and Urban Development to the Indian Health Service shall be administered under Public Law 86-121, the Indian Sanitation Facilities Act and Public Law 93-638, as amended: *Provided further*, That funds appropriated to the Indian Health Service in this Act, except those used for administrative and program direction purposes, shall not be subject to limitations directed at curtailing Federal travel and transportation: Provided further, That none of the funds made available to the Indian Health Service in this Act shall be used for any assessments or

charges by the Department of Health and Human Services unless identified in the budget justification and provided in this Act, or approved by the House and Senate Committees on Appropriations through the reprogramming process: *Provided further*, That notwithstanding any other provision of law, funds previously or herein made available to a tribe or tribal organization through a contract, grant, or agreement authorized by title I or title V of the Indian Self-Determination and Education Assistance Act of 1975 (25 U.S.C. 450), may be deobligated and reobligated to a self-determination contract under title I, or a self-governance agreement under title V of such Act and thereafter shall remain available to the tribe or tribal organization without fiscal year limitation: *Provided further*, That none of the funds made available to the Indian Health Service in this Act shall be used to implement the final rule published in the Federal Register on September 16, 1987, by the Department of Health and Human Services, relating to the eligibility for the health care services of the Indian Health Service until the Indian Health Service has submitted a budget request reflecting the increased costs associated with the proposed final rule, and such request has been included in an appropriations Act and enacted into law: *Provided further*, That with respect to functions transferred by the Indian Health Service to tribes or tribal organizations, the Indian Health Service is authorized to provide goods and services to those entities on a reimbursable basis, including payments in advance with subsequent adjustment, and the reimbursements received therefrom, along with the funds received from those entities pursuant to the Indian Self-Determination Act, may be credited to the same or subsequent appropriation account from which the funds were originally derived, with such amounts to remain available until expended: *Provided further*, That reimbursements for training, technical assistance, or services provided by the Indian Health Service will contain total costs, including direct, administrative, and overhead associated with the provision of goods, services, or technical assistance: *Provided further*, That the appropriation structure for the Indian Health Service may not be altered without advance notification to the House and Senate Committees on Appropriations.

GENERAL PROVISIONS

SEC. 408. Notwithstanding any other provision of law, amounts appropriated to or otherwise designated in committee reports for the Bureau of Indian Affairs and the Indian Health Service by Public Laws 103-138, 103-332, 104-134, 104-208, 105-83, 105-277, 106-113, 106-291, 107-63, 108-7, 108-108, 108-447, 109-54, 109-289, division B and Continuing Appropriations Resolution, 2007 (division B of Public Law 109-289, as amended by Public Laws 110-5 and 110-28), Public Laws 110-92, 110-116, 110-137, 110-149, 110-161, 110-329, 111-6, 111-8, 111-88, 112-10, 112-74, and _____ for payments for contract support costs associated with self-determination or self-governance contracts, grants, compacts, or annual funding agreements with the Bureau of Indian Affairs or the Indian Health Service as funded by such Acts, are the total amounts available for fiscal years 1994 through **[**2012**]** *2013* for such purposes, except that the Bureau of Indian Affairs, tribes and tribal organizations may use their tribal priority allocations for unmet contract support costs of ongoing contracts, grants, self-governance compacts, or annual funding agreements.

SEC. 435. (a) Notwithstanding any other provision of law and until October 1, 2013, the Indian Health Service may not disburse funds for the provision of health care services pursuant to Public Law 93-638 (25 U.S.C. 450 et seq.) to any Alaska Native village or Alaska Native village corporation that is located within the area served by an Alaska Native regional health entity.

(b) Nothing in this section shall be construed to prohibit the disbursal of funds to any Alaska Native village or Alaska Native village corporation under any contract or compact entered into prior to May 1, 2006, or to prohibit the renewal of any such agreement.

(c) For the purpose of this section, Eastern Aleutian Tribes, Inc., the Council of Athabascan Tribal Governments, and the Native Village of Eyak shall be treated as Alaska Native regional health entities to which funds may be disbursed under this section.

Language Analysis

Language Provision	Explanation
GENERAL PROVISIONS	
SEC. 408. Notwithstanding any other provision of law, amounts appropriated to or otherwise designated in committee reports for the Bureau of Indian Affairs and the Indian Health Service by Public Laws 103-138, 103-332, 104-134, 104-208, 105-83, 105-277, 106-113, 106-291, 107-63, 108-7, 108-108, 108-447, 109-54, 109-289, division B and Continuing Appropriations Resolution, 2007 (division B of Public Law 109-289, as amended by Public Law 110-5 and 110-28), Public Laws 110-92, 110-116, 110-137, 110-149, 110-161, 110-329, 111-6, 111-8, and 111-88, 112-10, 112-74 and _____ for payments for contract support costs associated with self-determination or self-governance contracts, grants, compacts, or annual funding agreements with the Bureau of Indian Affairs or the Indian Health Service as funded by such Acts, are the total amounts available for fiscal years 1994 through **[**2012**]** *2013* for such purposes, except that for the Bureau of Indian Affairs, tribes and tribal organizations may use their tribal priority allocations for unmet contract support costs of ongoing contracts, grants, self-governance compacts or annual funding agreements.	Added to continue provision to limit payments for Contract Support Costs in past years (FY 1994 through 2012) to the funds available in law and accompanying the report language in those years for the Bureau of Indian Affairs and Indian Health Service.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
SERVICES

Amounts Available for Obligations

	FY 2011	FY 2012	FY 2013
General Fund Discretionary Appropriation:			
Appropriation (Interior)	$3,665,273,000	$3,872,377,000	$3,978,974,000
Across-the-board reductions (Interior)	$0	($6,196,000)	$0
Subtotal, Appropriation (Interior)	$3,665,273,000	$3,866,181,000	$3,978,974,000
Subtotal, adjusted appropriation	$3,665,273,000	$3,866,181,000	$3,978,974,000
Mandatory Appropriation:			
Appropriation	$150,000,000	$150,000,000	$150,000,000
Offsetting Collections:			
Federal sources	($366,000,000)	($368,000,000)	($368,000,000)
Non-federal sources	($792,000,000)	($797,000,000)	($797,000,000)
Subtotal	($1,158,000,000)	($1,165,000,000)	($1,165,000,000)
Unobligated Balance, Start of Year	434,000,000	744,000,000	776,000,000
Unobligated Balance End of Year	744,000,000	776,000,000	809,000,000
Total Obligations	$2,197,273,000	$2,669,181,000	$2,780,974,000

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FACILITIES

Amounts Available for Obligations

	FY 2011	FY 2012	FY 2013
General Fund Discretionary Appropriation:			
Appropriation (Interior)	$403,947,000	$441,052,000	$443,502,000
Across-the-board reductions (Interior)	$0	($706,000)	$0
Subtotal, Appropriation (Interior)	$403,947,000	$440,346,000	$443,502,000
Subtotal, adjusted appropriation	$403,947,000	$440,346,000	$443,502,000
Offsetting Collections:			
Federal sources	($190,000,000)	($190,000,000)	($6,000,000)
Subtotal	($190,000,000)	($190,000,000)	($6,000,000)
Unobligated Balance, Start of Year	181,000,000	215,000,000	243,000,000
Unobligated Balance End of Year	215,000,000	243,000,000	74,000,000
Total Obligations	$179,947,000	$222,346,000	$606,502,000

INDIAN HEALTH SERVICE
SERVICES
Summary of Changes

FY 2012 Enacted	$3,866,181,000
Total estimated budget authority	3,866,181,000
Less Obligations	(3,866,181,000)
FY 2013 Estimate	3,978,974,000
Less Obligations	(3,978,974,000)
Net Change	112,793,000
Less Obligations	(112,793,000)

		FY 2012 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2012 CO Pay Raise (3months)	--	n/a	--	455,000
2	FY 2013 Pay Raise CO (9months)	--	n/a	--	1,447,000
3	Annualization of FY 2012 CS Pay Raise (3months)	--	n/a	--	2,401,000
4	FY 2013 Pay Raise CS (9months)	--	n/a	--	2,272,000
5	One Days Pay	--	n/a	--	2,327,000
6	Tribal Pay Cost	--	n/a	--	17,275,000
7	Increased Cost of Travel	--	41,031,000	--	1,432,000
8	Increased Cost of Transportation & Things	--	6,791,000	--	152,000
9	Increased Cost of Printing	--	450,000	--	4,000
10	Increased Cost of Rents, Communications, & Utilities	--	25,000,000	--	461,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	651,781,000	--	22,343,000
12	Increased Cost of Supplies	--	141,251,000	--	4,836,000
13	Increased Cost of Medical or other Equipment	--	13,753,000	--	619,000
14	Increased Cost of Land & Structure	--	1,104,000	--	15,136,000
15	Increased Cost of Grants	--	2,255,255,000	--	31,998,000
16	Increased Cost of Insurance / Indemnities	--	1,259,000	--	8,000
17	Increased Cost of Interest / Dividends	--	61,000	--	0
18	Population Growth	--	n/a	--	46,535,000
	Subtotal, Built-In	--	3,137,736,000	--	149,701,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	381	44,780,000
C. Program Increases		--	0	--	32,124,000
	TOTAL INCREASES	--	3,137,736,000	381	226,605,000
DECREASES					
A. Built-In					
	Absoprtion of Built-In Increases	--	0	--	(113,812,000)
	TOTAL DECREASES	--	0	--	(113,812,000)
NET CHANGE		--	**$3,137,736,000**	**381**	**$112,793,000**

INDIAN HEALTH SERVICE
Clinical Services
Summary of Changes

FY 2012 Enacted	$3,083,867,000
Total estimated budget authority	3,083,867,000
Less Obligations	(3,083,867,000)
FY 2013 Estimate	3,186,678,000
Less Obligations	(3,186,678,000)
Net Change	102,811,000
Less Obligations	(102,811,000)

		FY 2012 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2012 CO Pay Raise (3months)	--	n/a	--	411,000
2	FY 2013 Pay Raise CO (9months)	--	n/a	--	1,296,000
3	Annualization of FY 2012 CS Pay Raise (3months)	--	n/a	--	2,144,000
4	FY 2013 Pay Raise CS (9months)	--	n/a	--	2,020,000
5	One Days Pay	--	n/a	--	2,071,000
6	Tribal Pay Cost	--	n/a	--	15,343,000
7	Increased Cost of Travel	--	38,935,000	--	1,382,000
8	Increased Cost of Transportation & Things	--	5,696,000	--	135,000
9	Increased Cost of Printing	--	409,000	--	3,000
10	Increased Cost of Rents, Communications, & Utilities	--	23,321,000	--	451,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	556,289,000	--	21,929,000
12	Increased Cost of Supplies	--	137,607,000	--	4,729,000
13	Increased Cost of Medical or other Equipment	--	12,467,000	--	594,000
14	Increased Cost of Land & Structure	--	1,096,000	--	15,106,000
15	Increased Cost of Grants	--	1,659,096,000	--	21,102,000
16	Increased Cost of Insurance / Indemnities	--	1,240,000	--	8,000
17	Increased Cost of Interest / Dividends	--	61,000	--	0
18	Population Growth	--	n/a	--	43,891,000
	Subtotal, Built-In	--	2,436,217,000	--	132,615,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	350	41,117,000
C. Health IT		--	0	--	6,000,000
D. Contract Health Service		--	0	--	20,000,000
TOTAL INCREASES		--	2,436,217,000	350	199,732,000
DECREASES					
A. Built-In					
Absoprtion of Built-In Increases		--	0	--	(96,921,000)
TOTAL DECREASES		--	0	--	(96,921,000)
NET CHANGE		--	**$2,436,217,000**	**350**	**$102,811,000**

INDIAN HEALTH SERVICE
Hospitals & Health Clinics
Summary of Changes

FY 2012 Enacted	$1,810,966,000
Total estimated budget authority	1,810,966,000
Less Obligations	(1,810,966,000)
FY 2013 Estimate	1,849,310,000
Less Obligations	(1,849,310,000)
Net Change	38,344,000
Less Obligations	(38,344,000)

		FY 2012 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2012 CO Pay Raise (3months)	--	n/a	--	337,000
2	FY 2013 Pay Raise CO (9months)	--	n/a	--	1,046,000
3	Annualization of FY 2012 CS Pay Raise (3months)	--	n/a	--	1,816,000
4	FY 2013 Pay Raise CS (9months)	--	n/a	--	1,703,000
5	One Days Pay	--	n/a	--	1,746,000
6	Tribal Pay Cost	--	n/a	--	11,770,000
7	Increased Cost of Travel	--	6,791,000	--	186,000
8	Increased Cost of Transportation & Things	--	5,172,000	--	119,000
9	Increased Cost of Printing	--	404,000	--	3,000
10	Increased Cost of Rents, Communications, & Utilities	--	22,520,000	--	438,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	159,145,000	--	5,746,000
12	Increased Cost of Supplies	--	92,772,000	--	3,824,000
13	Increased Cost of Medical or other Equipment	--	11,129,000	--	223,000
14	Increased Cost of Land & Structure	--	1,096,000	--	15,106,000
15	Increased Cost of Grants	--	967,359,000	--	14,000
16	Increased Cost of Insurance / Indemnities	--	1,226,000	--	0
17	Increased Cost of Interest / Dividends	--	1,000	--	0
18	Population Growth	--	n/a	--	25,531,000
	Subtotal, Built-In	--	1,267,615,000	--	69,608,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	265	31,961,000
C. Health IT		--	0	--	5,000,000
	TOTAL INCREASES	--	1,267,615,000	265	106,569,000
DECREASES					
A. Built-In					
	Absoprtion of Built-In Increases	--	0	--	(68,225,000)
	TOTAL DECREASES	--	0	--	(68,225,000)
NET CHANGE		--	**$1,267,615,000**	**265**	**$38,344,000**

INDIAN HEALTH SERVICE
Dental Health
Summary of Changes

FY 2012 Enacted	$159,440,000
Total estimated budget authority	159,440,000
Less Obligations	(159,440,000)
FY 2013 Estimate	166,297,000
Less Obligations	(166,297,000)
Net Change	6,857,000
Less Obligations	(6,857,000)

		FY 2012 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2012 CO Pay Raise (3months)	--	n/a	--	62,000
2	FY 2013 Pay Raise CO (9months)	--	n/a	--	206,000
3	Annualization of FY 2012 CS Pay Raise (3months)	--	n/a	--	190,000
4	FY 2013 Pay Raise CS (9months)	--	n/a	--	185,000
5	One Days Pay	--	n/a	--	189,000
6	Tribal Pay Cost	--	n/a	--	931,000
7	Increased Cost of Travel	--	700,000	--	16,000
8	Increased Cost of Transportation & Things	--	230,000	--	7,000
9	Increased Cost of Printing	--	2,000	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	307,000	--	5,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	7,664,000	--	297,000
12	Increased Cost of Supplies	--	5,950,000	--	234,000
13	Increased Cost of Medical or other Equipment	--	1,236,000	--	37,000
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	77,849,000	--	1,191,000
16	Increased Cost of Insurance / Indemnities	--	8,000	--	6,000
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	2,221,000
	Subtotal, Built-In	--	93,946,000	--	5,777,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	50	5,589,000
C. Health IT		--	0	--	1,000,000
	TOTAL INCREASES	--	93,946,000	50	12,366,000
DECREASES					
A. Built-In					
	Absoprtion of Built-In Increases	--	0	--	(5,509,000)
	TOTAL DECREASES	--	0	--	(5,509,000)
NET CHANGE		--	**$93,946,000**	**50**	**$6,857,000**

INDIAN HEALTH SERVICE
Mental Health
Summary of Changes

FY 2012 Enacted	$75,589,000
Total estimated budget authority	75,589,000
Less Obligations	(75,589,000)
FY 2013 Estimate	78,131,000
Less Obligations	(78,131,000)
Net Change	2,542,000
Less Obligations	(2,542,000)

		FY 2012 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2012 CO Pay Raise (3months)	--	n/a	--	6,000
2	FY 2013 Pay Raise CO (9months)	--	n/a	--	23,000
3	Annualization of FY 2012 CS Pay Raise (3months)	--	n/a	--	86,000
4	FY 2013 Pay Raise CS (9months)	--	n/a	--	83,000
5	One Days Pay	--	n/a	--	86,000
6	Tribal Pay Cost	--	n/a	--	543,000
7	Increased Cost of Travel	--	279,000	--	8,000
8	Increased Cost of Transportation & Things	--	235,000	--	6,000
9	Increased Cost of Printing	--	2,000	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	110,000	--	2,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	4,399,000	--	243,000
12	Increased Cost of Supplies	--	1,656,000	--	40,000
13	Increased Cost of Medical or other Equipment	--	206,000	--	3,000
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	44,626,000	--	636,000
16	Increased Cost of Insurance / Indemnities	--	2,000	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	1,055,000
	Subtotal, Built-In	--	51,515,000	--	2,820,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	24	2,513,000
	TOTAL INCREASES	--	51,515,000	24	5,333,000
DECREASES					
A. Built-In					
	Absoprtion of Built-In Increases	--	0	--	(2,791,000)
	TOTAL DECREASES	--	0	--	(2,791,000)
NET CHANGE		--	**$51,515,000**	**24**	**$2,542,000**

INDIAN HEALTH SERVICE
Alcohol and Substance Abuse
Summary of Changes

FY 2012 Enacted	$194,297,000
Total estimated budget authority	194,297,000
Less Obligations	(194,297,000)
FY 2013 Estimate	195,378,000
Less Obligations	(195,378,000)
Net Change	1,081,000
Less Obligations	(1,081,000)

		FY 2012 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2012 CO Pay Raise (3months)	--	n/a	--	6,000
2	FY 2013 Pay Raise CO (9months)	--	n/a	--	21,000
3	Annualization of FY 2012 CS Pay Raise (3months)	--	n/a	--	52,000
4	FY 2013 Pay Raise CS (9months)	--	n/a	--	49,000
5	One Days Pay	--	n/a	--	50,000
6	Tribal Pay Cost	--	n/a	--	2,099,000
7	Increased Cost of Travel	--	263,000	--	8,000
8	Increased Cost of Transportation & Things	--	58,000	--	3,000
9	Increased Cost of Printing	--	0	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	101,000	--	2,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	7,291,000	--	332,000
12	Increased Cost of Supplies	--	2,413,000	--	57,000
13	Increased Cost of Medical or other Equipment	--	373,000	--	9,000
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	169,118,000	--	2,651,000
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	2,752,000
	Subtotal, Built-In	--	179,617,000	--	8,091,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	11	1,054,000
	TOTAL INCREASES	--	179,617,000	11	9,145,000
DECREASES					
A. Built-In					
	Absoprtion of Built-In Increases	--	0	--	(8,064,000)
	TOTAL DECREASES	--	0	--	(8,064,000)
NET CHANGE		--	**$179,617,000**	**11**	**$1,081,000**

INDIAN HEALTH SERVICE
Contract Health Service
Summary of Changes

FY 2012 Enacted	$843,575,000
Total estimated budget authority	843,575,000
Less Obligations	(843,575,000)
FY 2013 Estimate	897,562,000
Less Obligations	(897,562,000)
Net Change	53,987,000
Less Obligations	(53,987,000)

		FY 2012 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2012 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2013 Pay Raise CO (9months)	--	n/a	--	0
3	Annualization of FY 2012 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2013 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	--	30,902,000	--	1,164,000
8	Increased Cost of Transportation & Things	--	1,000	--	0
9	Increased Cost of Printing	--	1,000	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	283,000	--	4,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	377,790,000	--	15,311,000
12	Increased Cost of Supplies	--	34,816,000	--	574,000
13	Increased Cost of Medical or other Equipment	--	(477,000)	--	322,000
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	400,144,000	--	16,610,000
16	Increased Cost of Insurance / Indemnities	--	4,000	--	2,000
17	Increased Cost of Interest / Dividends	--	60,000	--	0
18	Population Growth	--	n/a	--	12,332,000
	Subtotal, Built-In	--	843,524,000	--	46,319,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	--	0
C. Contract Health Service		--	0	--	20,000,000
	TOTAL INCREASES	--	843,524,000	--	66,319,000
DECREASES					
A. Built-In					
	Absoprtion of Built-In Increases	--	0	--	(12,332,000)
	TOTAL DECREASES	--	0	--	(12,332,000)
NET CHANGE		--	**$843,524,000**	--	**$53,987,000**

INDIAN HEALTH SERVICE
Preventive Health
Summary of Changes

FY 2012 Enacted	$147,023,000
Total estimated budget authority	147,023,000
Less Obligations	(147,023,000)
FY 2013 Estimate	150,776,000
Less Obligations	(150,776,000)
Net Change	3,753,000
Less Obligations	(3,753,000)

		FY 2012 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2012 CO Pay Raise (3months)	--	n/a	--	20,000
2	FY 2013 Pay Raise CO (9months)	--	n/a	--	70,000
3	Annualization of FY 2012 CS Pay Raise (3months)	--	n/a	--	94,000
4	FY 2013 Pay Raise CS (9months)	--	n/a	--	96,000
5	One Days Pay	--	n/a	--	98,000
6	Tribal Pay Cost	--	n/a	--	1,353,000
7	Increased Cost of Travel	--	334,000	--	10,000
8	Increased Cost of Transportation & Things	--	934,000	--	14,000
9	Increased Cost of Printing	--	6,000	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	82,000	--	4,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	2,740,000	--	124,000
12	Increased Cost of Supplies	--	2,615,000	--	101,000
13	Increased Cost of Medical or other Equipment	--	423,000	--	18,000
14	Increased Cost of Land & Structure	--	6,000	--	30,000
15	Increased Cost of Grants	--	107,430,000	--	1,625,000
16	Increased Cost of Insurance / Indemnities	--	2,000	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	2,036,000
	Subtotal, Built-In	--	114,572,000	--	5,693,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	31	3,663,000
TOTAL INCREASES		--	114,572,000	31	9,356,000
DECREASES					
A. Built-In					
	Absoprtion of Built-In Increases	--	0	--	(5,603,000)
TOTAL DECREASES		--	0	--	(5,603,000)
NET CHANGE		--	**$114,572,000**	**31**	**$3,753,000**

INDIAN HEALTH SERVICE
Public Health Nursing
Summary of Changes

FY 2012 Enacted	$66,632,000
Total estimated budget authority	66,632,000
Less Obligations	(66,632,000)
FY 2013 Estimate	69,868,000
Less Obligations	(69,868,000)
Net Change	3,236,000
Less Obligations	(3,236,000)

		FY 2012 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2012 CO Pay Raise (3months)	--	n/a	--	19,000
2	FY 2013 Pay Raise CO (9months)	--	n/a	--	65,000
3	Annualization of FY 2012 CS Pay Raise (3months)	--	n/a	--	82,000
4	FY 2013 Pay Raise CS (9months)	--	n/a	--	83,000
5	One Days Pay	--	n/a	--	85,000
6	Tribal Pay Cost	--	n/a	--	406,000
7	Increased Cost of Travel	--	219,000	--	6,000
8	Increased Cost of Transportation & Things	--	854,000	--	12,000
9	Increased Cost of Printing	--	0	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	61,000	--	3,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	1,480,000	--	91,000
12	Increased Cost of Supplies	--	1,687,000	--	72,000
13	Increased Cost of Medical or other Equipment	--	314,000	--	10,000
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	33,464,000	--	509,000
16	Increased Cost of Insurance / Indemnities	--	1,000	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	918,000
	Subtotal, Built-In	--	38,080,000	--	2,361,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	24	3,152,000
	TOTAL INCREASES	--	38,080,000	24	5,513,000
DECREASES					
A. Built-In					
	Absoprtion of Built-In Increases	--	0	--	(2,277,000)
	TOTAL DECREASES	--	0	--	(2,277,000)
NET CHANGE		--	**$38,080,000**	**24**	**$3,236,000**

INDIAN HEALTH SERVICE
Health Education
Summary of Changes

FY 2012 Enacted	$17,057,000
Total estimated budget authority	17,057,000
Less Obligations	(17,057,000)
FY 2013 Estimate	17,450,000
Less Obligations	(17,450,000)
Net Change	393,000
Less Obligations	(393,000)

		FY 2012 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2012 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2013 Pay Raise CO (9months)	--	n/a	--	2,000
3	Annualization of FY 2012 CS Pay Raise (3months)	--	n/a	--	11,000
4	FY 2013 Pay Raise CS (9months)	--	n/a	--	11,000
5	One Days Pay	--	n/a	--	11,000
6	Tribal Pay Cost	--	n/a	--	158,000
7	Increased Cost of Travel	--	89,000	--	3,000
8	Increased Cost of Transportation & Things	--	48,000	--	1,000
9	Increased Cost of Printing	--	6,000	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	21,000	--	0
11	Increased Cost of Health Care Provided under Contracts & Grants	--	397,000	--	10,000
12	Increased Cost of Supplies	--	714,000	--	28,000
13	Increased Cost of Medical or other Equipment	--	74,000	--	8,000
14	Increased Cost of Land & Structure	--	6,000	--	0
15	Increased Cost of Grants	--	12,479,000	--	194,000
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	236,000
	Subtotal, Built-In	--	13,834,000	--	673,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	5	391,000
	TOTAL INCREASES	--	13,834,000	5	1,064,000
DECREASES					
A. Built-In					
	Absoprtion of Built-In Increases	--	0	--	(671,000)
	TOTAL DECREASES	--	0	--	(671,000)
NET CHANGE		--	**$13,834,000**	**5**	**$393,000**

INDIAN HEALTH SERVICE
Community Health Representatives
Summary of Changes

FY 2012 Enacted	$61,407,000
Total estimated budget authority	61,407,000
Less Obligations	(61,407,000)
FY 2013 Estimate	61,531,000
Less Obligations	(61,531,000)
Net Change	124,000
Less Obligations	(124,000)

		FY 2012 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2012 CO Pay Raise (3months)	--	n/a	--	1,000
2	FY 2013 Pay Raise CO (9months)	--	n/a	--	3,000
3	Annualization of FY 2012 CS Pay Raise (3months)	--	n/a	--	1,000
4	FY 2013 Pay Raise CS (9months)	--	n/a	--	2,000
5	One Days Pay	--	n/a	--	2,000
6	Tribal Pay Cost	--	n/a	--	764,000
7	Increased Cost of Travel	--	26,000	--	1,000
8	Increased Cost of Transportation & Things	--	32,000	--	1,000
9	Increased Cost of Printing	--	0	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	0	--	1,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	863,000	--	23,000
12	Increased Cost of Supplies	--	214,000	--	1,000
13	Increased Cost of Medical or other Equipment	--	35,000	--	0
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	59,560,000	--	922,000
16	Increased Cost of Insurance / Indemnities	--	1,000	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	855,000
	Subtotal, Built-In	--	60,731,000	--	2,577,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	2	120,000
	TOTAL INCREASES	--	60,731,000	2	2,697,000
DECREASES					
A. Built-In					
	Absoprtion of Built-In Increases	--	0	--	(2,573,000)
	TOTAL DECREASES	--	0	--	(2,573,000)
NET CHANGE		--	**$60,731,000**	**2**	**$124,000**

INDIAN HEALTH SERVICE
Immunization AK
Summary of Changes

FY 2012 Enacted	$1,927,000
Total estimated budget authority	1,927,000
Less Obligations	(1,927,000)
FY 2013 Estimate	1,927,000
Less Obligations	(1,927,000)
Net Change	0
Less Obligations	0

		FY 2012 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2012 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2013 Pay Raise CO (9months)	--	n/a	--	0
3	Annualization of FY 2012 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2013 Pay Raise CS (9months)	--	n/a	--	0
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	25,000
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	--	30,000
15	Increased Cost of Grants	--	1,927,000	--	0
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	27,000
	Subtotal, Built-In	--	1,927,000	--	82,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	--	0
	TOTAL INCREASES	--	1,927,000	--	82,000
DECREASES					
A. Built-In					
	Absoprtion of Built-In Increases	--	0	--	(82,000)
	TOTAL DECREASES	--	0	--	(82,000)
NET CHANGE		--	**$1,927,000**	**--**	**$0**

INDIAN HEALTH SERVICE
Other Services
Summary of Changes

FY 2012 Enacted	$635,291,000
Total estimated budget authority	635,291,000
Less Obligations	(635,291,000)
FY 2013 Estimate	641,520,000
Less Obligations	(641,520,000)
Net Change	6,229,000
Less Obligations	(6,229,000)

		FY 2012 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2012 CO Pay Raise (3months)	--	n/a	--	24,000
2	FY 2013 Pay Raise CO (9months)	--	n/a	--	81,000
3	Annualization of FY 2012 CS Pay Raise (3months)	--	n/a	--	163,000
4	FY 2013 Pay Raise CS (9months)	--	n/a	--	156,000
5	One Days Pay	--	n/a	--	158,000
6	Tribal Pay Cost	--	n/a	--	579,000
7	Increased Cost of Travel	--	1,762,000	--	40,000
8	Increased Cost of Transportation & Things	--	161,000	--	3,000
9	Increased Cost of Printing	--	35,000	--	1,000
10	Increased Cost of Rents, Communications, & Utilities	--	1,597,000	--	6,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	92,752,000	--	290,000
12	Increased Cost of Supplies	--	1,029,000	--	6,000
13	Increased Cost of Medical or other Equipment	--	863,000	--	7,000
14	Increased Cost of Land & Structure	--	2,000	--	0
15	Increased Cost of Grants	--	488,729,000	--	9,271,000
16	Increased Cost of Insurance / Indemnities	--	17,000	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	608,000
	Subtotal, Built-In	--	586,947,000	--	11,393,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	--	0
C, Direct Operations		--	0	--	1,115,000
D, Contract Support Costs		--	0	--	5,009,000
TOTAL INCREASES		--	586,947,000	--	17,517,000
DECREASES					
A. Built-In					
Absoprtion of Built-In Increases		--	0	--	(11,288,000)
TOTAL DECREASES		--	0	--	(11,288,000)
NET CHANGE		--	**$586,947,000**	**--**	**$6,229,000**

INDIAN HEALTH SERVICE
Urban Indian Health
Summary of Changes

FY 2012 Enacted	$42,984,000
Total estimated budget authority	42,984,000
Less Obligations	(42,984,000)
FY 2013 Estimate	42,988,000
Less Obligations	(42,988,000)
Net Change	4,000
Less Obligations	(4,000)

		FY 2012 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2012 CO Pay Raise (3months)	--	n/a	--	1,000
2	FY 2013 Pay Raise CO (9months)	--	n/a	--	3,000
3	Annualization of FY 2012 CS Pay Raise (3months)	--	n/a	--	4,000
4	FY 2013 Pay Raise CS (9months)	--	n/a	--	5,000
5	One Days Pay	--	n/a	--	4,000
6	Tribal Pay Cost	--	n/a	--	347,000
7	Increased Cost of Travel	--	119,000	--	2,000
8	Increased Cost of Transportation & Things	--	13,000	--	0
9	Increased Cost of Printing	--	0	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	345,000	--	1,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	4,177,000	--	134,000
12	Increased Cost of Supplies	--	249,000	--	2,000
13	Increased Cost of Medical or other Equipment	--	73,000	--	2,000
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	36,689,000	--	571,000
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	608,000
	Subtotal, Built-In	--	41,665,000	--	1,684,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	--	0
	TOTAL INCREASES	--	41,665,000	--	1,684,000
DECREASES					
A. Built-In					
	Absoprtion of Built-In Increases	--	0	--	(1,680,000)
	TOTAL DECREASES	--	0	--	(1,680,000)
NET CHANGE		--	**$41,665,000**	**--**	**$4,000**

INDIAN HEALTH SERVICE
Indian Health Professions
Summary of Changes

FY 2012 Enacted	$40,596,000
Total estimated budget authority	40,596,000
Less Obligations	(40,596,000)
FY 2013 Estimate	40,598,000
Less Obligations	(40,598,000)
Net Change	2,000
Less Obligations	(2,000)

		FY 2012 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2012 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2013 Pay Raise CO (9months)	--	n/a	--	2,000
3	Annualization of FY 2012 CS Pay Raise (3months)	--	n/a	--	5,000
4	FY 2013 Pay Raise CS (9months)	--	n/a	--	5,000
5	One Days Pay	--	n/a	--	5,000
6	Tribal Pay Cost	--	n/a	--	0
7	Increased Cost of Travel	--	72,000	--	1,000
8	Increased Cost of Transportation & Things	--	17,000	--	0
9	Increased Cost of Printing	--	11,000	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	0	--	0
11	Increased Cost of Health Care Provided under Contracts & Grants	--	7,137,000	--	36,000
12	Increased Cost of Supplies	--	22,000	--	0
13	Increased Cost of Medical or other Equipment	--	187,000	--	0
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	31,529,000	--	605,000
16	Increased Cost of Insurance / Indemnities	--	1,000	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	0
	Subtotal, Built-In	--	38,976,000	--	659,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	--	0
	TOTAL INCREASES	--	38,976,000	--	659,000
DECREASES					
A. Built-In					
	Absoprtion of Built-In Increases	--	0	--	(657,000)
	TOTAL DECREASES	--	0	--	(657,000)
NET CHANGE		--	**$38,976,000**	**--**	**$2,000**

INDIAN HEALTH SERVICE
Tribal Management
Summary of Changes

FY 2012 Enacted	$2,577,000
Total estimated budget authority	2,577,000
Less Obligations	(2,577,000)
FY 2013 Estimate	2,577,000
Less Obligations	(2,577,000)
Net Change	0
Less Obligations	0

		FY 2012 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2012 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2013 Pay Raise CO (9months)	--	n/a	--	0
3	Annualization of FY 2012 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2013 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	--	3,000	--	0
8	Increased Cost of Transportation & Things	--	0	--	0
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	--	179,000	--	0
12	Increased Cost of Supplies	--	1,000	--	0
13	Increased Cost of Medical or other Equipment	--	0	--	0
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	2,393,000	--	98,000
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	--	2,577,000	--	98,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	--	0
	TOTAL INCREASES	--	2,577,000	--	98,000
DECREASES					
A. Built-In					
	Absoprtion of Built-In Increases	--	0	--	(98,000)
	TOTAL DECREASES	--	0	--	(98,000)
NET CHANGE		--	**$2,577,000**	**--**	**$0**

INDIAN HEALTH SERVICE
Direct Operations
Summary of Changes

FY 2012 Enacted	$71,653,000
Total estimated budget authority	71,653,000
Less Obligations	(71,653,000)
FY 2013 Estimate	72,867,000
Less Obligations	(72,867,000)
Net Change	1,214,000
Less Obligations	(1,214,000)

		FY 2012 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2012 CO Pay Raise (3months)	--	n/a	--	23,000
2	FY 2013 Pay Raise CO (9months)	--	n/a	--	76,000
3	Annualization of FY 2012 CS Pay Raise (3months)	--	n/a	--	148,000
4	FY 2013 Pay Raise CS (9months)	--	n/a	--	140,000
5	One Days Pay	--	n/a	--	143,000
6	Tribal Pay Cost	--	n/a	--	232,000
7	Increased Cost of Travel	--	1,432,000	--	34,000
8	Increased Cost of Transportation & Things	--	121,000	--	3,000
9	Increased Cost of Printing	--	17,000	--	1,000
10	Increased Cost of Rents, Communications, & Utilities	--	1,239,000	--	5,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	5,759,000	--	100,000
12	Increased Cost of Supplies	--	700,000	--	4,000
13	Increased Cost of Medical or other Equipment	--	458,000	--	4,000
14	Increased Cost of Land & Structure	--	2,000	--	0
15	Increased Cost of Grants	--	18,091,000	--	295,000
16	Increased Cost of Insurance / Indemnities	--	16,000	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	0
	Subtotal, Built-In	--	27,835,000	--	1,208,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	--	0
C, Direct Operations		--	0	--	1,115,000
	TOTAL INCREASES	--	27,835,000	--	2,323,000
DECREASES					
A. Built-In					
	Absoprtion of Built-In Increases	--	0	--	(1,109,000)
	TOTAL DECREASES	--	0	--	(1,109,000)
NET CHANGE		--	**$27,835,000**	**--**	**$1,214,000**

INDIAN HEALTH SERVICE
Self-Governance
Summary of Changes

FY 2012 Enacted	$6,044,000
Total estimated budget authority	6,044,000
Less Obligations	(6,044,000)
FY 2013 Estimate	6,044,000
Less Obligations	(6,044,000)
Net Change	0
Less Obligations	0

		FY 2012 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2012 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2013 Pay Raise CO (9months)	--	n/a	--	0
3	Annualization of FY 2012 CS Pay Raise (3months)	--	n/a	--	6,000
4	FY 2013 Pay Raise CS (9months)	--	n/a	--	6,000
5	One Days Pay	--	n/a	--	6,000
6	Tribal Pay Cost	--	n/a	--	0
7	Increased Cost of Travel	--	136,000	--	3,000
8	Increased Cost of Transportation & Things	--	10,000	--	0
9	Increased Cost of Printing	--	7,000	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	12,000	--	0
11	Increased Cost of Health Care Provided under Contracts & Grants	--	1,119,000	--	20,000
12	Increased Cost of Supplies	--	5,000	--	0
13	Increased Cost of Medical or other Equipment	--	145,000	--	1,000
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	3,023,000	--	112,000
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	0
	Subtotal, Built-In	--	4,457,000	--	154,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	--	0
	TOTAL INCREASES	--	4,457,000	--	154,000
DECREASES					
A. Built-In					
	Absoprtion of Built-In Increases	--	0	--	(154,000)
	TOTAL DECREASES	--	0	--	(154,000)
NET CHANGE		--	**$4,457,000**	**--**	**$0**

INDIAN HEALTH SERVICE
Contract Support Costs
Summary of Changes

FY 2012 Enacted	$471,437,000
Total estimated budget authority	471,437,000
Less Obligations	(471,437,000)
FY 2013 Estimate	476,446,000
Less Obligations	(476,446,000)
Net Change	5,009,000
Less Obligations	(5,009,000)

		FY 2012 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2012 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2013 Pay Raise CO (9months)	--	n/a	--	0
3	Annualization of FY 2012 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2013 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	--	74,381,000	--	0
12	Increased Cost of Supplies	--	52,000	--	0
13	Increased Cost of Medical or other Equipment	--	0	--	0
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	397,004,000	--	7,590,000
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	--	471,437,000	--	7,590,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	--	0
C. Contract Support Costs		--	0	--	5,009,000
	TOTAL INCREASES	--	471,437,000	--	12,599,000
DECREASES					
A. Built-In					
	Absoprtion of Built-In Increases	--	0	--	(7,590,000)
	TOTAL DECREASES	--	0	--	(7,590,000)
NET CHANGE		--	**$471,437,000**	**--**	**$5,009,000**

INDIAN HEALTH SERVICE
FACILITIES
Summary of Changes

FY 2012 Enacted	$440,346,000
Total budget authority	440,346,000
Less Obligations	(440,346,000)
FY 2013 Estimate	443,502,000
Less Obligations	(443,502,000)
Net Change	3,156,000
Less Obligations	(3,156,000)

		FY 2012 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2012 CO Pay Raise (3months)	--	n/a	--	118,000
2	FY 2013 Pay Raise CO (9months)	--	n/a	--	392,000
3	Annualization of FY 2012 CS Pay Raise (3months)	--	n/a	--	276,000
4	FY 2013 Pay Raise CS (9months)	--	n/a	--	271,000
5	One Days Pay	--	n/a	--	278,000
6	Tribal Pay Cost	--	n/a	--	810,000
7	Increased Cost of Travel	--	2,546,000	--	63,000
8	Increased Cost of Transportation & Things	--	3,001,000	--	61,000
9	Increased Cost of Printing	--	89,000	--	0
10	Increased Cost of Rents, Communications, & Utilties	--	18,376,000	--	315,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	80,596,000	--	1,320,000
12	Increased Cost of Supplies	--	8,268,000	--	97,000
13	Increased Cost of Medical or other Equipment	--	9,152,000	--	479,000
14	Increased Cost of Land & Structure	--	16,332,000	--	645,000
15	Increased Cost of Grants	--	199,210,000	--	4,150,000
16	Increased Cost of Insurance / Indemnities	--	38,000	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Increased Cost of Service & Supply Fund	--	0	--	0
19	Population Growth	--	n/a	--	4,842,000
	Subtotal, Built-In	--	337,608,000	--	14,117,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	20	4,456,000
C. Program Increases		--	0	--	1,749,000
	TOTAL INCREASES	--	337,608,000		20,322,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(13,607,000)
B. Base Funding Reduction		--	0	--	(3,559,000)
	TOTAL DECREASES	--	0	--	(17,166,000)
NET CHANGE		**--**	**$337,608,000**	**20**	**$3,156,000**

INDIAN HEALTH SERVICE
Maintenance & Improvement
Summary of Changes

FY 2012 Enacted	$53,721,000
Total budget authority	53,721,000
Less Obligations	(53,721,000)
FY 2013 Estimate	55,470,000
Less Obligations	(55,470,000)
Net Change	1,749,000
Less Obligations	(1,749,000)

		FY 2012 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2012 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2013 Pay Raise CO (9months)	--	n/a	--	0
3	Annualization of FY 2012 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2013 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	--	49,000	--	2,000
8	Increased Cost of Transportation & Things	--	7,000	--	0
9	Increased Cost of Printing	--	1,000	--	0
10	Increased Cost of Rents, Communications, & Utilties	--	453,000	--	7,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	13,057,000	--	149,000
12	Increased Cost of Supplies	--	4,769,000	--	26,000
13	Increased Cost of Medical or other Equipment	--	422,000	--	5,000
14	Increased Cost of Land & Structure	--	3,664,000	--	348,000
15	Increased Cost of Grants	--	31,299,000	--	303,000
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	--	742,000
	Subtotal, Built-In	--	53,721,000	--	1,582,000
	TOTAL INCREASES	--	53,721,000	--	1,582,000
A.	Maintenance & Improvement	--	0	--	1,749,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(1,582,000)
	TOTAL DECREASES	--	0	--	(1,582,000)
NET CHANGE		**--**	**$53,721,000**	**--**	**$1,749,000**

INDIAN HEALTH SERVICE
Sanitation Facilities Construction
Summary of Changes

FY 2012 Enacted	$79,582,000
Total budget authority	79,582,000
Less Obligations	(79,582,000)
FY 2013 Estimate	79,582,000
Less Obligations	(79,582,000)
Net Change	0
Less Obligations	0

		FY 2012 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2012 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2013 Pay Raise CO (9months)	--	n/a	--	0
3	Annualization of FY 2012 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2013 Pay Raise CS (9months)	--	n/a	--	0
5	One Days Pay				
6	Tribal Pay Cost				
7	Increased Cost of Travel	--	87,000	--	1,000
8	Increased Cost of Transportation & Things	--	639,000	--	14,000
9	Increased Cost of Printing	--	11,000	--	0
10	Increased Cost of Rents, Communications, & Utilties	--	34,000	--	1,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	58,717,000	--	1,125,000
12	Increased Cost of Supplies	--	570,000	--	24,000
13	Increased Cost of Medical or other Equipment	--	180,000	--	3,000
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	11,820,000	--	395,000
16	Increased Cost of Insurance / Indemnities	--	1,000	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Increased Cost of Service & Supply Fund	--	0	--	0
19	Population Growth	--	0	--	1,036,000
	Subtotal, Built-In	--	72,059,000	--	2,599,000
	TOTAL INCREASES	--	72,059,000	--	2,599,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(2,599,000)
	TOTAL DECREASES	--	0	--	(2,599,000)
NET CHANGE		**--**	**$72,059,000**	**--**	**$0**

INDIAN HEALTH SERVICE
Health Care Facilities Construction
Summary of Changes

FY 2012 Enacted	$85,048,000
Total budget authority	85,048,000
Less Obligations	(85,048,000)
FY 2013 Estimate	81,489,000
Less Obligations	(81,489,000)
Net Change	(3,559,000)
Less Obligations	3,559,000

		FY 2012 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2012 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2013 Pay Raise CO (9months)	--	n/a	--	0
3	Annualization of FY 2012 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2013 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	--	14,000	--	0
10	Increased Cost of Rents, Communications, & Utilties	--	0	--	0
11	Increased Cost of Health Care Provided under Contracts & Grants	--	1,159,000	--	(34,000)
12	Increased Cost of Supplies	--	0	--	0
13	Increased Cost of Medical or other Equipment	--	0	--	0
14	Increased Cost of Land & Structure	--	11,843,000	--	293,000
15	Increased Cost of Grants	--	72,032,000	--	1,109,000
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Increased Cost of Service & Supply Fund	--	0	--	0
19	Population Growth	--	0	--	0
	Subtotal, Built-In	--	85,048,000	--	1,368,000
B. HCFC Increase		--	0	--	0
C. IHCIA Implementation		--	0	--	0
	TOTAL INCREASES	--	85,048,000	--	1,368,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(1,368,000)
B. Base Funding Reduction		--	0	--	(3,559,000)
	TOTAL DECREASES	--	0	--	(4,927,000)
NET CHANGE		**--**	**$85,048,000**	**--**	**($3,559,000)**

INDIAN HEALTH SERVICE
Facilities & Environmental Health Support
Summary of Changes

FY 2012 Enacted	$199,413,000
Total budget authority	199,413,000
Less Obligations	(199,413,000)
FY 2013 Estimate	204,379,000
Less Obligations	(204,379,000)
Net Change	4,966,000
Less Obligations	(4,966,000)

		FY 2012 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2012 CO Pay Raise (3months)	--	n/a	--	118,000
2	FY 2013 Pay Raise CO (9months)	--	n/a	--	392,000
3	Annualization of FY 2012 CS Pay Raise (3months)	--	n/a	--	276,000
4	FY 2013 Pay Raise CS (9months)	--	n/a	--	271,000
5	One Days Pay	--	n/a	--	278,000
6	Tribal Pay Cost	--	n/a	--	810,000
7	Increased Cost of Travel	--	2,404,000	--	60,000
8	Increased Cost of Transportation & Things	--	2,301,000	--	47,000
9	Increased Cost of Printing	--	63,000	--	0
10	Increased Cost of Rents, Communications, & Utilties	--	17,889,000	--	306,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	7,505,000	--	53,000
12	Increased Cost of Supplies	--	2,799,000	--	46,000
13	Increased Cost of Medical or other Equipment	--	2,665,000	--	38,000
14	Increased Cost of Land & Structure	--	814,000	--	1,000
15	Increased Cost of Grants	--	67,725,000	--	1,951,000
16	Increased Cost of Insurance / Indemnities	--	33,000	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Increased Cost of Service & Supply Fund	--	0	--	0
19	Population Growth	--	n/a	--	2,743,000
	Subtotal, Built-In	--	104,198,000	--	7,390,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	20	4,456,000
	TOTAL INCREASES	--	104,198,000	--	11,846,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(6,880,000)
B. Base Adjustment:		--	0	--	0
	TOTAL DECREASES	--	0	--	(6,880,000)
NET CHANGE		**--**	**$104,198,000**	**20**	**$4,966,000**

INDIAN HEALTH SERVICE
Equipment
Summary of Changes

FY 2012 Enacted	$22,582,000
Total budget authority	22,582,000
Less Obligations	(22,582,000)
FY 2013 Estimate	22,582,000
Less Obligations	(22,582,000)
Net Change	0
Less Obligations	0

		FY 2012 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2012 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2013 Pay Raise CO (9months)	--	n/a	--	0
3	Annualization of FY 2012 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2013 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	--	6,000	--	0
8	Increased Cost of Transportation & Things	--	54,000	--	0
9	Increased Cost of Printing	--	0	--	0
10	Increased Cost of Rents, Communications, & Utilties	--	0	--	1,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	158,000	--	27,000
12	Increased Cost of Supplies	--	130,000	--	1,000
13	Increased Cost of Medical or other Equipment	--	5,885,000	--	433,000
14	Increased Cost of Land & Structure	--	11,000	--	3,000
15	Increased Cost of Grants	--	16,334,000	--	392,000
16	Increased Cost of Insurance / Indemnities	--	4,000	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Increased Cost of Service & Supply Fund	--	0	--	0
19	Population Growth	--	0	--	321,000
	Subtotal, Built-In	--	22,582,000	--	1,178,000
	TOTAL INCREASES	--	22,582,000	--	1,178,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(1,178,000)
B. Base Funding Reduction		--	0	--	0
	TOTAL DECREASES	--	0	--	(1,178,000)
NET CHANGE		**--**	**$22,582,000**	**--**	**$0**

INDIAN HEALTH SERVICE
Budget Authority by Activity
(Dollars in Thousands)

	2011 Enacted		2012 Enacted		2013 Request	
	FTE	Amount	FTE	Amount	FTE	Amount
SERVICES:						
Hospitals & Health Clinics	6,265	$1,762,865	6,358	$1,810,966	6,455	$1,849,310
Dental Services	692	152,634	697	159,440	704	166,297
Mental Health	219	72,786	223	75,589	225	78,131
Alcohol & Substance Abuse	178	194,409	178	194,497	178	195,378
Contract Health Services	0	779,927	0	843,575	0	897,562
Total Clinical Services	7,354	2,962,621	7,456	3,084,067	7,562	3,186,678
Public Health Nursing	253	63,943	256	66,632	261	69,868
Health Education	27	16,649	29	17,057	30	17,450
Comm. Health Reps.	7	61,505	7	61,407	7	61,531
Immunization AK	0	1,930	0	1,927	0	1,927
Total Preventive Health	287	144,027	292	147,023	298	150,776
Urban Health	5	43,053	5	42,984	5	42,988
Indian Health Professions	21	40,661	21	40,596	21	40,598
Tribal Management	0	2,581	0	2,577	0	2,577
Direct Operations	312	68,583	324	71,653	343	72,867
Self-Governance	12	6,054	12	6,044	12	6,044
Contract Support Costs	0	397,693	0	471,437	0	476,446
Total Services	7,991	3,665,273	8,110	3,866,381	8,241	3,978,974
FACILITIES:						
Maintenance & Improvement	0	53,807	0	53,721	0	55,470
Sanitation Facilities Constr.	136	95,665	136	79,582	136	79,582
Health Care Facs. Constr.	0	39,156	0	85,048	0	81,489
Facil. & Envir. Health Supp.	1,029	192,701	1,039	199,413	1,044	204,379
Equipment	0	22,618	0	22,582	0	22,582
Total Facilities	1,165	403,947	1,175	440,346	1,180	443,502
Total IHS	9,156	$4,069,220	9,285	$4,306,727	9,421	$ 4,422,476

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

INDIAN HEALTH SERVICE

Authorizing Legislation

(Dollars in Thousands)

January 12, 2012

	FY 2012		FY 2013	
	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.	3,866,181	3,866,181	3,978,974	3,978,974
2. 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).	440,346 7,500	440,346 7,500	443,502 7,500	443,502 7,500
3. Public and Private Collections: IHCIA sec. 206, 25 U.S.C. 1621e. Social Security Act, sec. 1880 & 1911, 42 U.S.C. 1395qq & 1396j.	921,717	921,717	921,717	921,717
4. Special Diabetes Program for Indians: 42 U.S.C. 245c-3.	150,000	150,000	150,000	150,000
Unfunded authorizations:	0	0	0	0
Total appropriations:	5,385,744	5,385,744	5,501,693	5,501,693
Total appropriations against Definite authorizations:	5,385,744	5,385,744	5,501,693	5,501,693

INDIAN HEALTH SERVICE
Appropriation History Table
Services

January 11, 2012

	Budget Request to Congress	House Allowance	Senate Allowance	Appropriation
2004	$2,502,393,000	$2,556,082,000	$2,546,524,000	$2,561,932,000
Rescission (PL 108-108)	-	-	-	($16,550,000)
Rescission (PL 108-199)	-	-	-	($15,018,000)
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			

INDIAN HEALTH SERVICE
Appropriation History Table
Facilities

January 11, 2012

	Budget Request to Congress	House Allowance	Senate Allowance	Appropriation
2004	$387,269,000	$392,560,000	$391,188,000	$396,232,000
Rescission (PL 108-108)	-	-	-	($2,560,000)
Rescission (PL 108-199)	-	-	-	($2,322,000)
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			

Physicians' Comparability Allowance (PCA)

Indian Health Service

Table 1

		PY 2011 (Actual)	CY 2012 (Estimates)	BY 2013* (Estimates)
1) Number of Physicians Receiving PCAs		56	56	56
2) Number of Physicians with One-Year PCA Agreements		8	8	8
3) Number of Physicians with Multi-Year PCA Agreements		48	48	48
4) Average Annual PCA Physician Pay (without PCA payment)		$155,489	$155,489	$155,489
5) Average Annual PCA Payment		$23,076	$23,076	$23,076
6) Number of Physicians Receiving PCAs by Category (non-add)	Category I Clinical Position	51	51	51
	Category II Research Position			
	Category III Occupational Health			
	Category IV-A Disability Evaluation			
	Category IV-B Health and Medical Admin.	5	5	5

*FY 2013 data will be approved during the FY 2014 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 category allowance, duties and location (remote), allowance for mission-specific factors, board certification and retention incentives.

Most of our physicians have moved over to Title 38 Physician and Dentist Pay but the Areas who do not use Title 38 still utilize PCA and have tenure.

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.)*

Physician vacancy rates continue in the 20% range due to a shortage of physicians, particularly in primary care specialties.

Follow-up Question: Please describe why the Actual FY 2011 PCA usage (56) was less than anticipated for FY 2011 (68). Is this due entirely to more physicians being transitioned to Title 38? Will numbers of PCA continue to fall due to Title 38 transitions?

Response: The physician comparability allowance paid under 5 U.S.C. 5948(g)(1) for IHS continued to include physicians identified by the agency under 5 CFR 595.107(b) clinical positions involving the practice of medicine for direct patient care to patients. Physicians excluded include physicians paid under title 38 U.S.C., Commissioned Corps Officers of the U.S. Public Health Service, and certain physicians under 5 U.S.C. 5948(b).

It had been identified that physicians with greater than 24 months receiving the PCA of up to $30,000 were those continuing to receive a PCA. It was further identified that the flexibilities and pay scale of title 38 U.S.C., provided greater recruitment opportunity than the PCA especially for identified recruitment difficulty areas such as Aberdeen, Navajo, and Billings Area. Thus the decline continues as those physicians with greater than 24 months either

decline, retire, or convert to title 38 U.S.C.

Any potential pay freeze considered by DHHS involving PCS or title 38 U.S.C would severely affect the Indian Health Service ability to recruit and retain physicians.

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.)*

10% of IHS civil service physicians are currently taking advantage of this recruitment and retention tool.

11) Provide any additional information that may be useful in planning PCA staffing levels and amounts in your agency.

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

(Dollars in Thousands)

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request	FY 2013 +/- FY 2012
BA	$2,962,621	$3,083,867	$3,186,678	+$102,811
FTE*	7,354	7,456	7,562	+106

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

SUMMARY OF THE BUDGET REQUEST

The FY 2013 budget submission for Clinical Services is $3,186,678,000, an increase of $102,811,000 over the FY 2012 Enacted. This change represents increases of $76,811,000 for Commissioned Officer pay costs, inflation, and staffing six new and expanded facilities. The detailed explanation of the request is described in each of the budget narratives that follow.

- The FY 2013 budget request for **Hospitals and Health Clinics** is $1.849 billion, an increase of $1.3 million to cover federal Commissioned Officer pay costs, $32 million for staffing new facilities, and a $5 million Health Information Technology increase. Funds will support access to quality healthcare in IHS and Tribal hospitals, clinics and health stations and help address health priorities such as diabetes, cardiovascular disease, obesity, maternal and child health, and behavioral health issues. The $5 million Health Information Technology program increase will provide funding to meet ICD-10 requirements.

- The FY 2013 budget request for **Dental Health** is $166.3 million, an increase of $268,000 for federal Commissioned Officer pay costs, $5.6 million for staffing new facilities and a $1 million program increase that will be used in FY 2013 to implement approximately 18 Electronic Dental Records at sites nationwide. Dental Health funds provide primarily preventive and basic care, with about 90 percent of services covering basic and emergency care. Basic services are prioritized over more complex rehabilitative care such as root canals, crown and bridge, dentures, and surgical extractions. The demand for dental treatment remains high due to the high dental caries rate in AI/AN children; however, a continuing emphasis on community oral health promotion/disease prevention is essential to impact long-term improvement of the oral health of AI/AN people.

- The FY 2013 budget request for **Mental Health** is $78.1 million, an increase of $29,000 for federal Commissioned Officer pay costs and $2.5 million for staffing new facilities. These funds 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.

- The FY 2013 budget request for **Alcohol and Substance Abuse** is $195.4 million, an increase of $27,000 for federal Commissioned Officer pay costs and $1.1 million for staffing new facilities. Funds will provide overall support to the Alcohol and Substance Abuse Program. The program exists as part of an integrated behavioral health team that works collaboratively to reduce the incidence of alcoholism and other drug dependencies in AI/AN communities.

- The FY 2013 budget request for **Contract Health Services** is $897.6 million, an increase of $54 million, which includes an increase of $34 million for inflation and $20 million to fund 848 inpatient admissions, 31,705 outpatient visits, and 1,166 one-way ambulance trips via ground or air. These funds will be used to purchase essential health care services not available in IHS/Tribal facilities including inpatient and outpatient care, routine emergency ambulatory care, transportation, and medical support services including laboratory, pharmacy, nutrition, diagnostic imaging, physical therapy, etc. The demand for CHS remains high as the cost of medical care increases. The CHS program continues to emphasize adherence to medical priorities, enrolling patients in alternate resources (such as Medicare, Medicaid and Private Insurance) available to them, 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 157 Federal and Tribal Service Units (local level) for 607 health care facilities providing care to 2.1 million AI/ANs primarily in service areas that are rural, isolated, and underserved.

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

Long Term Measure	Most Recent Result	Long Term Target
31: Childhood Weight Control: Proportion of children, ages 2-5 years, with a BMI of 95 percent or higher. IHS – All (Outcome)	FY 2011: 24.1% No annual target	FY 2013: 24.0%
31: Tribally Operated Health Programs (Outcome)	FY 2011: 23.6% (Context Only; no annual target)	Discontinued in FY 2012
28: Unintentional Injury Rates: Unintentional injury mortality rate in AI/AN population[1]. IHS – All (Outcome)	FY 2005: 93.8 FY 2005 Target: 94.0 (Target Exceeded)	FY 2013: 93.8 (Results available Dec 2016)
FAA-3: Unintentional Injury Rates: Unintentional mortality rate in AI/AN population[2]. (Outcome)	FY 2004: 90.5 FY 2004 Target: 92.2 (Target Exceeded)	Discontinued in FY 2012

[1] Targets and results are expressed as age-adjusted rates per 100,000 population.
[2] Targets and results are expressed as age-adjusted rates per 100,000 population.

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

HOSPITALS AND HEALTH CLINICS

(Dollars in Thousands)

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request	FY 2013 +/- FY 2012
BA	$1,762,865	$1,810,966	$1,849,310	+$38,344
FTE*	6,265	6,358	6,455	97

* 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 2013 Authorization.....Permanent

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

Hospitals and Health Clinics (H&HC) funds essential personal health services for 2.1 million American Indians and Alaska Natives (AI/AN) including medical and surgical inpatient care, routine and emergency ambulatory care, and medical support services including laboratory, pharmacy, nutrition, diagnostic imaging, medical records, and physical therapy. In addition, the program includes public/community health initiatives targeting health conditions disproportionately affecting AI/ANs such as programs for diabetes; maternal and child health; communicable diseases including influenza, HIV/AIDS, tuberculosis, and hepatitis; and a recent focus on planning and organizing regional trauma/emergency medical services delivery systems. The IHS system of care is unique in that personal health care services are integrated with community health services. Collecting, analyzing, and interpreting health information is done through a network of Tribally-operated epidemiology centers in collaboration with a national IHS coordinating center leading to the identification of health conditions as well as promoting interventions. Information technology that supports both personal health services (including the electronic health record and telemedicine) and public health initiatives is primarily funded through the H&HC budget.

Slightly more than one-half of the H&HC budget is transferred under P.L. 93-638 contracts or compacts to Tribal governments or Tribal organizations that design and manage the delivery of these individual and community health services. Most of the remainder is managed by direct Federal programs providing health care at the Service Unit (SU) and community level.

Although the health status of AI/ANs has improved significantly in the past 50 years since the inception of the IHS, the average life expectancy at birth is 72.5 years compared to the U.S. all races life expectancy of 77.5 years[1]. The IHS and Tribes primarily serve small, rural populations with mainly primary medical care and community-health services through approximately

[1] U.S. Department of Health and Human Services. Indian Health Service. Trends in Indian Health, 2002-2003 Edition. Washington: Government Printing Office, Released October 2009. ISSN 1095-2896. p.150.

700 locations, relying on the private sector for much of the secondary and all of the tertiary medical care needs. Some IHS and Tribal hospitals provide secondary medical services such as ophthalmology and orthopedics. Of 45 IHS and Tribal hospitals, only one has an average daily census of greater than 45 patients. Nineteen of these 45 hospitals have operating rooms, which demonstrates the IHS focus on primary and community based care rather than secondary or tertiary care.

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

Improving Patient Care –There are 89 sites participating in the Improving Patient Care (IPC) Program. The current goal is to expand to 168 sites by Fiscal Year (FY) 2013. The aim of the IPC program is to transform the Indian health system to a more integrated, well organized, and higher performing model of care. To advance the health and wellness of patients who utilize the Indian health system, the IPC program is leading participating sites to improve the health status and reduce the health disparities in care by improving the quality of and access to care across all ages and chronic conditions, assuring all preventive care needs are met, and improving our patients' experience of care. To achieve this transformation, teams will work to redefine clinical services by creating a health system, also known as a "Medical Home", for all AI/ANs that delivers health care services that are safe, timely, effective, efficient, and equitable.

The goal is to expand the elements of the Indian health medical home throughout the entire Indian health system. This expansion will require a national infrastructure to support innovative improvements throughout the Indian health system. Some of this infrastructure already exists in the staff of the Area Offices, regional Tribal organizations, and Tribal and IHS facilities whose role is to support the delivery of care. Enhanced capacity building efforts have been accomplished through the development of Improvement Support Teams (ISTs) from all 12 Area Offices. These ISTs currently provide team assessments, improvement training and technical assistance.

The IPC sites participate in a year-long collaborative that brings together a large number of teams from hospitals and clinics in an action-oriented forum to learn, adopt models for improvement, and share best practices. Participating I/T/U sites receive extensive training in the methodologies and strategies to improve quality and access to care and reduce health disparities. The collaborative uses virtual meeting technology to reach larger numbers of professionals in a cost-efficient manner. This process includes greater involvement and coordination by senior administrative staff, health professionals, allied health professionals, ancillary staff, community members, and Tribal leadership. To further support implementation of the Medical Home, participating IPC sites emphasize self-management support, delivery system design, decision support and clinical information systems. These areas of emphasis enable teams to provide better preventive care and screenings, improve care coordination for the management of chronic conditions, and enhance the experience of care. Other improvements include optimizing care teams and reducing waste and duplication, thereby delivering services in a cost effective manner while improving patient safety and meeting GPRA quality metric indicators.

A comprehensive measurement plan guides assessment in four domains: clinical prevention and screenings, care coordination of chronic conditions, patient experience of care, and access to care. Improvements have occurred in clinical prevention screenings for elevated blood pressure, depression, domestic violence/intimate partner violence, alcohol abuse, tobacco use, and body mass index for obesity; age-appropriate screening for colorectal, breast, and cervical cancer; chronic disease and care coordination for the treatment of high blood pressure, cardiovascular

disease including diabetes and hyperlipidemia; and in the patient experience of care. The IPC Evaluation Team is providing further analysis of the participating sites and has demonstrated statistically significant improvement in a number of measures after 18 - 36 months of participation.

Based on early combined team reporting from the IPC 3 Program, from March to September 2011, there were 136,196 active patients empanelled to a primary care provider. The following preliminary results of screening/prevention rates for teams reporting on individuals eligible for screening have exceeded IHS 2011 GPRA measures: Mammography 56%, Cervical Cancer 59.2%, Colorectal Cancer 47%, Depression 67.6%, and Domestic Violence/Intimate Partner Violence 66.4%. Of the IPC sites reporting on the Diabetes Comprehensive Care measure (HgbA1C, BP, LDL, nephropathy assessment, retinal screen, and foot exam) during this reporting period, 30.9% of eligible patients have received all appropriate screenings. The importance of this combined measure is to demonstrate the significance and importance of assuring diabetes standards of care are being met. This further potentiates early detection and prevention of co-morbid conditions.

Nursing - Nursing represents the largest provider of health care and has a major impact on patient safety and health care outcomes. Over 3,500 registered nurses work in Indian health programs with a vacancy rate of 16% in 2010 and 2011 (IHS Nurse Position Reports). The link between nurse staffing and adverse outcomes is well documented in the literature. Indicators chosen by the Joint Commission draw heavily on the literature regarding nurse staffing. Higher nurse staffing (staffing ratio of 1 Registered Nurse: 4 patients) are associated with lower failure-to-rescue incidents, lower rates of infection, and shorter hospital stays.

Nursing addresses all Agency priorities, but focuses heavily on the agency priority of improving quality and access to care for AI/ANs. Nurses are important leaders and contributors to every facet of clinical care for AI/ANs. Nurses are critical to the success of the Improving Patient Care initiative to transform the Indian health system to a patient-centered system of care. Nurses are often the first point of contact for patients; they conduct intake screening measures (e.g., blood pressure, tobacco use, depression) throughout the continuum of health care; and often initiate, implement or reinforce quality care for patients. Nurses are leading the IHS Baby Friendly Hospital Initiative, a component of the First Lady's Let's Move in Indian Country initiative, to promote breastfeeding that will reduce the risk for future development of obesity, diabetes and other obesity-related conditions in AI/ANs.

Trauma Care - The IHS is focusing more attention on trauma care and injury prevention. Combining these efforts results in greater synergy for reducing death and disability and controlling the high costs of traumatic injuries with their many chronic health sequelae. Trauma remains the largest cause of death and disability in Indian Country for those under age 45, and AI/AN trauma death rates are three times higher than U.S. all races rates.[1]

A trauma care program encompasses injury prevention, emergency medical services (EMS), emergency medicine, surgery, rehabilitation, hospital planning, and the regionalization of acute medical care. IHS and Tribal trauma care is often dependent on distant regional hospitals with advanced critical care capabilities for definitive care. The strength of the interrelationships developed between IHS and Tribal hospitals with their regional trauma centers influences patient outcomes. The goal is to ensure optimal trauma care through transfer agreements with a "first option" regional trauma center. These interrelationships are comprehensive and include patient care, patient care information sharing, health professional training, technical assistance, use of trauma registries, data coordination, and problem solving on a regional basis. Program

development began in FY2010 at IHS service units in the Tucson Area in affiliation with the University of Arizona; the program will continue to expand to other IHS Areas in FY 2012 and out-years. During FY 2011, all IHS and Tribal hospitals became active in the IHS-University of New Mexico Tele-Radiology Program to impact traumatic brain injury. Similarly, the IHS-University of Arizona "Smart Phone" Tele-Trauma Program is ongoing and making excellent progress. Major emphasis will be placed for implementation in the IHS Billings and Aberdeen Area hospitals in 2012, and both of these Trauma Regionalization projects are intended for system-wide implementation in 2013 and out-years.

The closest facility for EMS providers to transport individuals with traumatic injuries is frequently the local IHS or Tribal hospital. Staffing capacity and capabilities as well as state of the art equipment are essential. The role of diagnostic (e.g., CT scanners, ultrasound) and surgical and emergency department treatment equipment cannot be overstated. The CT is now the standard of care in trauma and many acute illnesses. Emergency medicine physicians, nurses, and other highly trained staff are essential for improving patient care and disaster management. Emergency room nurses are an essential and often underappreciated element in every trauma emergency plan and program. To address this critical need, IHS established a registered nurse "mini-residency" trauma and emergency medicine management course at the University of New Mexico (UNM) Regional Trauma Center in July 2010. Nurse training is ongoing in the IHS Albuquerque Area Service Units, and will be replicated for other IHS Areas following the Tele-Radiology program implementation.

Domestic Violence Prevention Initiative - According to the Center for Disease Control and Prevention, 39% of AI/AN women have experienced intimate partner violence – the highest percentage in the U.S.[2] In addition, one out of every three AI/AN women will be sexually assaulted in her lifetime,[3] and AI/AN women are more than five times as likely to die from domestic violence-related injuries than women of any other race.[4] Intimate partner violence and sexual assault have been correlated with adverse health conditions, including increases in heart disease, asthma, and stroke as well as migraines and fibromyalgia. Victims also experience mental health problems such as depression and post-traumatic stress disorder. Domestic violence and sexual assault have been correlated with an increase in high-risk health behaviors. People who have been victimized are more likely to smoke cigarettes, drink alcohol, use drugs, and engage in risky sexual behaviors.[5]

The Domestic Violence Prevention Initiative (DVPI) is a Congressionally-appropriated, nationally-coordinated demonstration/pilot program. The annual appropriation supports 65 pilot projects that target domestic violence and sexual assault prevention and intervention resources to communities in Indian Country. The IHS is using these funds to further expand its outreach advocacy programs into AI/AN communities, expand the Domestic Violence and Sexual Assault Pilot project, and provide for training and the purchase of forensic equipment to support the Sexual Assault Nurse Examiner and Sexual Assault Forensic Examiner programs. The projects

[1] Piland, Neil F., "The IHS Provider", September 2007
[2] Centers for Disease Control and Prevention. (2008). Adverse health conditions and health risk behaviors associated with intimate partner violence-United States, 2005. *MMWR, 57*(05), 113-117. Retrieved March 2, 2010, from http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5705a1.htm
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adhere to reporting requirements established by the IHS and report on data and evidence-based outcome measures designed to help determine the most effective means for combating these issues in Tribal and Urban Indian communities. The completion of a national, independent evaluation of the DVPI will allow identification of successful evidence-based and practice-based programs that can be replicated across the Indian health system.

IHS is collaborating with other agencies working in the field of domestic violence and sexual assault. IHS and the Department of Justice (DOJ) Office for Victims of Crime (OVC) established an Interagency Agreement to provide training and technical assistance to address the needs of sexual assault victims. The OVC has established a coordinated, multidisciplinary project, the Sexual Assault Nurse Examiner and Sexual Assault Response Team AI/AN Initiative, which will involve IHS, the Bureau of Indian Affairs, the Federal Bureau of Investigation, and the DOJ Office on Violence Against Women. The overall goal of the initiative is to restore the dignity, respect, and mental and physical health of victims of sexual assault and ensure more effective and victim-centered investigations and prosecutions. The initiative will support victim recovery, satisfaction, and cooperation with the Federal criminal justice system, as well as support victims of sexual assault and Tribal communities' need for justice.

FUNDING HISTORY

Fiscal Year	Amount	
2008 Enacted	$1,484,016,000	
2009 Recovery Act	$85,000,000*	Health IT, P.L. 111-5
2009 Omnibus	$1,597,777,000	
2010 Enacted	$1,754,383,000	
2011 Enacted	$1,762,865,000	
2012 Enacted	$1,810,966,000	

* see HIT narrative (separate)

BUDGET REQUEST

The FY 2013 budget request for Hospitals and Health Clinics of $1,849,310,000 is an increase of $38,344,000 over the FY 2012 enacted level of $1,810,966,000. The request includes:

Current Services +$33,344,000

- +$1,383,000 to cover federal Commissioned Officer pay costs.
- +$31,961,000 for staffing and operating costs at newly constructed facilities. These funds allow IHS to expand provision of health care in those areas where capacity has been expanded to address critical health care needs.

Staff for New Facility	Amount	Tribal Positions
Chickasaw Nation Health Clinic (JV), Ardmore, OK	$5,388,000	55
Cherokee Nation Health Center (JV), Vinita, OK	$1,638,000	17
Chickasaw Nation Health Clinic (JV), Tishomingo, OK	$3,181,000	32
Southcentral Foundation Valley Primary Care Center (JV), Wasilla, AK	$8,631,000	62
Tanana Chief Conference Interior Health Center (JV), Fairbanks, AK	$5,517,000	40
Norton Sound Regional Hospital, Nome, AK	$7,606,000	59
Grand Total:	**$31,961,000**	**265**

Program Increase +$5,000,000 for Health Information Technology (HIT)

With these additional funds, IHS will be able to complete systems development for the ICD-10 conversion and to deliver an acceptable minimum level of national training for affected staff. Funding is essential to provide necessary training and implementation support in order to prevent delays in filing claims, erroneous and rejected claims, reduced third party revenue capture, and potentially reduced services to underserved patients from IHS and Tribal health care facilities.

Outputs and Outcomes

Measure	Year and Most Recent Result/ Target for Recent Result/ (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 Target +/- FY 2012 Target
5: Diabetes: Nephropathy Assessment: Proportion of patients with diagnosed diabetes assessed for nephropathy. IHS-All	FY 2011: 56.5% Target: 51.9% (Target Exceeded)	57.8%	55.3%	-2.5%
5: Tribally Operated Health Programs	FY 2011: 44.4% Target: 40.5% (Target Exceeded)	45.4%	43.4%	-2.0%
20: Accreditation: Percent of hospitals and outpatient clinics accredited (excluding tribal and urban facilities)	FY 2011: 100% Target: 100% (Target Met)	100%	100%	0
6: Diabetic Retinopathy: Proportion of patients with diagnosed diabetes who receive an annual retinal examination. IHS-All	FY 2011: 53.5% Target: 50.1% (Target Exceeded))	54.8%	55.8%	+1.0%
6: Tribally Operated Health Programs	FY 2011: 48.8% Target: 45.4% (Target Exceeded)	49.9%	50.9%	1.0%
7: Pap Smear Rates: Proportion of eligible women who have had a Pap screen within the previous three years. IHS-All	FY 2011: 58.1% Target: 55.7% (Target Exceeded)	59.5%	56.9%	-2.6%
7: Tribally Operated Health Programs	FY 2011: 58.6% Target: 55.7% (Target Exceeded)	60.0%	57.4%	-2.6%
8: Mammogram Rates: Proportion of eligible women who have had mammography screening within the previous two years. IHS-All	FY 2011: 49.8% Target: 46.9% (Target Exceeded)	51.7%	49.5%	-2.2%
8: Tribally Operated Health Programs	FY 2011: 50.1% Target: 46.2% (Target Exceeded))	52.0%	49.8%	-2.2%
9: Colorectal Cancer Screening Rates: Proportion of eligible patients who have had appropriate colorectal cancer screening. IHS-All	FY 2011: 41.7% Target: 36.7% (Target Exceeded)	43.2%	41.3%	-1.9%
9: Tribally Operated Health Programs	FY 2011: 43.7% Target: 37.8% (Target Exceeded)	45.2%	43.3%	-1.9%
TOHP-2: Number of designated annual	FY 2011: 17/17	13/17	13/17	0

Measure	Year and Most Recent Result/ Target for Recent Result/ (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 Target +/- FY 2012 Target
clinical performance goals met. (Outcome)	Target: 13/17 (Target Exceeded)			
TOHP-4: Years of Potential Life Lost (YPLL) in the American Indian/Alaska Native (AI/AN) populations served by tribal health Programs (Outcome)	FY 2005: 63.8 No Target	Discontinued but consolidated in FY 2012	N/A	N/A
FAA-2: Years of Potential Life Lost (YPLL) in American Indian/Alaska Native population (Outcome)	FY 2005: 80.9 (No target)	Discontinued but consolidated in FY 2012	N/A	N/A
44: Years of Potential Life Lost (YPLL) in the American Indian/Alaska Native (AI/AN) population (Outcome) IHS-All	N/A	Baseline	TBD	N/A
24: Combined (4:3:1:3:3:1:4) Childhood Immunization rates: AI/AN children patients aged 19-35 months IHS - All (Outcome)	FY 2011: 75.9% Target: 74.6% (Target Exceeded)	77.8%	74.5%	-3.3%
24: Tribally Operated Health Programs	FY 2011: 72.3% Target: 71.7% (Target Exceeded)	74.1%	70.9%	-3.2%
FAA-E: Hospital Admissions per 100,000 service population for long term complications of diabetes in federally administered facilities. (Efficiency)	FY 2010: 140.6 FY 2010 Target: 130.7 (Target Not Met)	Discontinued, but consolidated in FY 2012	N/A	N/A
45: Hospital Admissions per 100,000 service population for long term complications of diabetes. (Efficiency) IHS-All	N/A	Baseline	TBD	N/A
FAA-1: Children ages 2-5 years with a BMI at the 95th percentile or higher.	FY 2010: 25.5% Target: 24% (Target Not Met)	Discontinued in FY 2012	N/A	N/A
TOHP-3: Percentage of AI/AN patients with diagnosed diabetes served by tribal health programs that achieve ideal blood sugar control	FY 2011: 35.0% (No Annual Target; Long-term Measure)	Discontinued in FY 2012	N/A	N/A
16: Domestic (Intimate Partner) Violence Screening: Proportion of women who are screened for domestic violence at health care facilities. IHS-All	FY 2011: 55.3% Target: 52.8% (Target Exceeded)	55.3%	52.1%	-3.2%
16: Tribally Operated Health Programs	FY 2011: 46.1% Target: 44.5% (Target Exceeded)	46.1%	43.4%	-2.7%
25: Adult Immunizations: Influenza: Influenza vaccination rates among adult patients aged 65 years and older. IHS-All	FY 2011: 62.0% Target: 58.5% (Target Exceeded)	63.4%	60.7%	-2.7%
25: Tribally Operated Health Programs	FY 2011: 58.2% Target: 56.5% (Target Exceeded)	59.7%	57.1%	-2.6%

Measure	Year and Most Recent Result/ Target for Recent Result/ (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 Target +/- FY 2012 Target
26: Adult Immunizations: Pneumovax: Pneumococcal vaccination rates among adult patients aged 65 years and older. IHS-All	FY 2011: 85.5% Target: 79.3% (Target Exceeded)	87.5%	83.7%	-3.8%
26: Tribally Operated Health Programs	FY 2011: 80.7% Target: 75.4% (Target Exceeded)	82.6%	79.0%	-3.6%
33: HIV Screening: Proportion of pregnant women screened for HIV	FY 2011: 80.0% Target: 73.6% (Target Exceeded)	81.8%	78.3%	-3.5%
FAA-4 (43 in FY 2013): Breastfeeding Rates: Proportion of infants 2 months old (45-89 days old) that are exclusively or mostly breastfed.	FY 2010: 28.5% Target: 28.6% (Target Not Met)	28.6%	Baseline	N/A
21: **Patient Safety:** Percent of patient falls in an IHS-funded facility in persons age 65 and older as a result of taking high risk medication.	FY 2010: 3.6% Baseline	Discontinued in FY 2011	N/A	N/A
H&HC 4: Inpatient Admissions - IHS Direct *(Output)*	FY 2011: 27,333 Target: 27,200 (Target Exceeded)	26,900	27,700	800
Domestic Violence Prevention Initiative				
Percentage of Domestic Violence Prevention Initiative-funded programs providing case management services to victims and children of victims *(Output)*	FY 2011: 63.4% Target: Baseline	63.4%	63.4%	0
Percentage of sexual assault community developed model programs that have an active interdisciplinary Sexual Assault Response Team (SART) *(Output)*	FY 2011: 84.6% Target: Baseline	84.6%	84.6%	0
Percentage of SANE/SART Programs with written sexual assault response policies and procedures *(Output)*	FY 2011: 85.7% Target: Baseline	85.7%	85.7%	0

GRANTS AWARDS

	FY 2011 Enacted*	FY 2012 Enacted	FY 2013 Request
Number of Awards	47	2	2
Average Award	$125,957	$750,000	$750,000
Range of Awards	$24,975-$1,000,000	$500,000-$1,000,000	$500,000-$1,000,000
Total Awards	**$5,920,000**	**$1,500,000**	**$1,500,000**

*FY 2011 reflects actual data.

AREA ALLOCATION – Hospitals and Health Clinics

Discretionary SERVICES	**FY 2011 Enacted**	**FY 2012 Enacted**	**FY 2013 Request**	**FY 2013 +/- FY 2012**
Aberdeen	$152,545,971	$174,874,619	$175,490,988	$616,370
Alaska	260,512,676	261,335,232	284,010,344	22,675,112
Albuquerque	79,470,765	79,721,690	80,002,680	280,990
Bemidji	100,117,597	100,433,713	100,787,706	353,993
Billings	65,889,583	66,097,626	66,330,596	232,970
California	72,573,889	72,803,038	73,059,642	256,604
Nashville	57,414,557	57,595,841	57,798,845	203,005
Navajo	233,120,651	233,856,718	234,680,978	824,260
Oklahoma	321,580,477	333,456,448	344,838,761	11,382,313
Phoenix	165,142,276	165,663,705	166,247,609	583,905
Portland	77,169,844	77,413,504	77,686,359	272,855
Tucson	20,683,063	20,748,369	20,821,499	73,130
Headquarters	156,643,651	166,965,498	167,553,991	588,493
Total, H&HC	**$1,762,865,000**	**$1,810,966,000**	**$1,849,310,000**	**+$38,344,000**

Note: FY 2011 amounts reflect actual data. FY 2012 and FY 2013 are estimates.

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

(Dollars in Thousands)

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request	FY 2013 +/- FY 2012
BA – H&HC	$1,762,865	$1,810,966	$1,849,310	+$38,344
Epi Centers	*$4,686*	*$4,679*	*$4,679*	*+$0*
FTE*	13	13	13	0

Note: *Italicized* dollar amounts and FTE are non-add.
*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 2013 Authorization.....Permanent

Allocation Method.....Cooperative Agreements

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

Congress authorized funding for the innovative Indian Health Service (IHS) Tribal Epidemiology Center (TEC) program in FY 1996. The intent has been to develop public health infrastructure by augmenting existing Tribal organizations with expertise in epidemiology and public health through the establishment of Epidemiology Centers. Funding is distributed to the TECs through Cooperative Agreements to Tribes and Tribal organizations such as Indian health boards.

Operating within Tribal organizations, TECs are uniquely positioned to provide support to local Tribal disease surveillance and control programs, and assess the effectiveness of public health programs. All TECs monitor the health status of their constituent Tribes, produce reports annually or biannually, and provide critical support to Tribes who self-govern their health programs. Data generated locally and analyzed by TECs enable Tribes to evaluate Tribal and community-specific health status for planning the needs of their Tribal membership. Immediate feedback is provided to the local data systems and leads to improvements in Indian health data overall. TECs support national public health goals by working to improve data for GPRA reports and monitoring of the Healthy People 2020 objectives at the Tribal level. Standardization of health status reports across all TECs will lead to a more comprehensive picture of Indian health.

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

FUNDING HISTORY

Over 90 percent of the TEC Program budget is distributed through cooperative agreements. Up to $1,000,000 in funding for each TEC is authorized by the Indian Health Care Improvement Act.

Initially, four Tribal organizations competed and received funding based on recommendations from an objective review panel in the amount of $155,000 each. In FY 2000, the four original TECs plus two new centers received funding for the next five years. In FY 2006, after another recent competitive 5-year cooperative agreement award process, the IHS TEC program expanded to include 11 TECs. In FY 2008, the California Area established a TEC. All 12 existing TECs now serve a major portion of the AI/AN population in 12 regions comparable to the IHS Administrative Area service population. In FY 2011, through another competitive 5-yr cooperative agreement award process, all 12 TECs were again awarded.

Fiscal Year	Amount
2008 Enacted	$4,548,361
2009 Omnibus	$4,609,489
2010 Enacted	$4,686,346
2011 Enacted	$4,686,346
2012 Enacted	$4,678,502

BUDGET REQUEST

The FY 2013 budget request for the Tribal Epidemiology Centers program of $4,678,502 is the same as the FY 2012 enacted level of $4,678,502.

The TEC program was recently evaluated by an external company to highlight strengths and address weaknesses at each TEC. Results from the TECs and their Tribal or Urban Indian health boards indicate the number one recommendation for strengthening the TEC Program Performance is to: "Increase Core Funding," to continue to build on public health capacity, improve data collection and analysis, and provide services to assist Tribes. Increased public health capacity aids Tribes, Tribal organizations and Urban Indian Health Organizations in identifying community health needs and in program planning and evaluation. TECs improve data on AI/AN health not only through individual data collection, but also through collaboration with States and other organizations to improve existing data sets by filling gaps in AI/AN data and correcting racial misclassification in data sets. In addition, TECs develop the AI/AN public health and research workforce through training, skills development, and job opportunities that provide young AI/AN professionals with mentoring and experience.

FY 2013 Tribal Epidemiology Centers Allocation (Estimated)			
1	Alaska Native Tribal Health Consortium	Anchorage, AK	$360,000
2	Albuquerque American Indian Health Board	Albuquerque, NM	$360,000
3	Great Lakes Inter-Tribal Council	Lac du Flambeau, WI	$360,000
4	Inter Tribal Council of Arizona	Phoenix, AZ	$360,000
5	Montana/Wyoming Tribal Leaders Council	Billings, MT	$360,000
6	Navajo Nation Division of Health	Window Rock, AZ	$360,000
7	Northern Plains – Aberdeen Area	Rapid City, SD	$360,000
8	Northwest Portland Area Indian Health Board	Portland, OR	$360,000
9	Oklahoma City Area Inter-Tribal Health Board	Oklahoma City, OK	$360,000
10	Seattle Indian Health Board	Seattle, WA	$360,000
11	United South and Eastern Tribes, Inc.	Nashville, TN	$360,000
12	California Rural Indian Health Board	Sacramento, CA	$360,000
	Administrative and technical support	Albuquerque, NM	$359,000
	TOTAL		**$4,679,000**

Addressing Agency Priorities:

1. Renew and strengthen our partnership with Tribes
   The TECs are fundamental to the IHS' partnership with Tribes by supporting epidemiology and public health functions critical to the delivery of healthcare services. Independent TEC goals are set as directed by their constituent Tribes and health boards. DEDP tracks these goals and objectives as written in their cooperative agreements, i.e. surveillance of disease and control programs, and collecting epidemiological data for use in determining health status of Tribal communities. DEDP sets a national outcome for each TEC to develop and disseminate regional health profiles for their constituent Tribes and communities.

2. Bring reform to the IHS
   TECs represent an important link to IHS reform efforts through their efforts to build capacity in the Indian health system to evaluate and monitor the effectiveness of health programs.

3. Improve the quality of and access to care
   In the expanding environment of Tribally-operated health programs, epidemiology centers provide additional public health services, such as disease control and prevention programs in the areas including sexually transmitted disease control, HIV and cancer prevention. TECs assist Tribes with projects such as conducting behavioral risk factor surveys to establish baseline data for successfully evaluating intervention and prevention activities. The TEC program supports Tribal communities by providing technical training in public health practice and prevention-oriented research and promoting public health career pathways for Tribal members. DEDP works with NIH and CDC to supplement the TECs, create stronger interagency partnerships, and prevent costly duplication of effort.

4. Make all our work accountable, transparent, fair and inclusive
   The DEDP continues to make all our work accountable, transparent, fair and inclusive to IHS, Tribes, TECs, other Federal agencies, and the public through reports, meetings and the recent TEC program evaluation.

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

Outputs and Outcomes Table

Measure	Year and Most Recent Result/ Target for Recent Result/ (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 Target +/- FY 2012 Target
Health Status & Monitoring* **Measured by surveys, assessments, reports (Output)*	FY 2011: 12 of 12 TECs FY 2011 Target: 12 of 12 TECs (Target Met)	12 of 12 TECs	12 of 12 TECs	0
Provide regional health profiles *(Output)*	FY 2011: 12 of 12 TECs FY 2011 Target: 12 of 12 TECs (Target Met)	12 of 12 TECs	12 of 12 TECs	0
Tribal support -tech training in public health practice *(Output)*	FY 2011: 12of 12 TECs FY 2011 Target: 12 of 12 TECs (Target Met)	12of 12 TECs	12of 12 TECs	0

GRANTS AWARDS

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request
Number of Awards	12	12	12
Average Award*	$390,000	$360,000	$360,000
Range of Awards	$275,000 - $425,000	$300,000 - $500,000	$300,000 -$475,000

* 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.

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 2011 Enacted	FY 2012 Enacted	FY 2013 Request	FY 2013 +/- FY 2012
BA	$1,762,865	$1,810,966	$1,849,310	+$38,344
HIT	*$169,025*	*$172,149*	*$177,149*	*+$5,000*

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 2013 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 IT to improve health care delivery and quality, enhance access to care, reduce medical errors, and modernize administrative functions consistent with the Department of Health and Human Services (HHS) enterprise initiatives. The IHS HIT program provides support for the Indian Health Care system. IHS has over 25 years of experience with HIT as a major enabler of clinical care that supports the goal of achieving health equity and improving clinical outcomes for the American Indian and Alaska Native (AI/AN) population. Continued investment in HIT has the ongoing potential to transform health care delivery by lowering costs and improving quality. HIT funding increases continue to improve the quality of the care that physicians and other caregivers provide as well as ensure patient safety within the Indian health system.

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

1) **RPMS** is the key IHS enterprise health information system that underlies the clinical, practice management and revenue cycle business processes at IHS, Tribal, and Urban (I/T/U) facilities across the country. RPMS is used at approximately 400 Indian health care facilities, and supplies a Certified Electronic Health Record (EHR) which is in use at over 320 of these locations with continued deployment activities underway. The IHS-wide adoption of RPMS provides substantial savings to IHS by lowering the cost of providing health care, eliminating unnecessary health care services, and improving the quality of care.
2) **IOAT** provides the technical infrastructure for IHS healthcare facilities and is the foundation upon which RPMS is delivered. The IOAT investment includes a highly available and secure wide area network, a national e-mail and telecommunications capability, and the supporting hardware including servers and end-user devices. The IHS IT infrastructure incorporates

government and industry standards for the collection, processing, storage, and transmission of information and is poised to respond to new and innovative opportunities.

3) **NPIRS** is an enterprise-wide data warehouse environment that produces reports required by statute and regulation and provides a broad range of clinical and administrative information to managers at all levels of the Indian health system.

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

FY 2011 Accomplishments

The IHS Office of Information Technology achieved numerous accomplishments during FY 2011, including the following examples:

- IHS became the first Federal agency to have its health information system certified for Meaningful Use. The RPMS suite was certified as a Complete EHR for both Ambulatory and Inpatient settings as of April 8, 2011. This means that the 40 IHS and Tribal hospitals and thousands of eligible providers at IHS, Tribal and Urban health care facilities can qualify for substantial payments through the Medicare and Medicaid incentive programs.
- IHS was cited by the Secretary of HHS through the HHS*innovates* program for its development of near real-time surveillance of influenza-like illness in response to the H1N1 flu outbreak.
- IHS was the first HHS agency to implement Continuous Monitoring as an effective IT security strategy.
- In support of OMB's "25 Point Implementation Plan to Reform Federal IT Management," IHS migrated the National Patient Information Reporting System to a private cloud system with fully virtualized servers to increase efficiency of system use while simultaneously reducing the number of physical systems in the data center.
- IHS consolidated its largest data center in Albuquerque, NM through collaboration with the U.S. Department of Interior, Bureau of Indian Affairs with significant cost savings.

IHS has continued to expand its support for telehealth through improvement of the infrastructure and network expansion required for telehealth delivery. This support helps ensure that the backbone of the network can remain adequate for the timely transmission of telehealth consultations. Telehealth enables a "best practice" model of specialist health care delivery. This model of enhanced access, improved clinical quality, and increased organizational cost-efficiency is possible through the integration of emerging technical and clinical innovations, such as expert teleconsultation and remote patient monitoring/care coordination.

Collaboration with other federal agencies is a key initiative within the IHS HIT Program. IHS works closely with Office of the National Coordinator for HIT, Centers for Medicare and Medicaid Services, Agency for Healthcare Research and Quality, Veterans Health Administration, Department of Defense, and other Federal entities on IT initiatives to ensure that the direction of its HIT system is consistent with other Federal agencies. In addition, IHS has routinely shared HIT artifacts (design and requirement documents, clinical quality logic, etc.) with both public and private organizations. IHS considers the RPMS suite to be a public utility, making it available without cost to all interested parties.

The IHS HIT Program makes use of all available resources to implement critically important initiatives that are aimed at meeting federal mandates and improving the overall delivery of care that IHS provides, while upgrading its systems and infrastructure to meet the technology and

security demands of the 21st century. The IHS HIT Program faces increased workload and costs in FY 2012 and FY 2013, including the following:

- Implementing the International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10)
- Implementing mandates from the Health Information Technology for Economic and Clinical Health Act (HITECH) to enhance the RPMS suite to meet Stage 2 and Stage 3 requirements of Meaningful Use
- Implementing Homeland Security Presidential Directive 12 (HSPD12) and Federal Identity, Credential, and Access Management (FICAM) requirements
- Upgrading the IHS network to achieve the Federal Communications Commission (FCC) recommended capability
- Supporting health care reform
- Supporting other IT reforms
- Expanding and developing additional Behavioral Health applications to meet new requirements
- Expanding telehealth initiatives

The IHS HIT Program will provide the highest-quality support and necessary modernization of HIT within available resources as well as the balancing of mandates and enhancements, including cloud based solutions and virtualization.

FUNDING HISTORY

Fiscal Year	Amount *
2008	*$112,006,000*
2009 Recovery Act	*$10,985,000*
2009 Omnibus	*$114,506,000*
2010 Recovery Act	*$74,015,000*
2010 Enacted	*$172,405,000***
2011 Enacted	*$169,024,509*
2012 Enacted	*$172,149,000*

*This represents the total cost of HIT within IHS. The majority is from the Hospital & Health Clinics budget line with a small amount from Direct Operations for federal personnel and travel.
** The increase of $57,899,000 from 2009 Omnibus to 2010 Enacted includes a $16,251,000 program increase for HIT and $41,648,000 increase which reflects a change in reporting requirements to include field IT related expenses that were previously reported program operation budgets only.

FY 2012 Enacted Funding

IHS received an increase in funding for FY 2012, with $3.394 million designated for Health IT Security. A portion of the new funds will be distributed to Tribal programs through the self-determination process to maintain/improve their IT security as they interface with IHS IT, and IHS will use the remaining funding to:

- Implement a centralized patch management system that will address the most significant security vulnerability in a decentralized system such as ours, i.e. inconsistent application of security-related patches released by software vendors.
- Address the evolving and ever more stringent security requirements for health information technology related to EHR Certification and Meaningful Use, Health Information Exchange, and Telehealth.
- Support Continuous Monitoring for security vulnerabilities across the IHS Wide Area Network.

In addition, IHS will continue to manage its existing IT investments and programs, delivering the highest quality Information Technology and Health Information Technology products and services to Federal, Tribal and Urban Indian health program customers.

Immediate Priorities and Challenges

The principal priorities for the IHS HIT Program in FY 2013 will be completion of the system-wide transition to version 10 of the International Classification of Diseases (ICD-10) and preparing for 2014 EHR Certification and Stage 2 Meaningful Use. In 2012 IHS is analyzing and conducting development on the 60-plus software applications that require modification for ICD-10, and is planning for training of thousands of billers, coders, clinicians and other staff. During 2013 extensive testing and coordinated release of the software changes will take place along with the nationwide training. Simultaneously with the ICD-10 project, the IHS HIT Program will be preparing for Stage 2 Meaningful Use, which begins on October 1, 2013. Considerable additional development in RPMS, the Personal Health Record, and in IHS Health Information Exchange capabilities will need to take place in order for the systems to retain certified status for Stage 2. The Notices of Proposed Rule Making for 2014 EHR Certification (ONC) and Stage 2 Meaningful Use (CMS) introduce, among other things, a new requirement for implementation of the SNOMED-CT vocabulary in Certified EHR systems. The simultaneous technical development and training requirements for both ICD-10 and SNOMED-CT will be extremely complex and require a high level of planning and coordination. Because of the greater financial risk and impact of the ICD-10 mandate, this is considered to be the highest priority.

BUDGET REQUEST

The FY 2013 budget request for Health Information Technology of $177,149,000 is an increase of $5,000,000 over the FY 2012 enacted level of $172,149,000. The request includes:

Program Increase +$5,000,000

IHS will use funds to complete systems development for the ICD-10 conversion and to deliver an acceptable level of national training for affected staff. Funding is essential to provide necessary training and implementation support in order to prevent delays in filing claims, erroneous and rejected claims, reduced third party revenue capture, and potentially reduced services to underserved patients from IHS and Tribal health care facilities.

HIT in IHS is an instrument to support health care efficiency and quality. The IHS HIT Program has made substantial strides in the past few years by using innovative solutions to improve the IHS' infrastructure and to provide healthcare providers with the tools and information they need to make life-saving decisions at the point of care. The FY 2013 budget request will allow the IHS HIT Program to maintain current gains in HIT and complete the work on ICD-10 which is critical to maintaining the revenue streams for IHS, Tribal and Urban health care facilities.

The IHS request includes funding to support the President's information technology initiatives and Departmental enterprise information technology initiatives identified through the HHS strategic planning process.

IHS Investments

(Dollars in Thousands)

Program Name	IT Investment Title	UPI	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request
Hospitals & Health Clinics	IHS Resource and Patient Management System – Maintenance & Enhancements	009-17-01-02-01-1010-00	$88,825	$94,876	$107,563
Hospitals & Health Clinics	IHS National Patient Information and Reporting System – Maintenance & Enhancements	009-17-01-02-01-1020-00	$8,183	$9,000	$9,285
Hospitals & Health Clinics	IHS Infrastructure, Office Automation, & Telecommunications (IOAT)	009-17-02-00-01-1040-00	$52,504	$54,578	$55,858
Hospitals & Health Clinics	Non-major Investments including Security and Enterprise Architecture Programs	N/A	$8,088	$9,255	$9,707

Outputs and Outcomes

Measure	Year and Most Recent Result/ Target for Recent Result/ (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 Target +/- FY 2012 Target
RPMS-E1 and E2: Average days in accounts receivable for hospitals. *(Efficiency)*	FY 2010: 64 Target: Baseline (Target Met)	Discontinued in FY 2012	N/A	N/A
RPMS-E2: Average days in accounts receivable for small ambulatory clinics. *(Efficiency)*	FY 2010: 62 Target: Baseline (Target Met)	Discontinued in FY 2012	N/A	N/A
RPMS-2: Derive all clinical measures from RPMS and integrate with EHR (Clinical Measures/Areas) (RPMS Program Assessment)	FY 2011: 69/12 Target: 65/12 (Target Exceeded)	69/12	69/12	0
RPMS-7: Number of patients with clinical images captured or displayed for use in the RPMS Electronic Health Record (RPMS Program Assessment)	FY 2011: 386,535 Target: 368,888 (Target Exceeded)	Discontinued in FY 2012	N/A	N/A

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

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

(Dollars in Thousands)

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request	FY 2013 +/- FY 2012
BA	$152,634	$159,440	$166,297	+$6,857
FTE*	692	697	704	+7

* 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 2013 Authorization.....Permanent

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

PROGRAM DESCRIPTION and ACCOMPLISHMENTS

The purpose of the Dental Program is to raise the oral health status of the American Indian/Alaska Native (AI/AN) population to the highest possible level through the provision of quality preventive and treatment services, at both community and clinic sites. The Dental Program is a service oriented program providing basic dental services (diagnostic, emergency, preventive, and basic restorative care). Approximately 90 percent of the dental services provided fall into the basic dental services category. In FY 2011, the dental program provided a total of 3,229,405 documented basic dental services. More complex rehabilitative care (i.e., root canals, crown and bridge, dentures and surgical extractions) is provided where resources allow and account for the additional 354,457 dental services provided in FY 2011.

By age eight, 90 percent of AI/AN children suffer from dental caries, while only 50 percent of the U.S. population has experienced cavities. In addition to this disparity in prevalence, there is a significant disparity in severity of dental disease. AI/AN children ages 2-5 exhibit an average of six decayed teeth, while the same age group in the U.S. population averages one decayed tooth. The demand for dental treatment remains high due to the high incidence of dental caries in AI/AN children. A continuing emphasis on community oral health promotion/disease prevention is essential in order to address the current high prevalence and to reduce the severity of oral disease and improve the oral health of AI/AN people. Prevention activities reduce both the amount and the cost of subsequent dental care and improve oral health.

The dental program maintains data and tracks three key program objectives: 1) increase the number of dental sealants placed; 2) increase the number of patients who receive at least one topical fluoride application; and 3) increase access to care. The Dental Program met all three annual targets for the GPRA year ending June 2011. Topical fluorides and dental sealants are extensively researched and documented in the dental literature as safe and effective preventive interventions to reduce tooth decay. The high prevalence of sealants represents a notable accomplishment for the IHS Dental Program as significant numbers of susceptible tooth surfaces

are now protected by dental sealants. Access to dental services is a prerequisite to the control of oral disease in susceptible or high-risk populations.

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

Congressional appropriations were earmarked for the creation of the DSC's in both 1999 and 2000. In the ensuing years, these DSCs had an immediate positive impact on the direct delivery of dental care in a number of ways:

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

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

The targeted percentage of patients receiving dental services was exceeded during FY 2011, as were the number of patients receiving at least one topical fluoride application and number of sealants placed. The IHS Dental program will continue its efforts to recruit and retain dental providers to improve dental access and to meet all annual performance objectives.

FUNDING HISTORY

Fiscal Year	Amount
2008 Enacted	$133,637,000
2009 Omnibus	$141,936,000
2010 Enacted	$152,634,000
2011 Enacted	$152,634,000
2012 Enacted	$159,440,000

BUDGET REQUEST

The FY 2013 budget request for Dental Services of $166,297,000 is an increase of $6,857,000 over the FY 2012 enacted level of $159,440,000. The request includes:

Current Services +$5,857,000

- +268,000 to cover federal Commissioned Officer pay costs.
- +$5,589,000 for staffing and operating costs for new/expanded facilities. These funds will support increases in workforce necessary to staff newly constructed facilities.

Staff for New Facility	Amount	Tribal Positions
Chickasaw Nation Health Clinic (JV), Ardmore, OK	$1,143,000	12
Cherokee Nation Health Center (JV), Vinita, OK	$508,000	5
Chickasaw Nation Health Clinic (JV), Tishomingo, OK	$513,000	5
Southcentral Foundation Valley Primary Care Center (JV), Wasilla, AK	$1,593,000	13
Tanana Chief Conference Interior Health Center (JV), Fairbanks, AK	$882,000	7
Norton Sound Regional Hospital, Nome, AK	$950,000	8
Grand Total:	**$5,589,000**	**50**

Program Increase +$1,000,000

- The $1,000,000 increase will be used to implement the Electronic Dental Record (EDR) in approximately 18 additional sites, including the associated costs, throughout the Indian health system to improve the quality of and access to dental care, and move closer to meeting the President's initiative regarding the implementation of electronic health records in the Federal government.
- Results expected include increased quality and a modest increase in access to care and the number of sites implemented will increase from 100 (43%) to 118 (51%) for the 230 total planned sites.

Outputs and Outcomes

Measure	Year and Most Recent Result/ Target for Recent Result/ (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 Target +/- FY 2012 Target
12: **Topical Fluorides:** Number of American Indian and Alaska Native patients receiving at least one topical fluoride application.	FY 2011: 161,461 Target: 135,604 (Target Exceeded)	161,461	Baseline	N/A
13: **Dental Access:** Percent of patients who receive dental services.	FY 2011: 26.9% Target: 23.0% (Target Exceeded)	26.9%	25.0%	-1.9%
14: **Dental Sealants:** Number of sealants placed per year in AI/AN patients.	FY 2011: 276,893 Target: 257,261 (Target Exceeded)	276,893	Baseline	N/A

GRANTS AWARDS

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request
Number of Awards	4	4	4
Average Award	$249,998	$249,998	$249,998
Range of Awards	$249,996-250,000	$249,996-250,000	$249,996-$250,000
Total Awards	**$1,000,000**	**$1,000,000**	**$1,000,000**

AREA ALLOCATION – Dental Services

Discretionary SERVICES	**FY 2011 Enacted**	**FY 2012 Enacted**	**FY 2013 Request**	**FY 2013 +/- FY 2012**
Aberdeen	$14,250,193	$17,381,285	$17,519,516	$138,230
Alaska	19,091,894	19,061,289	22,637,880	3,576,591
Albuquerque	8,518,665	8,505,009	8,572,648	67,639
Bemidji	4,362,824	4,355,830	4,390,471	34,641
Billings	7,621,988	7,609,770	7,670,289	60,519
California	1,806,814	1,998,605	2,014,500	15,895
Nashville	2,885,615	2,880,989	2,903,901	22,912
Navajo	30,093,813	30,045,571	30,284,519	238,947
Oklahoma	32,816,630	36,466,079	38,920,088	2,454,009
Phoenix	13,745,099	13,723,065	13,832,202	109,137
Portland	7,802,224	7,789,717	7,851,667	61,950
Tucson	1,897,151	1,894,110	1,909,173	15,064
Headquarters	7,741,090	7,728,681	7,790,146	61,465
Total, DENTAL	**$152,634,000**	**$159,440,000**	**$166,297,000**	**+$6,857,000**

Note: FY 2011 amounts reflect actual data. FY 2012 and FY 2013 are estimates.

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

(Dollars in Thousands)

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request	FY 2013 +/- FY 2012
BA	$72,786	$75,589	$78,131	+$2,542
FTE*	219	223	225	+2

* 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 2013 Authorization.....Permanent

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The IHS Mental Health/Social Services (MH/SS) program is a community-based clinical and preventive service program that provides vital outpatient mental health counseling and access to dual diagnosis services, mental health crisis response and triage, case management services, community-based prevention programming, and outreach and health education activities. The most common MH/SS program model is an acute, crisis-oriented outpatient service staffed by one or more mental health professionals providing individual, family, and group psychotherapeutic services and case management. After hour emergency services are generally provided through local emergency departments and service units will often contract with non-IHS hospitals and crisis centers for such services. Inpatient services are generally purchased from non-IHS hospitals or provided by State or County mental health hospitals. Intermediate level services such as group homes, transitional living support, intensive case management, and related activities are sometimes available, but generally are not reimbursable through IHS mechanisms. Therefore, access to intermediate level services is typically offered through State and local resources.

The MH/SS addresses the Agency's priorities to renew and strengthen our partnership with Tribes and to improve the quality of and access to care through these collaborative activities. The MH/SS also works to integrate behavioral health into primary care. Tribal contracting and compacting has enabled behavioral health programs to transition from IHS to local community control. As a result, over half the Tribes now administer and deliver their own mental health programs. The IHS MH/SS program assists Tribes in bringing programs and program collaborations to their own communities.

Across Indian Country today, the high incidence of alcohol and substance abuse, mental health disorders, suicide, violence, and behavior-related chronic diseases is well documented. Each of these serious behavioral health issues has a profound impact on the health of individuals, public health, and community well-being both on- and off-reservations. American Indians and Alaska Natives (AI/AN) are at higher risk for certain mental health disorders than other racial/ethnic

groups. For example, the Office of Minority Health reports that AI/ANs experience higher rates than all races in the following areas:

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

AI/ANs are also overrepresented among high-need populations requiring mental health services (e.g., people who are homeless, incarcerated, drug/alcohol abusers, and exposed to trauma as well as children who are in foster care) (Surgeon General's Report, 1999). Behavioral health issues are a top Tribal priority for both treatment and prevention.

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

Suicide Prevention: The AI/AN suicide rate (17.9 per 100,000) for the three year period (2002-2004) in the IHS service areas is 1.7 times that of U.S. all races rate (10.8 per 100,000) for 2003. Suicide is the second leading cause of death behind unintentional injuries for Indian youth ages 15 - 24 residing in IHS service areas and is 3.5 times higher than the national average. Suicide is the sixth leading cause of death overall for males residing in IHS service areas and ranks ahead of homicide. AI/AN young people ages 15-34 comprise 64 percent of all suicides in Indian Country.[1] Suicide mortality rates have increased from 45.9 per 100,000 to 55.2 per 100,000 in AI/AN youth ages 15-24, comparing data from 2003-2005 to those from 1999-2001. Overall, suicide mortality is 73 percent greater in AI/AN populations in IHS service areas compared to U.S. - All races.[2]

IHS has developed a suicide surveillance reporting tool to document incidents of suicide in a standardized and systematic fashion. The suicide surveillance tool captures data related to a specific incident of suicide, including date and location of act, method, contributing factors, and other useful epidemiological information to better understand the problem and target resources appropriately. Use of the suicide surveillance form is an IHS performance measure and the FY 2011 target for the use of the suicide surveillance form was met and exceeded.

TeleBehavioral Health: The MH/SS program model also includes telebehavioral health technology. Over 50 IHS and Tribal facilities in eight IHS Areas offer some level of telebehavioral health services. In the remaining four IHS Areas, eight facilities are developing telebehavioral health services or have recently used telebehavioral health services. The newly established TeleBehavioral Health Center of Excellence in Albuquerque has already negotiated service support agreements with the Aberdeen Area to help meet the urgent need for behavioral health services and provides these services to regional southwest Tribal sites. Improvements in the availability of videoconferencing units and supporting bandwidth are significantly lowering the barriers to using telehealth-based services generally. The central limitation of expanding telebehavioral health services is the lack of adequate infrastructure and need for clinical professionals and employees at remote sites to effectuate service delivery. The expansion of telebehavioral health cannot be separated from the need for infrastructure and staffing resources.

[1] Indian Health Service. Office of Public Health Support. Division of Program Statistics. *Trends in Indian Health*, 2002-2003. Rockville, MD: Indian Health Service.
[2] Unpublished data, Office of Public Health Support. Division of Program Statistics. Indian Health Service.

Behavioral Health Management Information System (MIS): The IHS Resource and Patient Management System (RPMS) is a national health information system that effectively captures diagnostic, treatment, outcomes, and referral information regarding significant health issues electronically. To support clinical best practices and disease surveillance, RPMS includes standardized tools for screening as well as clinical decision support tools to facilitate routine and effective screening and treatment. RPMS output reports and clinical quality performance measurement tools provide information from local facility to national level data on screening results and screening rates. The Behavioral Health MIS is used to share patient care documents and electronic charts across wide geographic areas in real-time and in accordance with the Health Insurance Portability and Accountability Act regulations. Future MIS-related activities will focus on further development and collection of suicide event-related data as well as improvements in the ability to monitor and respond to clinically actionable health information.

Child/Family Protection: Child abuse and the cycle of repeat abuse in adulthood are well documented in the AI/AN literature. Family violence affects all members of the community, but AI/AN women and children are particularly vulnerable to abuse. To help victims of violence, the IHS provides direct services, advocacy, interagency consultation, and collaboration with other Federal agencies to provide AI/AN child/family protection services.

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

Strategies to address mental health and suicide include collaborations and partnerships with consumers and their families, Tribes and Tribal organizations, Urban Indian health programs, Federal, State, and local agencies, as well as public and private organizations. This effort seeks to establish effective long-term strategic approaches to address mental health and suicide prevention in Indian Country.

IHS, the Substance Abuse and Mental Health Services Administration (SAMHSA), Bureau of Indian Affairs (BIA), and Bureau of Indian Education (BIE) held ten regional suicide prevention listening sessions across Indian Country in 2011 to seek input on how the agencies can most effectively work in partnership with Tribes to prevent suicide. The Tribal listening sessions provided important information on suicide prevention needs, concerns, programs, and practices. This information was reviewed by the agencies and utilized as foundational information for the planning of the Action Summits for Suicide Prevention. The Summits were held in Scottsdale, Arizona from August, 1 – 4, 2011 and in Anchorage, Alaska from October 25 – 27, 2011. This collaborative work also paved the way for other Federal partners to join in the effort to prevent suicide among AI/ANs. IHS and the Veterans Health Administration (VHA) Suicide Prevention Office have developed a joint plan to address suicide among Native veterans. The VHA Suicide Prevention Office participated in several of the listening sessions and in both Action Summits for Suicide Prevention held in Arizona and Alaska.

On September 10, 2010, Department of Health and Human Services Secretary Kathleen Sebelius and Department of Defense Secretary Robert M. Gates announced the creation of the National Action Alliance for Suicide Prevention. The Action Alliance is expected to provide an operating structure to prompt planning, implementation and accountability for updating and advancing the National Strategy for Suicide Prevention. On December 30, 2010, the National Action Alliance for Suicide Prevention announced three new task forces to address suicide prevention efforts

within high-risk populations including AI/ANs. Jointly leading the AI/AN Task Force are Yvette Roubideaux, M.D., M.P.H., Director, Indian Health Service; Larry Echo Hawk, J.D., Assistant Secretary of Indian Affairs, Department of the Interior; and McClellan Hall, M.A., Executive Director, National Indian Youth Leadership Project.

In FY 2013, IHS will continue to focus on integration of behavioral health into primary care. IHS supports changing the paradigm of mental health services from being episodic, fragmented, specialty, and/or disease focused to being a part of primary care and the "Medical Home." This offers new opportunities for interventions that identify high-risk individuals before their actions or behavior becomes more clinically significant. There will continue to be a focus on a comprehensive and integrated approach to reducing the loss and suffering from suicide and suicidal behaviors. This effort will continue to bring together multiple disciplines, perspectives, and resources to create an integrated system where services can be accessed across multiple settings. To help victims of violence, the IHS provides direct services, advocacy, interagency consultation, and collaboration with other Federal agencies to provide child and family protection services to AI/AN children and families. Plans also include improving the RPMS to support clinical best practices and disease surveillance.

FUNDING HISTORY

Fiscal Year	Amount
2008 Enacted	$63,531,000
2009 Omnibus	$67,748,000
2010 Enacted	$72,786,000
2011 Enacted	$72,786,000
2012 Enacted	$75,589,000

BUDGET REQUEST

The FY 2013 budget request for Mental Health of $78,131,000 is an increase of $2,542,000 over the FY 2012 enacted level of $75,589,000. The request includes:

Current Services +$2,542,000

- +$29,000 to cover federal Commissioned Officer pay costs.
- +$2,513,000 for staffing and operating costs for new/expanded facilities. These funds will support increases in workforce necessary to staff newly constructed facilities.

Staff for New Facility	Amount	Tribal Positions
Chickasaw Nation Health Clinic, Ardmore, OK	$559,000	6
Cherokee Nation Health Center, Vinita, OK	$94,000	1
Chickasaw Nation Health Clinic, Tishomingo, OK	$376,000	4
Southcentral Foundation Valley Primary Care Center, Wasilla, AK	$841,000	7
Tanana Chief Conference Interior Health Center, Fairbanks, AK	$343,000	3
Norton Sound Regional Hospital, Nome, AK	$300,000	3
TOTAL	**$2,513,000**	**24**

Outputs and Outcomes

Measure	Year and Most Recent Result/ Target for Recent Result/ (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 Target +/- FY 2012 Target
29. **Suicide Surveillance:** Increase the incidence of suicidal behavior reporting by health care (or mental health) professionals.	FY 2011: 1,930 Target: 1,784 (Target Exceeded)	1,807	1,807	0
18. **Behavioral Health:** Proportion of adults ages 18 and over who are screened for depression. IHS-All	FY 2011: 56.5% Target: 51.9% (Target Exceeded)	56.5%	53.2%	-3.3%
18. Tribally Operated Health Programs	FY 2011: 49.7% Target: 45.4% (Target Exceeded)	49.7%	46.8%	-2.9%

The FY 2013 suicide surveillance target is 1,807 forms completed. The Suicide Reporting Database is beginning to provide a more detailed picture of who is completing or attempting suicide and identifies salient factors contributing to the events. Completion of forms should provide more complete information about the incidence of suicidal ideation, attempts and completions, which will provide far more accurate and timely data to national policy makers and will allow interventions to be evaluated for effectiveness in ways not previously possible.

The FY 2013 depression screening target is 53.2 percent. Depression screening improves detection of mental health needs. Depression is often an underlying component contributing to suicide, accidents, domestic/intimate partner violence, and alcohol and substance abuse. Early identification of depression will allow 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 such a response over time. The screening tools and results are incorporated into the IHS Electronic Health Record. The system is now deployed and in operation in over 250 clinical sites across the country.

The IHS depression screening target supports the HHS Strategic Plan. The depression screening and the suicide surveillance targets for FY 2011 were exceeded. The Agency has made great strides in addressing suicide and depression despite a growing AI/AN population.

GRANT AWARDS – The program does not anticipate any grant awards for FY 2013.

AREA ALLOCATION – Mental Health

Discretionary SERVICES	**FY 2011 Enacted**	**FY 2012 Enacted**	**FY 2013 Request**	**FY 2013 +/- FY 2012**
Aberdeen	$9,002,178	$9,798,493	$9,802,252	$3,759
Alaska	6,374,460	6,364,272	7,850,714	1,486,442
Albuquerque	4,432,714	4,425,630	4,427,328	1,698
Bemidji	2,324,780	2,321,065	2,321,955	890
Billings	3,939,931	3,933,634	3,935,143	1,509
California	1,684,612	2,034,355	2,035,136	780
Nashville	1,776,300	1,773,461	1,774,142	680
Navajo	14,658,286	14,634,859	14,640,474	5,615
Oklahoma	12,151,608	13,888,376	14,922,704	1,034,328
Phoenix	7,694,234	7,681,937	7,684,884	2,947
Portland	4,198,852	4,192,141	4,193,750	1,608
Tucson	1,487,229	1,484,852	1,485,422	570
Headquarters	3,060,816	3,055,924	3,057,097	1,172
Total, MENTAL HLTH	**$72,786,000**	**$75,589,000**	**$78,131,000**	**+$2,542,000**

Note: FY 2011 amounts reflect actual data. FY 2012 and FY 2013 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 2011 Enacted	FY 2012 Enacted	FY 2013 Request	FY 2013 +/- FY 2012
BA	$194,409	$194,297	$195,378	+$1,081
FTE*	178	178	178	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 2013 Authorization.....Permanent

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The purpose of the Indian Health Service (IHS) Alcohol and Substance Abuse Program (ASAP) is to raise the behavioral health status of American Indians and Alaska Natives (AI/ANs) to the highest possible level through the provision of preventive, educational, and treatment services at both the community and clinic levels. These programs provide alcohol and substance abuse prevention, educational, and treatment services within both rural and urban community settings. The ASAP exists as part of an integrated behavioral health approach to reduce the incidence of alcoholism and substance abuse in AI/AN communities by behavioral health providers working collaboratively with medical providers. 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 work to integrate behavioral health into primary care. Behavioral health has also been identified as the number one Tribal health priority for FY 2013.

Alcoholism, addiction, and alcohol and substance abuse are among the most severe public health and safety problems facing AI/AN individuals, families, and communities, resulting in devastating social, economic, physical, mental, and spiritual consequences. AI/ANs suffer disproportionately from substance abuse disorder compared with other racial groups in the United States. In a 2010 report from the National Survey on Drug Use and Health (NSDUH), the rates of past month binge alcohol use and illicit drug use were higher among AI/AN adults compared to national averages (30.6 vs. 24.5 percent and 11.2 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 vs. 9.6 percent).[1]

Alcohol abuse and alcohol dependence contribute to high rates of mortality from liver disease, unintentional injury, and suicide. AI/AN communities suffer from some of the highest rates of

[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.

Fetal Alcohol Spectrum Disorders (FASD) in the nation, and the damaging effects of alcohol use to an unborn baby during pregnancy are permanent. Methamphetamine and other drug abuse are increasingly significant problems among AI/AN people and have a devastating impact on families and communities. To illustrate, there are marked disparities in behavioral health morbidity and resulting mortality between the AI/AN population and the nation as a whole. The following are examples:

- The age-adjusted[2] alcohol related death rate for AI/ANs is 43.3 (2003-2005) and is over six times the U.S. all races rate of 7.0 (2004).[3]
- The age-adjusted drug related death rate for AI/ANs is 15.0 (2002-2004) and is 1.5 times greater than the U.S. all races rate of 9.9 (2003).[4]

Additionally, over the last 15 years, ASAP programs have transitioned from IHS to local community control via Tribal contracting and compacting. In FY 2011, the majority of the ASAP programs were Tribally-managed. To support this shift, IHS is transitioning from direct service only to primarily direct service support to enable communities to plan, develop, and implement culturally-informed ASAP programming. Organized to develop programs and program leadership, the major ASAP activities and focus areas are:

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

Youth Regional Treatment Centers (YRTCs): There are 11 YRTCs which provide substance abuse and mental health treatment services to AI/AN youth. Congress authorized the establishment of these YRTCs in each of the 12 IHS Areas, with two (northern and southern) specifically authorized for the California Area. Some Tribes within certain IHS Areas (e.g., Bemidji and Billings) elected not to construct YRTCs but to contract for similar services. The Alaska Area divided their funds to provide residential treatment services for two programs.

Fetal Alcohol Spectrum Disorders (FASD): IHS supports two projects that target FASD through the Northwest Portland Area Indian Health Board (NPAIHB). The FASD Training Project with the University of Washington School of Medicine is a research-based project that focuses on FASD interventions. The Parent Child Assistance Program (PCAP) is an intervention that serves high-risk, substance-abusing pregnant and parenting women and their families at 10 sites throughout the State of Washington.

Methamphetamine and Suicide Prevention Initiative (MSPI): The MSPI is a nationally-coordinated demonstration/pilot program, focusing on providing targeted methamphetamine and suicide prevention and intervention resources to communities in Indian Country with the greatest need for these programs. The $16.3 million annual appropriation supports 127 pilot projects that promote the establishment of innovative evidence-based and practice-based models created and

2 Age-adjusted rate per 100,000 population. Rates have been adjusted to compensate for misreporting of AI/AN race on state death certificates.
3 Unpublished data. OPHS/Division of Program Statistics (2003-2005 AI/AN age- adjusted rates based on 2000 census with bridged – race categories.)
4 U.S. Department of Health and Human Services. Indian Health Service. Trends in Indian Health, 2002-2003 Edition. Washington: Government Printing Office, Released October 2009. ISSN 1095-2896. p. 195.

managed by communities themselves. These model programs are connected to the entire national network of recipients to share program, service, and evaluation information. All MSPI pilot programs are community developed and delivered and represent the growing support from IHS to help communities address the dual crises of methamphetamine abuse and suicide in Indian Country.

TeleBehavioral Health: The ASAP program model also includes telebehavioral health technology. Over 50 IHS and Tribal facilities in eight IHS Areas offer some level of telebehavioral health services. In the remaining four IHS Areas, eight facilities are developing telebehavioral health services or have recently used telebehavioral health services. The TeleBehavioral Health Center of Excellence in Albuquerque, established in 2008, has already negotiated service support agreements with the Aberdeen Area to help meet the urgent need for behavioral health services. The Center of Excellence continues to be active in providing these services to regional southwest Tribal sites. Improvements in the availability of videoconferencing units and supporting bandwidth are significantly lowering the barriers to using telehealth-based services generally. The central limitation of expanding telebehavioral health services is the lack of adequate IHS infrastructure and need for clinical professionals and employees at remote sites to effectuate service delivery. The expansion of telebehavioral health cannot be separated from the need for infrastructure and staffing resources.

Behavioral Health Management Information System (MIS): The IHS Resource and Patient Management System (RPMS) is a national health information system that effectively captures diagnostic, treatment, outcomes, and referral information regarding significant health issues electronically. To support clinical best practices and disease surveillance, RPMS includes standardized tools for screening as well as clinical decision support tools to facilitate screening and treatment. Alcohol screening allows for early detection of substance abuse and the recently developed ASBI codes allows for documentation of brief interventions. RPMS output reports and clinical quality performance measurement tools provide information from local facility to national level data on screening rate results. In addition, the Behavioral Health MIS is used to share patient care documents and electronic charts across wide geographic areas in real-time (in full accordance with the Health Insurance Portability and Accountability Act regulations).

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

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

The Department of Interior (DOI) through the Bureau of Indian Affairs (BIA) and the Bureau of Indian Education (BIE) and the IHS have a memorandum of agreement (MOA) on Indian alcohol and substance abuse prevention. Through this MOA, the BIA, the BIE, and the IHS will coordinate and implement plans in cooperation with Tribes, which have the primary

responsibility for protecting and ensuring the well-being of their members. The MOA emphasizes assisting Tribal governments in their efforts to address behavioral health issues. The MOA includes coordination of data collection, resources, and programs of the IHS, BIA, and BIE.

The Tribal Law and Order Act (TLOA) requires a significant amount of interagency coordination and collaboration among HHS (IHS and SAMHSA), DOI (BIA/BIE), Department of Justice (DOJ) (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 the scope of alcohol and substance abuse problems as well as effective prevention and treatment programs. A Memorandum of Agreement (MOA) required by Section 241 of the TLOA was signed on July 29, 2011 by the Secretaries of the Departments of Health and Human Services and the Interior and the Attorney General to: 1) determine the scope of the alcohol and substance abuse problems faced by Tribes; 2) identify and delineate the resources each entity can bring to bear on the problem; 3) set standards for applying those resources to the problems; and 4) coordinate existing agency programs with those established under the 1986 Act.

In FY 2013, the ASAP will continue to focus on integration of behavioral h**e**alth into primary care. IHS supports changing the paradigm of mental health services from being fragmented, episodic, stigmatized, specialty, and disease focused to being a part of primary care and the "Medical Home." This offers new opportunities for interventions that identify high-risk individuals before their actions or behavior become more clinically significant. IHS will continue to promote the ASBI as an integral part of a primary care based behavioral health program. IHS will provide support to YRTCs in meeting the needs of youth. There will continue to be a focus on the MSPI pilot program which provides methamphetamine and suicide prevention and intervention resources to communities in Indian Country with the greatest need for these programs. Plans also include ongoing improvements for the RPMS to support clinical best practices and disease surveillance in collaboration with Tribal and Federal partners.

FUNDING HISTORY

Fiscal Year	Amount	Program Increases
2008 Enacted	$173,243,000	$13,782,000 – MSPI
2009 Omnibus	$183,769,000	$2,609,000 - MSPI
2010 Enacted	$194,409,000	
2011 Enacted	$194,409,000	
2012 Enacted	$194,297,000	

BUDGET REQUEST

The FY 2013 budget request for Alcohol & Substance Abuse of $195,378,000 is an increase of $1,081,000 over the FY 2012 enacted level of $194,297,000. The request includes:

Current Services +$1,081,000

- +$27,000 to cover federal Commissioned Officer pay costs.
- +$1,054,000 for staffing and operating costs for newly constructed facilities. Funding new facilities allows IHS to expand provision of health care in those areas where capacity has been expanded to address critical health care needs.

Staff for New Facility	Amount	Tribal Positions
Chickasaw Nation Health Clinic (JV), Ardmore, OK	$273,000	3
Cherokee Nation Health Center (JV), Vinita, OK	$91,000	1
Chickasaw Nation Health Clinic (JV), Tishomingo, OK	$183,000	2
Southcentral Foundation Valley Primary Care Center (JV), Wasilla, AK	$285,000	3
Tanana Chief Conference Interior Health Center (JV), Fairbanks, AK	$126,000	1
Norton Sound Regional Hospital, Nome, AK	$96,000	1
Grand Total:	**$1,054,000**	**11**

Outputs and Outcomes

Measure	Year and Most Recent Result/ Target for Recent Result/ (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 Target +/- FY 2012 Target
10. **YRTC Improvement/ Accreditation:** Accreditation rate for Youth Regional Treatment Centers (in operation 18 months or more)	FY 2011: 91% Target: 100% (Target Not Met)	100%	100%	0
11. **Alcohol Screening (FAS Prevention):** Alcohol-use screening (to prevent Fetal Alcohol Syndrome) among appropriate female patients. IHS-All	FY 2011: 57.8% Target: 56.1% (Target Exceeded)	58.7%	56.6%	-2.1%
11. Tribally Operated Health Programs	FY 2011: 49.2% Target: 45.0% (Target Exceeded)	50.1%	48.3%	-1.8%
Methamphetamine and Suicide Prevention Initiative (MSPI)				
The number of identified meth using patients who enter methamphetamine treatment program* *(Output)*	FY 2011: 1,520 Target: 1,240 (Target Exceeded)	1,240	1,240	0
The number of youth (ages 6 – 21) who participate in evidence-based and/or promising practice prevention or intervention programs* *(Output)*	FY 2011: 78,342 Target: 42,895 (Target Exceeded)	42,895	42,895	0
Establishment of trained suicide crisis response teams** *(Output)*	FY 2011: 3,911 Target: 674 (Target Exceeded)	674	674	0
Increase Telebehavioral health encounters*** *(Output)*	FY 2011: 2,255 Target: 617 (Target Exceeded)	617	2,255	0

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

The accreditation measure for Youth Regional Treatment Centers reflects an evaluation of the quality of care associated with accreditation status by either the Joint Commission on Accreditation of Healthcare Organizations, the Commission on Accreditation of Rehabilitation Facilities (CARF), State certification, or regional Tribal health authority certification. The actual performance measure was not met in FY 2011 as a result of internal infrastructure challenges with one YRTC program. IHS is committed to providing the necessary technical assistance needed in order to assist this facility in obtaining CARF accreditation. The FY 2013 performance target for the YRTCs is 100 percent accreditation and certification status.

In FY 2011, the 56.1 percent target for FAS Prevention was exceeded. In FY 2013, the target is 56.6 percent for the proportion of women screened for alcohol to prevent Fetal Alcohol Syndrome (FAS). There have been significant increases in results since FY 2005, due to increased provider awareness, and an agency emphasis on behavioral health screening.

Heavy drinking during pregnancy can cause significant birth defects, including FAS. FAS is the leading known, and preventable, cause of mental retardation. 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.

GRANT AWARDS

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request
Number of Awards	15	15	15
Average Award	$100,000	$100,000	$100,000
Range of Awards	n/a	n/a	n/a
Total Awards	$1,500,000	$1,500,000	$1,500,000

AREA ALLOCATION – Alcohol and Substance Abuse

Discretionary SERVICES	**FY 2011 Enacted**	**FY 2012 Enacted**	**FY 2013 Request**	**FY 2013 +/- FY 2012**
Aberdeen	$14,440,399	$14,417,322	$14,419,325	$2,003
Alaska	31,378,669	31,328,523	31,839,877	511,353
Albuquerque	12,562,752	12,542,676	12,544,419	1,743
Bemidji	10,373,267	10,356,690	10,358,129	1,439
Billings	11,436,382	11,418,106	11,419,692	1,587
California	11,262,979	11,244,980	11,246,542	1,563
Nashville	9,091,507	9,076,978	9,078,239	1,261
Navajo	19,507,277	19,476,103	19,478,809	2,706
Oklahoma	15,783,079	15,956,538	16,505,756	549,217
Phoenix	17,117,449	17,090,094	17,092,469	2,375
Portland	16,724,811	16,698,083	16,700,404	2,320
Tucson	3,223,549	3,218,397	3,218,845	447
Headquarters	21,506,880	21,472,510	21,475,494	2,984
Total, A&SA	**$194,409,000**	**$194,297,000**	**$195,378,000**	**+$1,081,000**

Note: FY 2011 amounts reflect actual data. FY 2012 and FY 2013 are estimates.

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

CONTRACT HEALTH SERVICES

(Dollars in Thousands)

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request	FY 2013 +/- FY 2012
BA	$779,927	$843,575	$897,562	+$53,987
FTE*	0	0	0	0

*Contract Health Services funds are not used to support FTEs.

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 2013 Authorization.....Permanent

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

Contract Health Services (CHS) funds are used to purchase services from private health care providers in situations where (1) no IHS 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) supplementation of alternate resources is required (i.e., Medicare, private insurance) to provide comprehensive care to eligible Indian people. The annual allocation of CHS funds is based on each Area's established funding base for the prior year and increases for inflation and population growth are distributed against the Area or Tribes base. New CHS funds are distributed using a formula that consists of three basic integrated factors: active user population, relative cost of purchasing health care services within a geographic area and, access to care (lack of availability of inpatient care).

The demand for CHS is high. To manage its budget within appropriations, the CHS program uses the CHS eligibility criteria and the IHS medical priority system in order to determine priorities for purchasing services, and uses the Medicare-Like Rate to purchase all inpatient health care services, while utilizing alternate resources to ensure IHS is the payor of last resort. Tribes manage about 54 percent of the CHS budget and must adhere to the same regulations as the IHS managed CHS programs.

The rising cost of health care services and transportation, and the increased need for CHS services has led to increased demand for CHS. Medical inflation, providing care to an aging population and State Medicaid reforms also increase demand for CHS resources. In FY 2010 CHS denied an estimated 217,360 services needed by eligible American Indians and Alaska Natives (AI/AN). However, because Tribes operate more than 50 percent of the CHS budget, and do not always report excess need, as this is not required by law, it is difficult to measure total unmet need. At current funding levels, most programs are approving only medically emergent referrals (life or limb) and less urgent, routine and/or preventive care is deferred or denied pending additional appropriations. However, some programs have been able to approve referrals in other priority categories due to recent increases in CHS appropriations.

The CHS budget also includes $51.5 million for the Catastrophic Health Emergency Fund (CHEF) which provides funding for high cost cases (after meeting the threshold) such as burn victims, motor vehicle accidents, high risk obstetrics, and cardiology. CHEF is centrally managed at IHS Headquarters and is available to both IHS managed and Tribally managed CHS programs.

In FY 2011, 1,745 high cost cases were funded from CHEF funds on a rolling basis at a total cost of $48,000,000, however, there were 928 submitted cases that were not funded by the CHEF program at a total cost of $17,670,622. It is estimated that more cases may qualify for CHEF but were not reported due to the depletion of CHEF before the end of FY 2011.

The CHS program maximizes its annual resources by contracting with Blue Cross/Blue Shield of New Mexico as its fiscal intermediary (FI). The FI assists the IHS by ensuring CHS payments are in accordance with its payment policy, focuses on the appropriateness of care, and coordinates benefits with other payers to maximize the CHS resources. All IHS managed CHS programs and some tribally managed CHS programs utilize the FI to ensure the use of Medicare-Like Rates. In addition, CHEF claims are priced through the FI as well.

An important trend in IHS' health facility construction underscores the importance of CHS funding to IHS and Tribal facilities. Five hospitals have been or are planned to be replaced by ambulatory health centers with no inpatient services because the workload does not necessitate full service hospitals. These new ambulatory health centers will be required to purchase inpatient care from the private sector in order to maintain the same level of services placing an additional demand on CHS.

Based on input that the CHS program is a top Tribal priority, the IHS Director established a Tribal workgroup in FY 2010 to review and make recommendations on improving the business of the CHS program. Three work group meetings and two listening sessions were held in 2010 with recommendations on the distribution formula, how to better document the overall level of CHS need, and strategies to improve the business operations of CHS. A technical subcommittee was created to evaluate and make recommendations on how to better calculate the total current CHS need and financial estimates of future CHS need. Twelve Area work sessions were held in FY 2011 to develop recommendations on specific measurable changes to improve the business of the CHS program. IHS staff and Tribes will work together to implement the recommendations to improve CHS business practices over the next few years.

The CHS program is also involved in case management and best practice activities to ensure AI/AN patients receive quality patient care when referred to private providers and that all third party payers are identified prior to utilizing CHS funds. These activities directly relate to the Agency’s priority to improve the quality of and access to care and improve how the Agency does business. CHS programs are also developing training and education for patients and outside providers. The IHS Director posted a six-part blog on the IHS website entitled “Understanding the CHS Program” in 2011 that provided education on the CHS program for the general public and staff.

FUNDING HISTORY

Fiscal Year	CHS	CHEF	TOTAL
2008 Enacted	$552,755,366	$26,578,800	$579,334,000
2009 Omnibus	$603,477,366	$31,000,000	$634,477,000
2010 Enacted	$731,347,000	$48,000,000	$779,347,000
2011 Enacted	$731,927,000	$48,000,000	$779,927,000
2012 Enacted	$792,075,000	$51,500,000	$843,575,000

BUDGET REQUEST

The FY 2013 budget request for Contract Health Services of $897,562,000 is an increase of $53,987,000 over the FY 2012 enacted level of $843,575,000. The increase includes the following components:

The recurring base CHS budget through FY 2012 would provide the following services:

- $51,500,000 for CHEF high cost cases
- $792,075,000 to purchase:
    - 34,796 Inpatient admissions
    - 1,300,859 Outpatient visits
    - 47,847 one-way patient travel trips

The FY 2013 CHS increases would provide for the following services:

- $33,987,000 to fund inflationary cost increases
- $20,000,000 for CHS program increase will purchase the following estimated additional services over the FY 2012 levels:
    - 848 Inpatient admissions
    - 31,705 Outpatient visits, and
    - 1,166 One-way patient travel trips

The purchase of these additional services addresses medically necessary care and relates directly to the Agency's third priority to improve quality of and access to care while improving customer service for patients and providers.

These services are critical and provide needed care to thousands of patients who would otherwise not have access. These increases will improve the quality of care for AI/AN patients who require a higher level of care than what is available from a direct care facility. It will provide for needed specialty and secondary care including primary care in those areas with limited direct care services.

The CHEF funding will continue access and improve patient care, and lessen the burden of high costs cases, particularly for those smaller IHS and Tribally managed CHS programs with limited budgets.

Outputs and Outcomes

Measure	Year and Most Recent Result/ Target for Recent Result/ (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 Target +/- FY 2012 Target
1.1: Average Days between Service End and Purchase Order (PO) Issued *(outcome*)	FY 2011: 70.4 days Target: 78 days (Target Exceeded)	78 days	74 days	-4 days

AREA ALLOCATION – Contact Health Services

Discretionary SERVICES	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request	FY 2013 +/- FY 2012
Aberdeen	$78,908,161	$85,347,670	$90,809,738	$5,462,069
Alaska	75,781,210	81,965,536	87,211,155	5,245,619
Albuquerque	37,181,683	40,215,992	42,789,730	2,573,738
Bemidji	52,364,546	56,637,893	60,262,597	3,624,704
Billings	56,767,563	61,400,230	65,329,713	3,929,484
California	40,773,077	44,100,471	46,922,808	2,822,336
Nashville	30,155,332	32,616,237	34,703,607	2,087,370
Navajo	84,986,329	91,921,863	97,804,666	5,882,803
Oklahoma	95,265,179	103,039,545	109,633,856	6,594,311
Phoenix	63,049,120	68,194,410	72,558,706	4,364,297
Portland	83,216,850	90,007,981	95,768,299	5,760,319
Tucson	16,986,338	18,372,553	19,548,357	1,175,804
Headquarters	64,491,612	69,754,620	74,218,767	4,464,147
Total, CHS	**$779,927,000**	**$843,575,000**	**$897,562,000**	**+$53,987,000**

Note: FY 2011 amounts reflect actual data. FY 2012 and FY 2013 are estimates.

* The allocation of the FY 2013 CHS funds to Areas will be determined by the funding base, inflation, population growth, with new CHS program increases distributed using a formula that includes active user population, cost of purchasing health care services within a geographic area and, access to care (lack of availability of inpatient care).

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

(Dollars in Thousands)

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request	FY 2013 +/- FY 2012
BA	$144,027	$147,023	$150,776	+$3,753
FTE*	287	292	298	+6

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

SUMMARY OF THE BUDGET REQUEST

The FY 2013 budget request for Preventive Health of $150,766,000 is an increase of $3,753,000 over the FY 2012 Enacted level. This increase will fund federal Commissioned Officer pay costs and staffing for six newly constructed facilities.

- The FY 2013 budget request for **Public Health Nursing** (PHN) of $69,868,000 is an increase of $3,236,000 for pay costs and staffing of new facilities. The base funding supports prevention-focused health interventions for individuals, families, and community groups as well as improving health status by early detection through screening and disease case management. The Public Health Nursing program home visiting service provides primary, secondary, and tertiary prevention focused health interventions. Primary prevention targets healthy populations and activities are aimed at preventing the onset of disease in high risk populations through education, health awareness, immunizations, and risk reduction. For example, the PHNs provide childhood obesity prevention activities through breastfeeding promotion to the prenatal patient and during the postpartum time in home visits to mother and baby after hospital discharge. Secondary prevention detects and treats problems in the early stages of illness or disease. These interventions target disease before complications arise and before signs or symptoms appear and include health screening for diabetes and hypertension, fall risk assessments, and school health assessments. Tertiary prevention reduces further complications from a disease or illness and restores the individual to their optimum level of health. Interventions include chronic disease care, self-management education, medication management, and care coordination. For example, a PHN may make a home visit after a patient is discharged from a hospital to help reduce preventable complications and hospital readmissions.

- The FY 2013 budget request for **Health Education** of $17,450,000 is an increase of $393,000 over the FY 2012 enacted level of $17,057,000. The $393,000 request will be used to fund pay costs and staffing for newly constructed facilities 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 the IHS, including health literacy for clients, provision of professional education and training, and developing educational materials for staff, patients, families, and communities.

- The FY 2013 budget request for **Community Health Representatives** (CHRs) of $61,531,000 is an increase of $124,000 to fund pay costs and staffing of new facilities. The base funding helps 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 medical information about health promotion/disease prevention.

- The FY 2013 budget request for **Hepatitis B and Haemophilus Immunization Programs (Alaska)** is $1,927,000 to continue the provision of vaccines for preventable diseases, immunization consultation/education, research, and liver disease treatment and management through direct patient care, surveillance, and education. The Hepatitis B and Haemophilus Immunization Programs (Alaska) budget supports these priorities through direct patient care, surveillance, and educating AI/AN patients.

Preventive Health services contribute widely to the performance measures that fall under the auspices of Hospitals & Health Clinics. Public Health Nursing provides community based clinical services which directly contribute to overall performance achievement activities such as immunizations, case management, and patient education. Community Health Representatives are also community-based and integral in their contribution to follow up care and patient education. Health Education activities permeate the Indian health system and are integral to many of the 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 2011 Enacted	FY 2012 Enacted	FY 2013 Request	FY 2013 +/- FY 2012
BA	$63,943	$66,632	$69,868	+$3,236
FTE*	253	256	261	+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 2013 Authorization.....Permanent

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The IHS Public Health Nursing (PHN) Program is a community health nursing program that focuses on the goals of promoting health and quality of life and preventing disease and disability.

The PHN Program provides quality, culturally sensitive health promotion and disease prevention nursing through primary, secondary and tertiary prevention services to individuals, families, and community groups.

- *Primary prevention interventions* include health education 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. Other interventions include, chronic disease care, self-management education, medication management, and care coordination.

PHNs play a critical role in the surveillance of communicable diseases. The PHN expertise in communicable disease assessment, outreach, investigation, surveillance and monitoring interventions help to manage and prevent the spread of disease in communities. The PHNs contribute to the agency's primary prevention efforts by providing community immunization clinics and immunizations to home bound AI/ANs.

PHN home visiting nursing services include services for:

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

The Public Health Nursing Program awarded 15 grants and program awards in FY 2008 with continuation funding through FY 2011. PHN grants and competitive program awards provide funding to increase local public health nursing prevention services through public health nursing case management services for high risk and vulnerable patients and families. The intent of this project is to produce an array of PHN Best Practices to support an Implementation Plan in 2013.

A PHN data improvement project continues to evaluate data and provide training to standardize documentation. The PHN Data Mart captures data related to clinical and quality improvement activities. The PHN program uses Data Mart reports to determine demands for PHN services as well as to provide accountability and transparency in alignment with the Agency's priorities.

The PHN Program contributes to 10 agency performance measures. The FY 2010 target for the PHN measure was 430,000 encounters. The final result of 454,679 encounters exceeded the target by 24,679 encounters, a 5.7 percentage increase. The data quality improvement project began in 2009 and demonstrated increased performance in FY 2010; this is an ongoing project.

FUNDING HISTORY

Fiscal Year	Amount
2008 Enacted	$55,939,000
2009 Omnibus	$59,885,000
2010 Enacted	$64,071,000
2011 Enacted	$63,943,000
2012 Enacted	$66,632,000

BUDGET REQUEST

The FY 2013 budget request for PHN of $69,868,000 is an increase of $3,236,000 over the FY 2012 enacted level of $66,632,000. The request includes:

Current Services +$3,236,000

- +$84,000 to cover federal Commissioned Officer pay costs.
- +$3,152,000 to fund Staffing/Operating Cost Requirements for newly constructed facilities.

Staff for New Facility	Amount	Tribal Positions
Chickasaw Nation Health Clinic (JV), Ardmore, OK	$720,000	6
Cherokee Nation Health Center (JV), Vinita, OK	$121,000	1
Chickasaw Nation Health Center (JV), Tishomingo, OK	$486,000	4
Southcentral Foundation Valley Primary Care Center (JV), Wasilla, AK	$969,000	7
Tanana Chief Conference Interior Health Center (JV), Fairbanks, AK	$356,000	2
Norton Sound Regional Hospital, Nome, AK	$500,000	4
Grand Total:	**$3,152,000**	**24**

With the FY 2013 budget request, the PHN program will maintain its current services and achieve its performance targets of:

- Providing approximately 405,962 health activities and services to AI/AN patients in FY 2013;

- Continuing to support national measures of maternal-child health, such as childhood immunizations, prenatal visits, postpartum visits, and domestic violence screening through collaboration with related Federal, state, local and private programs;
- Implementing the best practices of the PHN Case Management 2008–2012 demonstration grant program; and
- Implementing a part of the President's Partnership for Patients initiative by reducing hospital readmissions by 20 percent by the end of calendar year (CY) 2013 (compared to 2010).

The PHN program will continue to coordinate and collaborate with related Federal, state, local and private programs to further leverage and promote efforts to expand and improve maternal child-health service. Home visiting is a long-standing, well-known prevention strategy used by states and communities to improve the health and well-being of women, children, and families, particularly those who are at risk. Early investments in home visiting programs have been shown to reduce costs caused by foster care placements, hospitalizations and emergency room visits, unintended pregnancies, and other more costly interventions.[1] [2]

Case management involves the client, family, and other members of the health care team. Quality of care, continuity, and assurance of appropriate and timely interventions are also crucial.[3] In addition to reducing the cost of health care, case management "has proven its worth in terms of improving rehabilitation, improving quality of life, increasing client satisfaction and compliance by promoting client self-determination."[4]

All PHN programs will report on new clinical performance measures for hospital readmissions that will be aligned with national quality measurements, such as the measurements stated in the President's Partnership for Patients initiative. By the end of CY 2013, preventable complications during a transition from one care setting to another will decrease, thereby reducing all hospital readmissions by 20 percent (compared to 2010). Achieving this goal would mean, on a national level, more than 1.6 million patients would recover from illness without suffering a preventable complication requiring re-hospitalization within 30 days of discharge.[5] [6]

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

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[1] Deanna S. Gomby, Paul L. Culross, and Richard E. Behrman, issue eds., "Home Visiting: Recent Program Evaluations," (published by The David and Lucille Packard Foundation) The Future of Children 9, no. 1 (Spring/Summer 1999).

[2] David Olds, Charles Henderson, Charles Phelps, Harriet Kitzman, and Carole Hanks, "Effect of prenatal and infancy nurse home visitation on government spending," Medical Care 31, no. 2 (1993): 155–174.

[3] Deanna S. Gomby, Paul L. Culross, and Richard E. Behrman, issue eds., "Home Visiting: Recent Program Evaluations," (published by The David and Lucille Packard Foundation) The Future of Children 9, no. 1 (Spring/Summer 1999).

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Jencks, Stephen F., Williams, Mark V., and Coleman, Eric A. 2009. Rehospitalizations among Patients in the Medicare Fee-for-Service Program. *N Engl J Med* 360 (14):1418-1428.

[6] Benbassat, J., Taragin, M. 2000. Hospital readmissions as a measure of quality of health care: advantages and limitations. *Archives of Internal Medicine* 160 (8):1074-1081.

Outputs and Outcomes

Measure	Year and Most Recent Result/ Target for Recent Result/ (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 Target +/- FY 2012 Target
23: **Public Health Nursing:** Total number of public health activities captured by the PHN data system; emphasis on primary, secondary and tertiary prevention activities to individuals, families and community groups.	FY 2010: 454,679 Target: 430,000 (Target Exceeded)	424,203	405,962	-18,241

GRANTS AWARDS

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request
Number of Awards	15	15	15
Average Award	$150,000	$150,000	$150,000
Range of Awards	$150,000	$150,000	$150,000

AREA ALLOCATION – Public Health Nursing

Discretionary SERVICES	**FY 2011 Enacted**	**FY 2012 Enacted**	**FY 2013 Request**	**FY 2013 +/- FY 2012**
Aberdeen	$8,029,870	$9,377,811	$9,389,633	$11,822
Alaska	3,879,602	3,873,382	5,703,265	1,829,883
Albuquerque	3,474,173	3,468,603	3,472,976	4,373
Bemidji	2,221,310	2,217,749	2,220,544	2,796
Billings	4,283,631	4,276,763	4,282,155	5,392
California	704,728	938,221	939,404	1,183
Nashville	1,084,739	1,083,000	1,084,365	1,365
Navajo	13,585,823	13,564,041	13,581,141	17,100
Oklahoma	11,792,624	12,969,797	14,313,147	1,343,350
Phoenix	7,201,119	7,189,574	7,198,637	9,064
Portland	3,007,142	3,002,321	3,006,106	3,785
Tucson	1,036,738	1,035,076	1,036,381	1,305
Headquarters	3,641,501	3,635,663	3,640,246	4,583
Total, PHN	**$63,943,000**	**$66,632,000**	**$69,868,000**	**+$3,236,000**

Note: FY 2011 amounts reflect actual data. FY 2012 and FY 2013 are estimates.

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

(Dollars in Thousands)

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request	FY 2013 +/- FY 2012
BA	$16,649	$17,057	$17,450	+$393
FTE*	27	29	30	+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 2013 Authorization.....Permanent

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The IHS Health Education program has been in existence since 1955 to educate AI/AN clients about their health. The program continues to focus on the importance of educating American Indian/Alaska Native (AI/AN) clients in a manner that empowers them to make better choices in their lifestyles and how they utilize health services. Good patient care includes the provision of education; but more importantly, accreditation requirements specifically require the provision of and documentation of education.

Headquarters leadership is provided to the 23 IHS fulltime field positions located throughout the IHS and focuses on assisting all staff and programs to provide education. Health Education funds support approximately 75 Tribal Health Education staff. Health Educators possess the expertise to assist non-education staff to provide standardized health education that is consistent with validated learning principles and practices.

Continued investment in the IHS Health Education program demonstrates IHS' commitment to integrate education and prevention services with clinical services to improve healthcare services for AI/AN people. The IHS Health Education program continues to meet, and in some cases exceed, its performance measures as documented in the outputs and outcomes table. Educational services provided by IHS, Tribal and Urban staff demonstrate a steady increase in the number of AI/AN clients that have a documented educational encounter. The number of visits in which education was provided has increased from approximately 777,000 visits in FY 2004, to 2,722,160 as of September, 2011. This is a three- and one half fold increase in health education services.

The Health Education program partners with other IHS disciplines and programs to ensure the education of IHS clients continues to occur, even at those sites without a full-time health educator. The headquarters Health Education program provides the technical assistance and guidance on educational issues to all disciplines and programs. All education encounters are documented and coded in the Resource and Patient Management System (RPMS). Health

Education provides leadership in the integration of Healthy People 2020 Objectives with goals that integrate Plain Language, health literacy, patient-provider communications and electronic health information opportunities for our clients.

The IHS Health Education program demonstrates accountability through the development of the Patient Education Protocols and Codes (PEPC) which is an IHS-wide reporting system providing local, on-demand education data reports documenting a broad range of clinical and administrative information to managers at all levels of the Indian health system. The PEPC is the basic infrastructure supporting the provision of health education. The IHS Health Education program makes use of all available resources to implement critically important initiatives that are focused on meeting accreditation requirements, patient safety, and Healthy People 2020 Objectives, all of which assist in improving the overall delivery of care provided by IHS.

Preventive health services include health education and prevention. In 2011, Health Education expanded injury prevention and behavioral health (BH) education protocols to include domestic and sexual violence/assault, suicide prevention, child/elder abuse and neglect, mental health, and alcohol and substance abuse. The expansion of existing BH education protocols for I/T/U healthcare delivery systems was included in the new Behavioral Health RPMS Reporting system.

In July 2011, the Health Education program partnered with the Alaskan Tanana Chiefs Council Community Health Aide Program (CHA-P) to integrate into RPMS the documentation and coding of all education provided to AI/ANs by the Community Health Aides in rural Alaska. The Alaskan CHA-P will now be able to report to governing bodies, as needed, with data on education. The Community Health Aide Program Patient Education Codes and Protocols will now be deployed to multiple Tribes/Tribal clinics throughout Alaska thus improving patient care and helping to unify the patient record.

The Health Education program maintains data tracking of two key program objectives: 1) tobacco cessation; and 2) the number of clients who received health education services. See Outputs and Outcomes Tables (below) for more information.

IHS Health Education maintains IHS-wide statistics on educational encounters. Examples of data available from educational encounters include: 1) the number of clients who received health education services, 2) which providers provided education, 3) where the education took place, 4) what information the patient was provided, 5) the amount of time spent providing this education, 6) whether the patient understood the education provided; and, 7) whether the patient set a behavior goal change. These IHS statistics are currently available from the RPMS system. In partnership with all IHS programs, disciplines and staff, the Health Education Program staff continues to:

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

The Health Education Program has identified the following areas of emphasis for FY 2013:

- Continue to strengthen the development of standardized, nationwide patient and health education programs through the integration of the IHS Patient Education Protocols into all IHS software packages including the Patient Care Component (PCC) and the electronic health record, with the continued provision of ongoing training to IHS and Tribal staff on the documentation and coding of patient and health education. This effort assists IHS to meet accreditation requirements as well as *Healthy People* objectives to improve consumer access to health information and to improve health communications to our clients.

- Increase focus on the area of *Healthy People* through health communications:
  - Increase the proportion of AI/ANs with access to health information;
  - Improve the health literacy of AI/ANs with inadequate or marginal literacy skills;
  - Increase the health information contained on www.ihs.gov ensuring that information disclosed is quality-assured and culturally appropriate for AI/AN clients;
  - Improve patient-provider communication skills.
  - Improve the use of plain language in written health communications materials.

FUNDING HISTORY

Fiscal Year	Amount
2008 Enacted	$14,991,000
2009 Omnibus	$15,723,000
2010 Enacted	$16,682,000
2011 Enacted	$16,649,000
2012 Enacted	$17,057,000

BUDGET REQUEST

The FY 2013 budget request for Health Education of $17,450,000 is an increase of $393,000 over the FY 2012 enacted level of $17,057,000. The request includes:

Current Services +$393,000

- +$2,000 to cover federal Commissioned Officer pay costs.
- +$391,000 to fund Staffing/Operating Cost Requirements for newly constructed facilities.

Staff for New Facilities	Amount	Tribal Positions
Chickasaw Nation Health Clinic (JV), Ardmore, OK	$91,000	1
Chickasaw Nation Health Clinic (JV), Tishomingo, OK	$61,000	1
Southcentral Foundation Valley Primary Care Center (JV), Wasilla, AK	$114,000	1
Tanana Chiefs Conference Interior Health Center (JV), Fairbanks, AK	$77,000	1
Norton Sound Regional Hospital, Nome, AK	$48,000	1
Grand Total:	**$391,000**	**5**

Outputs and Outcomes

Measure	Year and Most Recent Result/ Target for Recent Result/ (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 Target +/- FY 2012 Target
32: **Tobacco Cessation Intervention:** Proportion of tobacco-using patients that receive tobacco cessation intervention. IHS-All	FY 2011: 29.4% Target: 23.7% (Target Exceeded)	30.0%	28.7%	-1.3%
32: Tribally Operated Health Programs	FY 2011: 26.4% Target: 21.7% (Target Exceeded)	26.9%	25.7%	-1.2%
30: **CVD Comprehensive Assessment**: Proportion of Ischemic Heart Disease patients who have a comprehensive assessment for all CVD-related risk factors. IHS-All	FY 2011: 39.8% Target: 33.0% (Target Exceeded)	40.6%	32.3% Measure logic changes	N/A
30: Tribally Operated Health Programs	FY 2011: 33.7% Target: 28.3% (Target Exceeded)	34.4%	27.2% Measure logic changes	N/A
Number of Visits with Health/Patient Education *(Output)*	FY 2011: 2,722,160 Target: 2,486,730 (Target Exceeded)	2,722,160	2,858,268	+142,913

During the most recently completed national performance data collection period, the Health Education program contributed to increased performance of the proportion of tobacco-using patients that receive tobacco cessation interventions. The FY 2011 Tobacco Cessation measure result of 29.4 percent exceeded the 23.7 percent target by 5.7 percent.

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

AREA ALLOCATION – Health Education

Discretionary SERVICES	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request	FY 2013 +/- FY 2012
Aberdeen	$1,709,355	$1,969,238	$1,969,238	$0
Alaska	1,906,857	1,903,843	2,142,843	239,000
Albuquerque	1,225,775	1,223,838	1,223,838	0
Bemidji	635,163	634,159	634,159	0
Billings	1,231,459	1,229,513	1,229,513	0
California	258,246	257,838	257,838	0
Nashville	518,787	517,967	517,967	0
Navajo	2,351,444	2,347,728	2,347,728	0
Oklahoma	2,635,501	2,803,064	2,957,064	154,000
Phoenix	1,827,146	1,824,258	1,824,258	0
Portland	953,616	952,109	952,109	0
Tucson	222,842	222,490	222,490	0
Headquarters	1,172,809	1,170,955	1,170,955	0
Total, HEALTH ED	**$16,649,000**	**$17,057,000**	**$17,450,000**	**+$393,000**

Note: FY 2011 amounts reflect actual data. FY 2012 and FY 2013 are estimates.

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

COMMUNITY HEALTH REPRESENTATIVES

(Dollars in Thousands)

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request	FY 2013 +/- FY 2012
BA	$61,505	$61,407	$61,531	+$124
FTE*	7	7	7	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 2013 Authorization.....Permanent

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

Community Health Representatives (CHRs) are a critical part of the Indian health system as they link available health programs to the American Indian and Alaska Native (AI/AN) patients and communities. This is accomplished by utilizing indigenous community members as health paraprofessionals to expand health services and initiate community change. CHRs provide health care and health promotion and disease prevention services to Indian communities and Tribal members. Funds are distributed through Area allocations to the Tribes that employ approximately 1,600 CHRs.

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

Program accomplishments during FY 2011 include:

1) 497 CHRs trained in the IHS Resource Patient and Management System (RPMS) CHR Patient Care Component (PCC); 63 CHRs trained in Basic and Refresher courses; and final plans to purchase an online Learning Management System;
2) Enhanced collaboration with various disciplines and offices such as: a) the Improving Patient Care Initiative which focuses on patient-centered care in a medical home model and incorporates community based programs and services; b) sample training curricula from Federal and non-governmental resources to incorporate into existing curriculum; c) enhanced technical assistance to Tribes and Area staff; and d) enhanced management of

the IHS CHR website and listserv;
3) Progress in updating *Chapter 16, Community Health Representatives* in the *Indian Health Manual*,; and
4) Enhancements to the IHS Resource Patient and Management System (RPMS) CHR Patient Care Component (PCC) data application.

For FY 2011, data from 40 percent of reporting CHR Programs on types of services provided by CHRs showed that nearly, 21 percent provided direct Patient Care (taking vital signs, providing foot care, providing emotional support); 17 percent provided Case Finding/ Screening; 11 percent provided Transportation was; 12 percent Monitored Patients; 14 percent conducted Case Management; 11 percent provided Health Education; and 5 percent provided Other Patient Services.

FUNDING HISTORY

Fiscal Year	Amount
2008 Enacted	$54,925,000
2009 Omnibus	$57,796,000
2010 Enacted	$61,628,000
2011 Enacted	$61,505,000
2012 Enacted	$61,407,000

BUDGET REQUEST

The FY 2013 budget request for Community Health Representatives of $61,531,000 is an increase of $124,000 over the FY 2012 enacted level of $61,407,000. The increase includes:

Current Services +$124,000

- +$4,000 to cover federal Commissioned Officer pay costs.
- +$120,000 to fund Staffing/Operating Cost Requirements for newly constructed facilities.

Staff for New Facilities	Amount	Tribal Positions
Cherokee Nation Health Center (JV), Vinita, OK	$120,000	2
Grand Total:	**$120,000**	**2**

The total funding for Community Health Representatives will provide:
- $59,681,190 for Self-Determination contracts and compacts with Tribes for direct health care, health promotion and disease prevention services as identified in Tribal funding agreements and scopes of work to 1.9 million AI/AN population throughout 12 Areas in homes and other community-based settings.
- $1,845,810 is for training, information technology costs, special projects, and national education meeting(s), more than half of these funds being Tribally administered Federally retained funds will support the following plans for FY 2013, but are not limited to:
  - Training CHRs nationally on the CHR PCC data application;
  - Providing CHR basic and refresher training and paying registration, travel, and per diem for CHRs from Tribes leaving Headquarters shares for training;
  - Providing administrative and logistical, training, web management, listserv, and other program assistance;
  - Planning support for the FY 2014 bi-annual CHR National Education Conference (NEC),;

- Refining the CHR curriculum for cost-effective training through online training modules and training in person;
- Continuing investments in health information technology development and data support as refinements are identified to enhance the data application;
- Enhancement of the national CHR web-based tracking system to improve data reporting by Tribal and Federal CHR programs to IHS and by IHS to Congress at the national level;
- Continuing efforts to provide CHR education on the Improving Patient Care Initiative and Model for Improvement; testing and refinement of an assessment tool to identify improvements for CHR programs; and dissemination of information related to CHR involvement and integration into each patient's health care team and medical home; and
- Updating the CHR Resources and Requirements Methodology (RRM) module, part of the system IHS uses to prepare staffing estimates based on workload information for each discipline to Congress and Tribes.

Outputs and Outcomes

Measure	Year and Most Recent Result/ Target for Recent Result/ (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 Target +/- FY 2012 Target
Patient Services in Hours directed to Chronic Diseases (1), (2), (3)	FY 2011: 173,994 Target: 151,700 (Target Exceeded)	193,396	390,000 (Becomes number of patient encounters for chronic disease services in 2013)	+196,604
# of contacts (3), (4)	FY 2011: 1,878,979 Target: 1,321,500 (Target Exceeded)	1,836,168*	900,000 (Measure now identifies number of patient encounters in 2013)	-936,168
# of CHRs trained in basic, refresher, and first responder training	FY 2011: 63 Target: 70 (Target Not Met)	70[5]	Measure becomes part of measure, Number of CHRs trained, below	N/A
Number of CHRs trained on CHR PCC	FY 2011: 497 Target: 300 (Target Exceeded)	710[5]	433 (Measure will be number of CHRs trained)	-277

[1, 3]126 of 290, about 47 percent, CHR Programs assigned Program Codes reported in RPMS CHR PCC, the only way IHS Headquarters can track CHR data (42 percent reported in 2009; 55 percent in 2008; 33 percent in 2007). 193,706 service hours were extrapolated from 47 percent reporting.
[2]The Program Performance target above represents an effort by the IHS national CHR Program to obtain specific service hours provided in the categories of diabetes, heart, hypertension, nutrition, cancer, other chronic, dialysis, obesity, depression, renal failure, and liver disease related to IHS GPRA indicators and drawn from the CHR PCC software application.
[3]Training conducted on CHR PCC suggests that CHRs routinely under-report the services they provide. Typically they report 2-3 services, but when queried further they identify 5-7 additional services that regularly are unreported (checking homes for hazards as part of injury prevention efforts, providing homemaker services, providing health information on/checking medications, coordinating appointments, interpreting/translating, health education).
[4]Patient contacts are the number of services multiplied by number served
[5]Actual number trained was less than target due to unanticipated termination of interagency training agreement
*Revised from previously published estimates due to improved data system capacity

With the budget proposed for FY 2013, the CHR program will strive to maintain the level of services provided in FY 2012 and continue to work toward addressing the following challenges:

1) Coordinating data validations - currently, RPMS CHR PCC is the only data system by which IHS can furnish data for budget purposes or program management. With Tribes having the option of another data source, data validation coordination will be essential.

2) Improving connectivity for remote sites.
3) Ensuring necessary Federal security requirements for Tribal members to request access to RPMS.

GRANTS AWARDS

No grant awards are anticipated for FY 2013.

AREA ALLOCATION – Community Health Representatives

Discretionary SERVICES	**FY 2011 Enacted**	**FY 2012 Enacted**	**FY 2013 Request**	**FY 2013 +/- FY 2012**
Aberdeen	$7,302,693	$7,291,057	$7,291,057	$0
Alaska	4,442,171	4,435,093	4,435,093	0
Albuquerque	3,526,868	3,521,248	3,521,248	0
Bemidji	4,847,563	4,839,839	4,839,839	0
Billings	4,485,921	4,478,773	4,478,773	0
California	2,017,554	2,014,339	2,014,339	0
Nashville	3,486,988	3,481,432	3,481,432	0
Navajo	6,938,174	6,927,119	6,927,119	0
Oklahoma	9,015,599	9,001,234	9,125,234	124,000
Phoenix	6,295,290	6,285,259	6,285,259	0
Portland	4,716,761	4,709,245	4,709,245	0
Tucson	1,981,206	1,978,049	1,978,049	0
Headquarters	2,448,212	2,444,311	2,444,311	0
Total, CHR	**$61,505,000**	**$61,407,000**	**$61,531,000**	**+$124,000**

Note: FY 2011 amounts reflect actual data. FY 2012 and FY 2013 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 2011 Enacted	FY 2012 Enacted	FY 2013 Request	FY 2013 +/- FY 2012
BA	$1,930	$1,927	$1,927	$0
FTE*	0	0	0	0

*The program is operated by Tribal staff.

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

FY 2013 Authorization.....Permanent

Allocation Method..... Self-Governance Compact

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

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

Hepatitis B Program

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

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

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

The Program uses computer-based applications that integrate laboratory and other clinical data into a series of reports that allows program clinicians to follow a large number of patients with chronic hepatitis and other liver disease. The Program follows patients Statewide with chronic hepatitis B with the goal of reducing the lifetime risk of death from liver cancer or cirrhosis from 25 percent to <10 percent by early detection and removal of hepatocellular cancer and treatment with antiviral medications.

In 2011, 60 percent of AI/ANs with chronic hepatitis B or C infection (65 percent and 56 percent, respectively) were screened for liver cancer and for liver aminotransferase levels to detect liver inflammation and potential treatment candidates at least once during the year. Targets for chronic hepatitis B were nearly met and the proportion of those increased from that of 2010 (from 63 to 65 percent). Targets for chronic hepatitis C were exceeded; however the proportion screened decreased from that of 2010 (from 72 to 56 percent). This is due in part to a continued increase in newly diagnosed hepatitis cases (148 in 2010) and reduced testing. The program will increase patient outreach in an effort to resolve. A continuing challenge is to determine good candidates for antiviral therapy, especially with the advent and approval of several new potent and more effective antiviral agents. Within the next 5 to 10 years, an estimated 25–33 percent of patients will need therapy for Hepatitis C.

Immunization (Hib) Program

The Immunization (Haemophilus Influenza; Hib) Program started in 1989 with a targeted Haemophilus Influenzae type b prevention project in the Yukon Kuskokwim Delta and now maintains high vaccine coverage by providing resources, training and coordination to Tribal facilities throughout Alaska. The Program conducts activities through e-mail, phone consultation, onsite training, teleconferences, web-based trainings, written guidelines, presentations, and site visits. Regular meetings are held with regional Immunization Coordinators, Clinical Directors, Community Health Aide Program (CHAP), IHS Immunization Coordinators, and the State of Alaska Immunization Program. The Program works with Tribal public relations to address parental immunization hesitancy and highlight the importance of vaccines. Statewide Alaska Native immunization coverage rates are reported to IHS headquarters for infants 3-27 months, 19-35 months, adolescents and older adults and flu vaccine among all ages.

In 2011, the Program accomplished the following:

- Immunization Coverage for 19-35 month olds was 73%, compared to the national GPRA target of 74.6 percent for child vaccine coverage with 4:3:1:3:3:1:4 series (4 DTaP, 3 IPV, 1 MMR, 3 Hib, 3 Hep B, 1Var, 4 PCV). The target was not met because a new vaccine was added to the series requiring 4 additional immunizations;
- Pneumococcal vaccine coverage in elders $\geq$ 65 years (92%) greatly exceeded the 2011 national GPRA objective of 79.3 percent;
- Administered human papillomavirus (HPV) vaccine 1+ dose coverage in 79% percent of Alaska Native females 13-17 years olds, which is much higher than the US all races coverage;
- Achieved coverage with Haemophilus influenza type b (Hib) (92%) during the nation-wide Hib vaccine shortage, which is much higher than the US races;
- Implementation routine use of 13 valent pneumococcal conjugate vaccine which has resulted in a dramatic decrease in pneumococcal disease in Alaska Native children;
- Consulted on implementation of the new electronic health records at Alaska Native Medical Center;
- Published articles on infectious disease and empyema in American Indian/Alaska Native people, hepatitis B elimination in Alaska Native children, and risk factors for respiratory hospitalization in peer-reviewed journals;
- Collaborating with several agencies in a Healthy Homes study to evaluate the impact of reducing indoor air pollution from woodstoves and improper ventilation on respiratory visits and symptoms in high risk Alaska Native children.

Immunization Measure	Age Group	Alaska Native coverage 9/30/2011
4:3:1:3:3:1:4	19-35 mo	73%
4:3:1:3:3:1	19-35 mo	80%
3 Hib vaccines doses		92%
3 PCV (pneumococcal conjugate vaccine)	19-35 mo	94%
1+ HPV	13-17 years female	79%
Pneumococcal vaccine	65+ years	92%

FUNDING HISTORY

Fiscal Year	Amount
2008 Enacted	$1,733,000
2009 Omnibus	$1,823,000
2010 Enacted	$1,934,000
2011 Enacted	$1,930,000
2012 Enacted	$1,927,000

BUDGET REQUEST

The FY 2013 budget request for Immunization AK of $1,927,000 is the same as FY 2012 enacted level of $1,927,000.

Activities associated with this funding include the coordination of vaccine coverage reporting for Tribal facilities, training of Tribal immunization coordinators, and clinic staff in vaccine recommendations and documentation, and consultation in the migration to Electronic Health Records, and regular notification to hepatitis patients of the need to complete liver function screenings so that program clinicians can identify serious liver disease or liver cancer when it is at an early and treatable stage.

Hepatitis B Program

The Program recently added 0.5 days (total now 3.0 days) of outpatient clinics at the Alaska Native Medical Center (ANMC) and also travels to regional health centers to conduct outpatient clinics (13 days/year). Outpatient clinic time was added given an increasing number of Hepatitis C patients, as they require intensive workup and those who are on treatment require case management to ensure compliance and healthy outcomes.

As many of the patients that are monitored and their primary care provider resides outside of Anchorage, in FY 2012 the Program has implemented a venue for the education/ training of providers utilizing the established statewide Tribal Health System tele-health system (video-conferencing). The objective of the program's "LiverConnect" is to provide relevant clinical information to assist in the care and management of hepatitis and liver disease patients. The Program maintains and works to grow partnerships with Tribes throughout the Alaska Tribal Health System (ATHS). Annual field clinics are conducted at 13 sites 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.

The Program strives to achieve quality of and access to care by recruiting and retaining the highest level of clinical and support staff. To increase access to care, the Program is always on the lookout for new cases through the utilization of regular electronic health care records reviews and a statewide referral system. The Program strives to make all work accountable, transparent,

fair and inclusive through systematic reporting of upcoming clinical screenings to ATHS clinics and the notification of screening and subsequent report of results to the provider and patients. The Program ensures accountability by using customer satisfaction surveys and maintains flexibility in scheduling to accommodate programmatic and customer needs that might arise.

Immunization (Hib) Program

The budget request will be used for staff travel to provide program support for regional Tribal programs and limited printing media materials. Funding of these activities allows maintenance of current program support of Alaska Tribal immunization activities, statewide and national immunization advocacy and technical support, and Area reporting to IHS Headquarters.

The Program supports the HHS Strategic Plan:

- Preventing disease through immunization
- Improving maternal and infant health,
- Planning and preparing for public health emergencies by providing an infrastructure to maintain high immunization coverage for basic vaccines and have a rapid response to emergencies such as pandemic Flu.

Outputs during FY 2013 will include:

- The activities listed above under Program Description
- Technical support to Tribal agencies developing Electronic Health Records (EHR)
- Networking with other departments and agencies for Emergency Preparedness

New strategies include:

- Collaboration with other agencies such as CDC in developing media materials
- Network with IHS and other agencies to provide technical assistance regarding EHRs
- Obtain grant funding and technical assistance to support uncovered program activities such as emergency preparedness.

The future challenge of the diversity of EHRs employed by Tribal agencies that may result in a temporary loss or delay of Area-wide reporting of immunization coverage will continue to be addressed through coordinated technology efforts by IHS and Tribes.

Outputs and Outcomes

Measure	Year and Most Recent Result/ Target for Recent Result/ (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 Target +/- FY 2012 Target
Hepatitis Program (Targeted/Known Cases = T and Screened = S)				
Sum of Hepatitis Patients Targeted for Screening	FY 2011: 3069 Target: 2872 (Target Exceeded)	3231	3351	+120
Chronic Hepatitis B Patients Screened/Targeted	FY 2011: T=1105 S=718 FY 2011 Targets: T =1138 S =750 (T Target and S Target Not Met;)	T=1100 S=693	T=1070 S=674	T=-30* S=-19

Measure	Year and Most Recent Result/ Target for Recent Result/ (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 Target +/- FY 2012 Target
Chronic Hepatitis C Patients Screened/Targeted	FY 2011: T=1431 S=809 FY 2011 Targets: T=1314 S=788 (T Target and S Targets Exceeded)	T=1531 S=900	T=1631 S=950	T=+100 S=+50
Other Liver Disease Patients Screened/Targeted**	FY 2011: T=533 S=426 FY 2011 Targets: T=420 S=300 (T Target and S Targets Exceeded)	T=600 S=456	T=650 S=465	T=+50 S=+11
Hepatitis A/B vaccinations***	FY 2011: 5000 FY 2011 Target: 5000 (Target Met)	5000	5000	0

* Decline in hepatitis B cases due to an aging cohort and their deaths; discovery of new cases is rare given hepatitis B vaccinations.
** Other liver disease includes autoimmune hepatitis, primary biliary cirrhosis, nonalcoholic fatty liver disease.
*** Includes vaccination of patients at high risk (e.g., injection drug users, other liver disease, and hepatitis C and/or HIV infection) and scheduled/routine vaccination of infants, children and adults (number based on births, incidence of hepatitis and estimations). All data reported is that which is available to the Alaska Native Tribal Health Consortium.

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

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

(Dollars in Thousands)

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request	FY 2013 +/- FY 2012
BA	$43,053	$42,984	$42,988	+$4
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 2013 Authorization.....Permanent

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The Urban Indian Health Program (UIHP) was established in 1976 to provide affordable and accessible health care for the underserved urban American Indian/Alaska Native (AI/AN) population. IHS provides funding through limited, competing contracts and grants with 34 urban Indian 501(c)(3) non-profit organizations to provide health care in 41 sites throughout the U.S. Urban Indian Health Organizations (UIHO) define their scopes of work and services based upon the documented unmet needs of the urban AI/AN community they serve. Each UIHO is governed by a Board of Directors of whom at least 51 percent are AI/AN.

UIHOs provide primary medical care and public health case management wrap-around services for approximately 51,000 urban AI/ANs who do not have access to the resources offered through IHS and tribally operated health care facilities. Urban Indian primary care clinics and case management programs provide high quality, culturally accessible, affordable, and accountable health services. The services include ambulatory health care, health assessment, health promotion, disease education, child abuse prevention, immunizations, and behavioral health services. The UIHOs fulfill IHS data reporting requirements including the IHS Government Performance and Results Act (GPRA) report and the Diabetes Non-Clinical Audit report. Eight programs participate in the IHS Improving Patient Care program.

The UIHOs report on the amounts and purposes for which funding is used, including: a) the number of eligible urban AI/ANs for whom services are provided, and b) the number and type of services provided to urban AI/ANs. Information contained in the 2010 Uniform Data System (UDS) report indicated that the UIHO served a population that was 43 percent AI/AN. The UIHOs have policies requiring supporting documentation of the eligibility of a particular individual included in their Title V reports.

There are 21 full ambulatory facilities. A full ambulatory UIHO provides direct medical care to the population served for 40 or more hours per week. The range of services varies greatly among the programs that are defined as full ambulatory. Some full ambulatory programs have two or

more full time medical doctors, full time pharmacists, provide lab and radiology services, and have on-site dental providers. At the opposite end of the spectrum, some full ambulatory programs have a full time medical provider, but do not offer dental, pharmacy, lab or radiology services.

There are six limited ambulatory programs. A limited ambulatory facility provides direct medical care to the population served for less than 40 hours per week. The range of direct medical services provided by limited ambulatory programs varies greatly. These programs have medical providers on-site ranging from 32 hours per week to only 4 hours per week. No limited ambulatory program offers dental, pharmacy, lab or radiology services on-site.

There are seven outreach and referral programs that provide behavioral health counseling and education services, health promotion/disease prevention education and immunization counseling. These programs do not provide direct medical care services. All outreach and referral programs develop and implement a Memorandum of Understanding with their local health clinics to provide culturally relevant, competent health care services for urban AI/AN clients referred to the clinic for medical care.

As of May 2011, two programs have implemented IHS Resource and Patient Management System (RPMS)/Electronic Health Record (EHR); ten have fully implemented IHS RPMS and are working on transitioning to RPMS/EHR; fifteen programs are working to implement RPMS, and six programs have non-RPMS electronic systems.

The 2011 national measure reporting cycle (July 1, 2010 – June 30, 2011) was successful for the UIHOs. Areas of greatest accomplishment included: (1) 100 percent of the UIHO reported on 20 of the 20 performance measures, and (2) 21 UIHO reported through CRS; 13 reported using 100 percent review of appropriate data source (as opposed to sampling a smaller percentage of records). The goal is to transition to 100 percent electronic reporting for the UIHO using RPMS, and once the data is stabilized, advocate for inclusion in the IHS national clinical performance measure reporting.

Program challenges include increasing the number of programs using RPMS/EHR, providing training and technical assistance to increase third party billing revenue, hiring providers for 24/7 coverage to meet FQHC designation, increasing the number of Joint Commission or Accreditation Association for Ambulatory Health Care, Inc. accredited programs, facilities maintenance and repair improvements, implementation of Dentrix, and increasing quality of and access to preventative health services. Tribal leadership consistently demonstrates its support for funding urban Indian health programs to serve their members who reside away from their communities. These programs often provide the only affordable, culturally competent healthcare services available in these urban areas.

FUNDING HISTORY

Fiscal Year	Amount
2008 Enacted	$34,547,000
2009 Omnibus	$36,189,000
2010 Enacted	$43,139,000
2011 Enacted	$43,053,000
2012 Enacted	$42,984,000

BUDGET REQUEST

The FY 2013 budget request for Urban Health of $42,988,000 is an increase of $4,000 over the FY 2012 enacted level of $42,984,000.

Current Services +$4,000

Federal Pay Costs +$4,000 to cover federal Commissioned Officer pay costs.

Justification for Base Funding for 2013

Activities designed to increase the quality of and access to care for the urban AI/ANs include providing third party billing training and technical assistance, increasing the number of programs using RPMS/EHR, and increasing the number of accredited programs.

The program funding and accomplishments will strengthen and enhance implementation of the DHHS Strategic Plan for Fiscal Years 2010-2015, Goal 1: Transform Health Care by:

- Working with urban Indians to provide outreach, information and assistance to assure that urban AI/ANs are enrolled and able to use the benefits available under the IHCIA.
- Improving third party billing operations, implementing payment reforms and increasing quality improvement efforts.
- Increasing the number of urban medical homes for urban AI/AN patients.
- Emphasizing preventive health services including evaluation, dissemination and promotion of effective clinical preventive services.
- Implementing and utilizing tele-medicine.
- Expanding access to quality culturally competent care for urban AI/AN through close collaboration with the Department of Health and Human Services (HHS) Operating Divisions to implement the IHCIA.
- Increasing the number of health care providers to provide health services for urban AI/AN.
- Increasing technical assistance for implementing RPMS/EHR in 6 additional programs.

Outputs and Outcomes

Measure	Year and Most Recent Result/ Target for Recent Result/ (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 Target +/- FY 2012 Target
UIHP-E: Cost per service user in dollars per year. *(Efficiency)*	FY 2010: $1,033 Target: $1097 (Target Exceeded)	Discontinue	N/A	N/A
UIHP-1: Percent decrease in years of potential life lost. (Outcome 1)	FY 2003: 51.7No target (Baseline)	Discontinue but consolidate in FY 2012		N/A
UIHP-2: Percent of AI/AN patients with diagnosed diabetes served by urban health programs that achieve ideal blood sugar control. (Outcome)	FY 2011: 35.2% Target: Baseline	36.1%	34.5%	-1.6%
UIHP-3: Proportion of children, ages 2-5 years, with a BMI of 95 percent or higher (Outcome 2)	FY 2011: 16.2% Target: Baseline	N/A	16.1%	N/A
UIHP-6: Increase the number of diabetic AI/ANs that achieve ideal blood pressure control (Outcome 3)	FY 2011: 41% Target: 25.8% (Target Exceeded)	41%	41%	0

Measure	Year and Most Recent Result/ Target for Recent Result/ (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 Target +/- FY 2012 Target
UIHP-7: Number of AI/ANs served at Urban Indian Clinics. (Outcome)	FY 2011: 50,511 Target: 47,611 (Target Exceeded)	51,167	51,832	+665

1 Long-term measure, baseline for 2003 to be reported in 2009 after which a target will be set for 2009
2 Long-term measure, reportable in 2010 and 2013.

Grant Awards – Funding for the Urban Indian health programs for FY 2011 came from the FY 2011 appropriations for both the grants and contracts awarded to the programs.

GRANTS AWARDS

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request
Number of Awards	32	34	34
Average Award	$227,856	$227,856	$227,856
Range of Awards	$122,832 - $626,765	$122,832 - $626,765	$122,832 - $626,765

AREA ALLOCATION – Urban Health

Discretionary SERVICES	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request	FY 2013 +/- FY 2012
Aberdeen	$1,522,686	$1,520,246	$1,520,246	$0
Alaska	0	0	0	0
Albuquerque	2,424,165	2,420,280	2,424,280	4,000
Bemidji	4,417,356	4,410,276	4,410,276	0
Billings	2,266,794	2,263,161	2,263,161	0
California	6,492,575	6,482,170	6,482,170	0
Nashville	918,398	916,926	916,926	0
Navajo	716,872	715,723	715,723	0
Oklahoma	2,052,236	2,048,947	2,048,947	0
Phoenix	2,475,181	2,471,214	2,471,214	0
Portland	5,529,548	5,520,686	5,520,686	0
Tucson	514,978	514,153	514,153	0
Headquarters	13,722,211	13,700,219	13,700,219	0
Total, Urban Health	**$43,053,000**	**$42,984,000**	**$42,988,000**	**+$4,000**

Note: FY 2011 amounts reflect actual data. FY 2012 and FY 2013 are estimates.

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

INDIAN HEALTH PROFESSIONS

(Dollars in Thousands)

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request	FY 2013 +/- FY 2012
BA	$40,661	$40,596	$40,598	$2
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 2013 Authorization.....Permanent

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

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

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

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

Sections 103 and 104 of the Scholarship Program – Section 103 includes the preparatory and pre-graduate scholarship programs that prepare students for health profession 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 for AI/AN students from Federally recognized Tribes enrolled in health profession or allied health profession programs. Students accepting funding for programs under section 104 incur service obligations and payback requirements.

In 2008, the IHS compared the number of years each scholar served with the number they were obligated to serve. On average, students received scholarships under section 104 for 2.21 years

and provided 6.13 years full time clinical services in an Indian health program. Scholars served an average 3.92 years beyond their service obligation.

Students in the following disciplines received funding during FY 2011 school year:

Section 103 Preprofessional - 11 students				
Pharmacy	3		Medical Technology	1
Nursing	3		Occupational Therapy	0
Clinical Psychology	3		Social Work	1
Physical Therapy	0			
Section 103 Pregraduate - 16 students				
Medicine	5		Optometry	0
Dentistry	10		Podiatry	1
Section 104 Health Professions - 246 students				
Physician (DO and MD)	42		Dental Hygienist	0
Nurse (ADN, BS and MS)	59		Dietitian	1
Pharmacist	36		Occupational Therapist	3
Dentist	25		Chemical Abuse Counseling	3
Physical Therapist	17		Health Care Administration	0
Physician Assistant	14		Health Education	0
Clinical Psychologist	8		Health Records	1
Optometrist	7		Nurse Anesthetist	1
Nurse Practitioner	9		Podiatrist	0
X-Ray Technology	3		Respiratory Therapist	0
Engineer	2		Sanitarian	0
Medical Technology	1		Women's Health Nursing	2
Social Work	11		BioMedical Engineering	1

Loan Repayment Program (Section 108): The Loan Repayment Program is an invaluable tool for recruiting and retaining health-care professionals and offers these professionals the opportunity to reduce their student loan debts and places them in Indian health programs with critical staffing needs. Applicants agree to serve two years at an Indian health program in exchange for up to $20,000 per year in loan repayment funding and up to an additional $4,000 per year to offset tax liability. Loan repayment recipients with more than $40,000 in loan debt can extend their initial two-year contract on an annual basis and receive up to an additional $20,000 per year, plus up to $4,000 for taxes, until their original loan debt is paid.

In 2008, the IHS compared the number of years each LRP recipient served with the number they were obligated to serve. The service obligation period for a LRP recipient was, on average, 2.65 years. The average retention period for loan repayment recipients was 7.44 years. On average, they served 4.79 years beyond their required service obligation.

Applicants that apply for funding and do not receive funding, are identified as "matched unfunded" and "unmatched unfunded". The "matched unfunded" are employed in an Indian health program. Others decline job offers because they do not receive loan repayment funding and are the "unmatched unfunded". Applicants denied funding also includes those without suitable assignments. It is estimated that an additional $6.1 million would be needed to fund the 112 matched but unfunded applicants from FY 2011.

In FY 2011 (complete data for most recent year), the IHS LRP made loan repayment awards to the following disciplines:

Awards by Profession	Total Awards	New Awards	Contract Extensions	Matched Not Awarded
Nurses	163	146	17	38
Dental*	105	36	69	1
Pharmacists	152	79	73	38
Physicians	87	35	52	0
PA/APN	56	29	27	5
Behavioral Health	34	21	13	6
Optometrists	25	6	19	0
Podiatrists	19	6	13	0
Rehabilitative Services	21	14	7	6
Other Professions	39	35	4	18
TOTAL	**701**	**407**	**294**	**112**

***** Includes Dentists and Dental Hygienists

Other Professions	Total Awards	Matched Not Awarded
X-Ray Technician	10	4
Dietician	8	8
Medical Technician	8	3
Engineer	8	2
Sanitarian	2	0
Respiratory Therapist	2	1
Chiropractor	1	0
TOTAL	**39**	**18**

By Pay System	Awards
Tribal Employees	342
Civil Service	235
Commissioned Corps	118
Urban Health Employees	6
Total	**701**

Grant Programs - The IHP administers three grant programs which fund colleges and universities to train students for health professions: Indians into Nursing (Section 112); Indians into Medicine (Section 114); and Indians into Psychology (Section 217).

FUNDING HISTORY

Fiscal Year	Amount
2008 Enacted	$36,291,000
2009 Omnibus	$37,500,000
2010 Enacted	$40,743,000
2011 Enacted	$40,661,000
2012 Enacted	$40,596,000

BUDGET REQUEST

The FY 2013 budget request for Indian Health Professions of $40,598,000 is an increase of $2,000 above the FY 2012 enacted level of $40,596,000. Current programs will be continued with this funding.

Current Services +$2,000

Federal Pay Costs +$2,000 – to cover federal Commissioned Officer Pay costs.

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

Section	Title	FY 2012	FY 2013 Request	FY 2013 +/- FY 2012	Expected Performance
103	Health Professions Preparatory and Pre-Graduate Scholarships	$3,840,096	$3,840,096	0	25 continuing and 20 new student agreements
104	Health Professions Scholarship	$10,546,886	$10,546,886	0	170 continuing and 75 new student contracts
105	Extern Program	$1,181,932	$1,183,932	0	135 temporary clinical assignments
108	Loan Repayment Program	$21,338,884	$21,338,884	0	250 contract extensions and 400 new contracts.
112	Quentin N. Burdick American Indians Into Nursing Program	$1,768,497	$1,768,497	$0	5 grants
114	Indians into Medicine (INMED) Program	$1,162,319	$1,162,319	$0	3 grants
217	American Indians Into Psychology Program	$757,386	$757,386	$0	3 grants
	TOTAL	**$40,596,000**	**$40,598,000**	**0**	

In FY 2011, the IHS LRP received $5,153,716 of Hospitals and Clinics (H&C) funds, which continues the funding support for loan repayment awards first appropriated in FY 2001. Based on IHS staffing needs, along with number of FY 2011 "matched unfunded" as described previously, the IHS LRP awarded funded 112 new LRP contracts to various health professionals, including nurses, dentists, pharmacists, and mid-level practitioners from H&C. For FY 2013, the IHS LRP will continue to use the additional H&C funds to meet IHS priority staffing needs.

Outputs and Outcomes

Measure	Year and Most Recent Result/ Target for Recent Result/ (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 Target +/- FY 2012 Target
42: Scholarships: Proportion of Health Professionals Scholarship recipients placed in Indian health settings within 90 days of graduation.	FY 2011: 61.2% Target:78% (Target: Not Met)	78%	78%	0
Number of Scholarship Awards – Total				
Section 103 *(Outputs)*	FY 2011: 27 Target: 49 (Target: Not Met)	49	45	-4
Section 104 *(Outputs)*	FY 2011: 244 Target: 223 (Target Exceeded)	223	245	+22
Number of Externs (Section 105) *(Outputs)*	FY 2011: 142 Target: 135 (Target Exceeded)	135	135	0
Number of Loan Repayments Awarded – Total (Section 108)a/ *(Outputs)*	FY 2011: 701 Target: 685 (Target Exceeded)	685	650	-35
New Awards (2 Year Awards)(Outputs)	FY 2011: 407	425	400	-25

Measure	Year and Most Recent Result/ Target for Recent Result/ (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 Target +/- FY 2012 Target
	Target: 425 (Target Not Met)			
Contract Extensions (1 Year Awards)(Outputs)	FY 2011: 294 Target: 260 (Target exceeded)	260	250	-10
Continuation Awards (Funded in Previous Fiscal Year)(Outputs)	FY 2011: 413 Target: 176 (Target Exceeded)	407	401	-6

a/ Loan repayment figures do not show data from non-IHP funding (100 new two-year awards anticipated in FY 2013).

The IHS performance goal is to place scholars within 90 days from when they complete their health-profession degree or training. The IHP works with scholarship recipients as well as specific healthcare professional subject matter experts to place them in Indian health hospitals and clinics. IHS has made notable progress in reducing hiring times from approximately 140 days to approximately 90 days to hire a health care professional, from the time the request is submitted to the Office of Personnel Management (OPM) Capital HR program to when the person enters on duty. IHS will continue to focus on best practices to ensure that OPM and health-professional licensure requirements are carried so that a scholar can be placed within 90 days. The FY 2013 placement goal should remain the same as 2011 and its relevance re-evaluated for FY 2013. Indian Health Service hiring reforms and improved tracking of placements should result in meeting the performance objective.

GRANTS AWARDS

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request
Indians into Nursing (Section 112)			
Number of Awards	5	5	5
Average Award	$336,186	$336,186	$336,186
Range of Awards	$300,000 - $350,000	$300,000 - $350,000	$300,000 - $350,000
Indians Into Medicine(Section 114)			
Number of Awards	3	3	3
Average Award	$356,083	$356,083	$356,083
Range of Awards	$170,000 - $728,250	$170,000 - $728,250	$170,000 - $728,250
Indians Into Psychology (Section 217)			
Number of Awards	3	3	3
Average Award	$252,462	$252,462	$252,462
Range of Awards	$300,000-$350,000	$300,000-$350,000	$300,000-$350,000

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

TRIBAL MANAGEMENT GRANT PROGRAM

(Dollars in Thousands)

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request	FY 2013 +/- FY 2012
BA	$2,581	$2,577	$2,577	$0
FTE*	0	0	0	0

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

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

FY 2013 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, as amended. It was established to assist Tribes and/or Tribal organizations (T/TO) to plan and prepare for assumption of all or part of existing Indian Health Service (IHS) programs, functions, services, and activities (PFSA) under the authority of ISDEAA and to further develop and/or enhance their health program management capability and capacity. The TMG Program provides discretionary competitive grants to T/TO to establish goals and performance measures for current health programs; assess current management capacity to determine if new components are appropriate; analyze programs to determine if T/TO management is practicable; and develop and/or enhance infrastructure systems to manage or organize PFSA.

All federally-recognized Indian Tribes and Tribally-sanctioned Tribal organizations are eligible to apply for a TMG. The TMG Program has established three funding priorities. The first priority is for any Tribe that has received Federal recognition or restoration within the last five years. The TMG Program recognizes that newly recognized or restored Tribes need assistance implementing or developing management and infrastructure systems for their organization. The second priority focuses on T/TO that are addressing audit material weaknesses. The TMG Program recognizes the importance of addressing audit weaknesses in order to strengthen infrastructure to provide additional or improved services. The third priority includes all other projects and T/TO. Most applicants submit projects under this funding priority to perform feasibility studies, implement planning or evaluation projects, or improve their management capabilities.

The TMG funds are distributed primarily for direct grant awards. Approximately three percent of the appropriated funding is used for overall administration of the program; these funds provide program requirements training, grant writing workshops and general technical assistance. These efforts assist T/TO in developing proposals that fully address the TMG project cycle and are responsive to the program announcement. Past performance has demonstrated that T/TO who

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

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

1) Planning and 2) Evaluation Study projects are funded up to $50,000 with project periods not to exceed 12 months.
   - The Planning Project allows T/TO to establish goals and performance measures for current health programs or to design their health programs and management systems.
   - An Evaluation Study Project determines the effectiveness and efficiency of a program or if new components are needed to assist the T/TO improve its health care delivery system.

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

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

FUNDING HISTORY

Fiscal Year	Amount
2008 Enacted	$2,490,000
2009 Omnibus	$2,586,000
2010 Enacted	$2,586,000
2011 Enacted	$2,581,000
2012 Enacted	$2,577,000

BUDGET REQUEST

The FY 2013 budget request for Tribal Management Grants of $2,577,000 is the same as the FY 2012 enacted level of $2,577,000.

Outputs and Outcomes

Measure	Year and Most Recent Result/ Target for Recent Result/ (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 Target +/- FY 2012 Target
Planning Grants	FY 2011: 1 Target: 1 Target Met	FY 2012 1	1	0
Health Management Structure (HMS) grants	FY 2011: 22 Target: 22 Target Met	FY 2012 22	28	6

GRANTS AWARDS

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request
Number of Awards[1]	$2,581,000 13 Noncompeting Continuations and 13 New	$2,762,000 11 Noncompeting Continuations and 16 New	$2,679,000 16 Noncompeting Continuations and 14 New
Average Award	$99,240	$95,185	$89,300
Range of Awards	$49,980-$149,843	$50,000 - $150,000	$50,000 - $150,000

[1] Includes partial awards

AREA ALLOCATION – Tribal Management

Discretionary SERVICES	**FY 2011 Enacted**	**FY 2012 Enacted**	**FY 2013 Request**	**FY 2013 +/- FY 2012**
Headquarters	2,581,000	2,577,000	2,577,000	0
Total, TM	**$2,581,000**	**$2,577,000**	**$2,577,000**	**$0**

Note: Funds are not allocated on a recurring basis to Areas but awarded on a competitive basis to Tribes and Tribal organizations directly from Headquarters.

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

(Dollars in Thousands)

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request	FY 2013 +/- FY 2012
BA	$68,583	$71,653	$72,867	+$1,214
FTE	312	324	343	+19

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 2013 Authorization.....Permanent

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The IHS Headquarters provides Agency-wide leadership, oversight, and executive direction to ensure that comprehensive health care services are provided to American Indians and Alaska Natives (AI/ANs). In addition, Headquarters administers the Agency in the context of President and HHS goals and IHS mission and priorities while simultaneously maintaining the special Tribal-Federal relationship based in treaty and law.

The IHS Headquarters authorities and operations are set forth by statute and administrative requirements by the Department of Health and Human Services (DHHS), the Administration, and Congress. The IHS Headquarters provides general program direction and oversight for the 12 IHS Areas and 163 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 the DHHS to formulate and implement national health care priorities, goals, and objectives for AI/ANs. The IHS Headquarters works with the DHHS to formulate the annual budget and necessary legislative proposals. In addition, it responds to congressional inquiries and interacts with other governmental entities to enhance and support health care services for AI/ANs.

By delegation from the Director, IHS, the 12 Area Offices distribute resources, monitor and evaluate the full range of comprehensive health care and community oriented public health programs, and provide technical support to local Service Units and I/T/U staff. They ensure the delivery of quality health care through the 163 Service Units and participate in the development and demonstration of alternative means and improvement techniques of health services management and delivery to promote the optimal provision of health services to Indian people through the Indian health system.

The Direct Operations budget supports the leadership, overall management, and inherent federal functions and activities of the IHS to ensure effective support for the IHS mission. This includes

oversight of human resources, financial resources, facilities, information technology and administrative support resources and systems' accountability. With approximately 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 Direct Operations budget provides critical support in the overall administration and delivery of the health programs and services throughout the IHS and its funding is allocated to IHS Headquarters, 12 Area Offices, and Tribal Shares.

Overall leadership and direction is focused on the Agency's four priorities: to renew and strengthen the partnership with Tribes and improve the Tribal consultation process; to reform the IHS; to improve the quality and access to care for patients who are served by the IHS; and to be as transparent, accountable, fair, and inclusive as possible in the work performed. One example of the most recent accomplishments related to the Agency priority to renew and strengthen its partnership with Tribes is implementation of seven recommendations from Tribes to improve the Tribal consultation process including holding the first ever Tribal Consultation Summit in July 2011 where Tribes learned about current consultation activities in a "one stop shop" event. The IHS has been consulting with Tribes on numerous issues, including: improving the Tribal consultation process; improving the Contract Health Services program; priorities for health reform and implementation of the Indian Health Care Improvement Act; the annual IHS budget request; implementation of the Memorandum of Understanding between the Department of Veterans Affairs (VA) and the IHS; the Indian Healthcare Improvement Fund (IHCIF) allocation; the Special Diabetes Program for Indians 2-year extension; and, Tribal Epidemiology Centers data sharing agreement. The consultations on the IHCIF and the Diabetes 2-year extension resulted in decision announcements by the IHS Director in FY 2011. In addition, significant work has been accomplished through a Tribal workgroup on improving the Contract Health Services (CHS) program that resulted in recommendations and sharing of best practices that will improve management of IHS operated CHS programs and third-party collections. In addition to the consultations continuing into FY 2012, two new ones were initiated in early FY 2012 on issues surrounding the Federal Advisory Committee Act and on the Contract Support Costs policy in effect since 2007. All these consultations will result in better decisions for the future of IHS and will help to improve patient care.

The IHS continues comprehensive improvements, reforms and oversight in management and administration of key Agency-wide systems, including financial management, property management, performance management, and hiring reforms, including improved suitability determinations for new hires and ongoing oversight and improvements in healthcare provider credentialing and facility accreditation. One improvement is ensuring that employment and background verification requirements are fully met prior to on-boarding. The IHS checks the Office of Inspector General's exclusion list for all its employees and has standard security pre-clearance language for use in IHS solicitations that involve contractor access to IHS facilities and systems. Another example of improvement is IHS working closely with HHS on maintaining progress and completion of addressing the major audit findings for cash management and suspense reconciliations. The most recent focus is on refining and formalizing processes to ensure routine accomplishment of cash and suspense reconciliations. In FY 2011, the IHS achieved its most effective accounting of fund balances since implementing the Unified Financial Management System. As a result of the 2011 audit, the IHS achieved a clean opinion on the portion in which IHS participates. The Agency had only two IHS-specific findings compared to 20 in FY 2010. The IHS continues to maintain 100 percent accreditation/certification for IHS-operated hospitals, ambulatory clinics, and regional youth treatment centers and works in collaboration with national healthcare organizations to remain accredited/certified.

The Direct Operations budget also supports leadership and oversight for the accomplishment of the Agency's program performance. Direction includes specific focus on the Secretary's Key Initiatives and priorities and the HHS Strategic Plan for Fiscal Years 2010-2015. The IHS has exceeded both of its FY 2011 targets for its Agency-specific performance goals, depression screening and improving the Tribal consultation process, that are tracked as a part of the implementation the HHS Strategic Plan. In FY 2011, the Agency participated fully in HHS quarterly reviews of three Agency priority performance goals on hiring time, site eligibility for participation in the National Health Service Corps (NHSC), and improving the Tribal consultation process.

The improvement of the Human Resource Management and Servicing systems are a high priority of the IHS and include the following:

- The IHS is working on specific activities to improve and streamline the hiring process by making use of standardized position descriptions and improving use of the web-based hiring system. In FY 2011, the IHS reduced its average overall hiring time from 140 days to 81 days by making improvements in the processes it uses to hire employees.
- The Agency is working on improvements in pay systems and strategies to improve more timely recruitment and retention because it has been historically difficult for IHS to recruit and retain healthcare providers, due to remote locations and noncompetitive salaries.
- The collaborative work IHS continues with the Health Resources and Services Administration (HRSA) has resulted in approval of 490 IHS, Tribal and urban Indian health care delivery sites for placement of NHSC health care providers, and the number of placements has increased to 221 providers in FY 2011. The progress was made possible by the IHS and HRSA's NHSC working collaboratively to develop a process for a pre-approved method for site eligibility, an important first step to address health professional vacancies in medically underserved areas.
- These measures and others address many of the administrative aspects of providing health care to the AI/AN population and other Departmental goals of achieving equivalent and improved health status for all Americans.

Priorities for performance improvements in Direct Operations include:

- Responsiveness to key stakeholders (the Administration, the Congress, and Tribal partners) in a transparent and timely manner in achieving administrative requirements, demonstrating management improvements, responding to oversight requests;
- Implementing ongoing accountability to key stakeholders for new permanent authorities of the Indian Health Care Improvement Act (IHCIA); Implementation of the IHCIA for the HHS and is actively involved in provisions that directly affect American Indian and Alaska Native people. In undertaking the implementation of IHCIA provisions, the IHS has consulted with Tribes extensively.
- The IHS accomplished actions to meet requirements of IHCIA provisions due one year after its enactment.
- The IHS has assisted the HHS or collaborated with other federal agencies, such as the Centers for Medicaid and Medicare Services, Office of Personnel Management and the VA, to undertake the implementation of various provisions for which IHS was not the lead for implementation.
- Throughout the implementation activities, the IHS has kept the general public and key stakeholders updated on the progress.

FUNDING HISTORY

Fiscal Year	Amount
2008 Enacted	$63,624,000
2009 Omnibus	$65,345,000
2010 Enacted	$68,720,000
2011 Enacted	$68,583,000
2012 Enacted	$71,653,000

BUDGET REQUEST

The FY 2013 budget request for Direct Operations of $72,867,000 is an increase of $1,214,000 over the FY 2012 enacted level of $71,653,000.

Current Services +$99,000

Federal Pay Costs +$99,000 – to cover federal Commissioned Officer pay costs.

Program Increase +$1,115,000 to fund: (a) continuing investments to maintain improvements and reforms made to-date and to continue enhancements in the IHS' capacity for providing comprehensive oversight and accountability in key administrative areas such as: Human resources, property, financial management, performance management and CHS program improvements developed through CHS consultation recommendations on improving business practices related to CHS and third party reimbursements; (b) addressing recent Congressional oversight and reports issued by the General Accountability Office and the Office of Inspector General to make improvements in management of IHS programs, such as the CHS program (c) addressing unfunded mandates for national initiatives associated with privacy requirements, facilities, and personnel security; and (d) improving responsiveness to external authorities such as Congress, GAO, OIG on questions related to oversight recommendations and the implementation and continuing accountability for new permanent authorities of the reauthorization of the IHCIA. The IHS has placed a high priority on the issues raised in the Senate Committee on Indian Affairs (SCIA) investigation of the IHS Aberdeen Area, and, in addition to implementing a corrective action plan to address findings in the Aberdeen Area, IHS has established a schedule to conduct comprehensive reviews of all IHS Areas to ensure that the findings of the investigation are not happening in other Areas. In FY 2011, the Agency investigated four other IHS Areas and conducted a follow-up review in another Area that had previously undergone a management review prior to the SCIA investigation.

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

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request
Headquarters (56.5%)	$38,749,395	$41,483,945	$41,169,855
Title I Contracts (non-add)	*2,057,951*	*2,150,072*	*2,183,530*
Title V Compacts (non-add)	*5,809,357*	*6,069,403*	*6,163,850*
Area Offices (12) (43.5%)	29,833,605	31,169,055	31,697,145
Title I Contracts (non-add)	*873,502*	*912,603*	*926,804*
Title V Compacts (non-add)	*8,878,819*	*9,276,264*	*9,420,613*
BA	**$68,583,000**	**$71,653,000**	**$72,867,000**

AREA ALLOCATION – Direct Operations

Discretionary SERVICES	**FY 2011 Enacted**	**FY 2012 Enacted**	**FY 2013 Request**	**FY 2013 +/- FY 2012**
Aberdeen	$2,560,575	$2,675,195	$2,720,520	$45,325
Alaska	4,938,925	5,160,007	5,247,432	87,425
Albuquerque	1,368,020	1,429,257	1,453,473	24,216
Bemidji	1,467,578	1,533,272	1,559,249	25,978
Billings	2,345,172	2,450,150	2,491,662	41,512
California	1,548,987	1,618,325	1,645,744	27,419
Nashville	1,785,368	1,865,287	1,896,890	31,603
Navajo	3,215,990	3,359,948	3,416,875	56,927
Oklahoma	3,749,192	3,917,018	3,983,383	66,365
Phoenix	3,205,598	3,349,091	3,405,834	56,743
Portland	2,701,895	2,822,841	2,870,667	47,827
Tucson	713,359	745,291	757,919	12,627
Headquarters	38,982,341	40,727,318	41,417,352	690,033
Total, Direct Ops	**$68,583,000**	**$71,653,000**	**$72,867,000**	**+$1,214,000**

Note: FY 2011 amounts reflect actual data. FY 2012 and FY 2013 are estimates.

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

(Dollars in Thousands)

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request	FY 2013 +/- FY 2012
BA	$6,054	$6,044	$6,044	$0
FTE*	12	12	12	0

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

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

FY 2013 Authorization.....Permanent

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

In FY 1992, the IHS was instructed by Congress to initiate planning activities with Tribal governments with approved Department of Interior self-governance compacts for the development of a Self-Governance Demonstration Project (SGDP) as authorized by P.L. 100-472, the Indian Self-Determination Act Amendments of 1988. The Indian Health Care Amendments of 1992, P.L. 102-573, extended authority to fund the Tribal SGDP in IHS and established the Office of Tribal Self-Governance (OTSG). Through enactment of P.L. 106-260, the Tribal Self-Government Amendments of 2000, permanent authority for the Tribal Self-Governance Program was given to the IHS under Title V, Tribal Self-Governance, 25 U.S.C. §§ 458aaa-458aaa18. The Final Rule implementing Title V was promulgated on May 17, 2002, 42 C.F.R. § 137.

The OTSG is responsible for a wide range of agency functions that are critical to the IHS' relationship with American Indian and Alaska Native nations, Tribal organizations and other American Indian/Alaska Native 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; renews and strengthens our partnership with Tribes; in the context of national health reform, brings reform to IHS; improves the quality of and access to care for American Indian and Alaska Native individuals; and is accountable, transparent, fair, and inclusive.

Since 1993, the IHS, in cooperation with Tribal representatives, developed formula methodologies for identification of Tribal shares for all Indian Tribes. Tribal shares are those program and administrative funds that Tribes are eligible to assume through self-determination contracts and self-governance compacts[1]. As of September 2011, the IHS negotiated a total of 82 self-governance compacts and 107 funding agreements with Indian Tribal governments and Tribal organizations. In FY 2013, approximately $1.5 billion, or one-third, of the total IHS

[1] The Self-Governance budget line only accounts for Title V ISDEAA compacts and funding agreements.

budget appropriation, will be transferred to Tribes to support 90 ISDEAA Title V compacts and 115 funding agreements[2].

The Self-Governance budget supports activities, including but not limited to, nation-to-nation negotiations of Self-Governance compacts and funding agreements; oversight of the IHS Director's Agency Lead Negotiators (ALN); technical assistance on Tribal consultation activities; analysis of Indian Health Care Improvement Act new authorities; and, funding to support the activities of the IHS Director's Tribal Self-Governance Advisory Committee (TSGAC).

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

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

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

- Oversees the negotiations of Tribal Self-Governance compacts and funding agreements with participating Tribes;
- Negotiates new authorities available to Tribes under the Indian Health Care Improvement Act;

[2] Tribes who exercise Self-Governance authority under Title V of the ISDEAA must meet statutory requirements, including (a) successfully completes the planning phase; (b) has requested participation in self-governance by resolution or other official action by the governing body of each Indian tribe to be served; and (c) has demonstrated, for 3 fiscal years, financial stability and financial management capability (25 U.S.C. 458aaa–2; 42 C.F.R. Part 137, Subpart C).

For FY 2013, the IHS estimates an additional 8 Tribes entering into Title V ISDEAA compacts and funding agreements. The IHS offers Self-Governance Planning and Negotiation Cooperative Agreements where the criteria for funding mirror the statutory eligibility requirements. Approximately, 8 negotiation cooperative agreements are available each fiscal year. For this pool, an average estimate of $5 million per Tribe is used to project estimates for Tribes entering into a Title V ISDEAA compact and funding agreement.

- Provides support of projects that improve tribally-operated health programs GPRA reporting and facility accreditation.

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

- Provides support of projects that assist Tribally-operated health programs to enhance information technology infrastructure to prepare for Meaningful Use and other federal Agency reporting standards;
- Provides support for negotiation for Title V construction project agreements to assist Tribes to expand and to modernize health care facilities;
- Collaborates in 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 makes all work transparent, fair and inclusive:

- Maintains, troubleshoots, and updates a Title V database containing amendments and payments to Tribes that provides 24/7 access to IHS staff and Tribes. This database also meets all Federal Funding Accountability and Transparency Act requirements and reports all Title V compact and funding agreement amounts to the HHS Tracking Accountability in Government Grants System;
- Coordinates and reports Agency Tribal Consultation activities with Tribes, HHS, and other federal agencies in accordance with law, executive orders and policy;
- Publishes and disseminates Self-Governance information nationally to Tribes and Tribal organizations

FUNDING HISTORY

Fiscal Year	Amount
2008 Enacted	$5,836,000
2009 Omnibus	$6,004,000
2010 Enacted	$6,066,000
2011 Enacted	$6,054,000
2012 Enacted	$6,044,000

BUDGET REQUEST

The FY 2013 budget request for Self-Governance of $6,044,000 is the same as the FY 2012 enacted level of $6,044,000. Funding will be used to continue current activities.

Outputs and Outcomes

Measure	Year and Most Recent Result/ Target for Recent Result/ (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 Target +/- FY 2012 Target
TOHP-1: Percentage of TOHP clinical user population included in GPRA data.	FY 2011: 70.3% Target: 72% (Target Not Met)	70.3%	70.3%	0
TOHP-E: Tribally Operated Health Programs: Hospital admissions per 100,000 diabetics per year for long-term complications of diabetes.	FY 2010: 93.3 FY 2010 Target: 135.7 (Target Exceeded)	Discontinued in FY 2012. Replaced with IHS-All hospital rate	N/A	N/A
TOHP-SP: Implement recommendations from Tribes annually to improve the Tribal consultation process.	FY 2011: 7 Target: 3 (Target Exceeded)	3	3	0

AREA ALLOCATION – Self Governance

Discretionary SERVICES	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request	FY 2013 +/- FY 2012
Headquarters	6,054,000	6,044,000	6,044,000	0
Total, SELF-GOV	**$6,054,000**	**$6,044,000**	**$6,044,000**	**+$0**

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

CONTRACT SUPPORT COSTS

(Dollars in Thousands)

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request	FY 2013 +/- FY 2012
BA	$397,693	$471,437	$476,446	$5,009
FTE*	0	0	0	0

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

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

FY 2013 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 added to the program amount. CSC are defined as reasonable costs for activities that T/TO must carry out but that the Secretary either did not carry out in her direct operation of the program or provided from resources other than those under contract. In Fiscal Year (FY) 2011, approximately $2.3 billion of the IHS appropriations is contracted through the ISDEAA by T/TO.

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)

The IHS CSC policy was established in 1992 and amended in 2007 to provide guidance in the administration of CSC, and was developed through extensive consultation and participation of Tribes. The IHS continuously reviews the soundness of its CSC allocation policy to assure that CSC provided to T/TO is in accordance with the IHS CSC Policy and does not duplicate other funding provided by IHS. The CSC Policy was revised in 2007 and established as a permanent Chapter within the IHS Manual (Part 6, Chapter 3, TN-2007-05).

The 2007 policy contained a significant revision of the allocation methodology associated with new and expanded awards. Additional guidance was also issued for new or expanded contracts or compacts entered into since FY 2007 (in response to the March 2005 Supreme Court decision in

Cherokee Nation v. Leavitt[1]). This guidance requires IHS to inform Tribes of the limited availability of CSC funds and the Appropriations "cap" on CSC funding. If there is no agreement on the part of the Tribe, then the new or expanded program request may be declined (in whole or in part), consistent with *Southern Ute Indian Tribe v. Leavitt*[2].

The ongoing review of CSC policy is consistent with the IHS Priorities 3 and 4: To improve the quality of and access to care and to make all our work accountable, transparent, fair and inclusive. In FY 2011, IHS made significant improvements to the IHS business practices associated with the CSC policy and the improvements include:

- Improved business practices to ensure a fair, transparent and consistent application of the CSC policy, its guidance and its stated procedures;
- Improved internal Agency understanding of the CSC Policy principles and its application;
- Utilization of key Area Office and Headquarters staff for Tribal data verification, funds certification and allocations; and,
- Completion of the 2010 and 2011 CSC Funding Needs Reports, and currently on track for timely submission of the FY 2012 CSC Funding Needs Report.

IHS initiated a consultation with Tribes in November, 2011 to evaluate the 2007 CSC Policy. In 2007, the IHS Director implemented the policy with a plan for it to be evaluated after three years. A CSC Tribal advisory group will review the policy and make recommendations to the IHS Director for any updates or changes. The first meeting of the CSC Tribal advisory group is in January, 2012.

FUNDING HISTORY

Fiscal Year	Amount
2008 Enacted	$267,398,000
2009 Omnibus	$282,398,000
2010 Enacted	$398,490,000
2011 Enacted	$397,693,000
2012 Enacted	$471,437,000

BUDGET REQUEST

The FY 2013 budget request for CSC of $476,446,000 is an increase of $5,009,000 over the FY 2012 enacted level of $471,437,000.

The CSC base funding will be distributed according to the CSC policy as a regular Pool 2 distribution. The CSC funding increase of $5,009,000 will be distributed according to the CSC policy as Pool 3 funds to address existing CSC shortfalls associated with ongoing contracts and compacts. The IHS Manual, Part 6, Chapter 3, specifies that fifty percent of the CSC increase

[1] In ***Cherokee Nation of Oklahoma et. al. v. Leavitt, Secretary of Health and Human Services, et. al.***, the Supreme Court ruled that the IHS had received an unrestricted appropriation sufficient to provide plaintiff Tribes full funding of the contract support cost funding promised in their ISDEAA contracts with the Federal Government in fiscal years 1995, 1996, and 1997.

[2] In ***Southern Ute Indian Tribe v. Leavitt***, the District Court for the District of New Mexico ruled that, if IHS awards a contract when no CSC funding is available from the capped appropriation for CSC, the annual funding agreement requires the parties to identify the terms of payment and $0 is properly identified as the amount for CSC.

will be allocated to those Tribes with the greatest unfunded CSC level of need in such a way as to raise the minimum CSC level of need funded to the highest possible level – a bottom up approach. The remaining 50 percent of the FY 2013 increase will be allocated to all Tribes who have a CSC shortfall, in proportion to their overall share of CSC.

The requested FY 2013 program increase of $5,009,000 will be applied to the CSC shortfall associated with ongoing contracts and compacts. However, if other program increases are approved in the FY 2013 budget, they may generate additional CSC need that will be included in the FY 2014 CSC Needs Report that will summarize the total CSC deficiency as of the end of FY 2013.

Outcomes and Outputs

Measure	Year and Most Recent Result/ Target for Recent Result/ (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 Target +/- FY 2012 Target
Total annual CSC need	FY 2008: $418,112,917	Pending	Pending	--

AREA ALLOCATION – Contact Support Costs

Discretionary SERVICES	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request	FY 2013 +/- FY 2012
Aberdeen	$13,275,020	$15,736,600	$15,903,801	$167,201
Alaska	128,368,756	152,172,106	153,788,928	1,616,823
Albuquerque	11,972,862	14,192,983	14,343,783	150,800
Bemidji	24,439,224	28,970,976	29,278,792	307,816
Billings	10,029,427	11,889,178	12,015,500	126,322
California	38,208,925	45,293,985	45,775,232	481,247
Nashville	17,332,930	20,546,966	20,765,277	218,311
Navajo	30,562,423	36,229,597	36,614,535	384,938
Oklahoma	63,018,307	74,703,758	75,497,482	793,725
Phoenix	17,981,042	21,315,257	21,541,731	226,474
Portland	40,411,593	47,905,093	48,414,083	508,990
Tucson	2,092,491	2,480,500	2,506,856	26,355
Headquarters	0	0	0	0
Total, CSC	**$397,693,000**	**$471,437,000**	**$476,446,000**	**+$5,009,000**

Note: FY 2011 amounts reflect actual data. FY 2012 and FY 2013 are estimates.

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

PUBLIC AND PRIVATE COLLECTIONS

(Dollars in Thousands)

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request	FY 2013 +/- FY 2012
Medicare:				
Federal	$132,711,000	$134,618,000	$134,618,000	0
Tribal [1]	6,986,000	6,986,000	6,986,000	0
Tribal [2]	57,244,000	57,244,000	57,244,000	0
Subtotal:	196,941,000	198,848,000	198,848,000	0
Medicaid:				
Federal	490,359,000	495,443,000	495,443,000	0
Tribal [1]	22,217,000	22,217,000	22,217,000	0
Tribal [2]	124,203,000	124,203,000	124,203,000	0
Subtotal:	636,779,000	641,836,000	641,836,000	0
Medicare/Medicaid Total:	833,720,000	840,711,000	840,711,000	0
Private Insurance	81,006,000	81,006,000	81,006,000	0
TOTAL:	**$914,726,000**	**$921,717,000**	**$921,717,000**	**0**
FTE*	6,462	6,462	6,462	0

[1] Represents CMS Tribal collection estimates.

[2] Represents estimates of Tribal collections due to direct billing that began in FY 2002.

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

Authorizing Legislation .....Economy Act of 31 U.S.C. 686 Section 301, P.L. 94-437, and Title IV of Indian Health Care Improvement Act.

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

Public and private collections are a significant part of the IHS and Tribal budgets, and provide increased access to quality health care services for American Indian and Alaska Natives (AI/AN). The IHS, in furtherance of the provisions authorized by the Indian Health Care Improvement Care Act, as amended, places the highest priority on meeting all accreditation standards for its healthcare facilities. The use of the Medicare and Medicaid (M&M) reimbursements will continue to be used to support and maintain facility accreditation and improve the delivery and access to health care for AI/AN people.

IHS has had legislative authority to bill M&M since 1976. The collection of third party revenue is essential to maintaining facility accreditation and standards of health care through the Joint Commission on Accreditation of Healthcare Organizations or the Accreditation Association for Ambulatory Health Care. Collections are also used to maintain the certification required by the Centers for Medicare and Medicaid Services (CMS) for participation in the Medicare and Medicaid programs.

A most recent accomplishment has been the development and implementation of a data system that IHS is currently using to identify deficiencies and monitor the third party collection process for IHS operated facilities. This “on line” data tool provides necessary information for local managers and Headquarters staff to monitor compliance with applicable policies and procedures so they can take necessary corrective actions and improve overall program activity.

Area Directors and Service Unit Chief Executive Officers now have access to improved data reports that assist them with managing and making program improvements for IHS operated facilities.

Medicare/Medicaid -- The FY 2011 and FY 2012 estimates are based primarily on the CY 2010 actual Collections and the estimated impacts of the CY 2010 and approved CY 2011 rate changes by CMS. The 2012 rates are in the process of being updated and the specific impact on collections is not known yet. In addition, estimates reflect increased Tribal assumption of major health care programs that will impact federal collections. All rate changes are calculated utilizing the IHS cost reports submitted to CMS. Accurate and complete cost reports will continue to be a priority since they provide valuable information in setting the Agency's future Medicare and Medicaid rates.

Estimates for FY 2011 Medicare program collections are expected to increase over FY 2010 levels by approximately $2,286,000 directly related to the CY 2010 rate increase. For FY 2012, the IHS estimates a Medicare increase of $1,907,000 related to the full impact of the CY 2011 rate increase.

For the Medicaid program, IHS estimates FY 2011 collections to increase over the FY 2010 level by $14,456,000 due to the CY 2010 rate increase. For FY 2012, IHS estimates a Medicaid increase of $5,084,000 rated to the full impact of the CY2011 rate increases.

During FY 2011 and FY 2012, IHS will continue to place a priority on development of a third party interface with the Unified Financial Management System and to develop and enhance systems and processes to meet new legislative requirements for IHS operated facilities. The program will also work on initiatives such as the electronic health record and implementing ICD-10 codes. The IHS will continue to strengthen its business office policies and management practices, including internal controls, patient benefits coordination, provider documentation training, certified procedural coding training and electronic claims processing. Priority efforts include the continued development of modifications to third party billing and accounts receivable software to improve effectiveness and to ensure system integration with its business processes and compliance with M&M regulations. These improvements for IHS operated facilities will be coordinated with concurrent improvements in Contract Health Services business practices related to alternative 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 electronic health records by providers and facilities will have a direct impact on increased collections over the next few years and have been considered by workgroups to maximize impact for all IHS Federal, Tribal and Urban Indian health care facilities.

IHS will continue to work with the CMS and the State Medicaid agencies to identify patients who are eligible to enroll in M&M and CHIP programs and in the implementation of provisions in ARRA, CHIPRA, ACA and the IHCIA. IHS works with the 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. The IHS has partnered with CMS to provide a number of training sessions for both Tribal and IHS employees, focusing on outreach and accessing Medicare and Medicaid programs. Also, IHS continues to train staff in the areas of accounts receivable, UFMS, coding and monitoring program activities.

Private Insurance Collection -- The FY 2011, FY 2012 and FY 2013 private insurance estimates assume the continuation of the FY 2010 level. During FY 2012 and FY 2013, IHS will continue to work to enhance each IHS operated facility's capability to identify patients who have private insurance coverage, improve claims processing, including a more robust program to monitor and follow up on outstanding bills. This initiative will maintain current collections efforts notwithstanding various reports that the downturn in the economy has affected private insurance coverage for AI/ANs. The local Service Units utilize the funds collected to improve services such as the purchase of medical supplies and equipment and to improve local Service Unit business management practices. The IHS continues to make use of private contractors to pursue collections on outstanding claims from private payers.

The following table shows how Medicare, Medicaid and private insurance collections are used.

Type of Obligation	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request
Personnel Benefits & Compensation	$387,037,000	$387,569,000	$393,599,000
Travel & Transportation	6,627,000	6,744,000	6,632,000
Non-Patient Transportation	4,283,000	4,363,000	4,288,000
Comm./Util./Rent	23,076,000	23,562,000	23,117,000
Printing & Reproduction	233,000	239,000	234,000
Other Contractual Services	112,776,000	115,078,000	112,914,000
Supplies	126,708,000	129,261,000	126,833,000
Equipment	15,329,000	15,619,000	15,361,000
Land & Structures	6,795,000	6,916,000	6,807,000
Grants	21,031,000	21,533,000	21,100,000
Insurance / Indemnities	176,000	178,000	177,000
Interest/Dividends	5,000	5,000	5,000
Subtotal	$704,076,000	$711,067,000	$711,067,000
Tribal Collections (est)	$210,650,000	$210,650,000	$210,650,000
Total Collections	**$914,726,000**	**$921,717,000**	**$921,717,000**

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

SPECIAL DIABETES PROGRAM FOR INDIANS

(Dollars in Thousands)

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request	FY 2013 +/- FY 2012
BA	$150,000	$150,000	$150,000	+$0
FTE*	0	0	0	0

*The Special Diabetes Program for Indians funds are not used to support FTEs.

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, and the H.R. 4994 Medicare and Medicaid Extenders Act of 2010 to extend SDPI funding through FY 2013. The program authorization is set to expire in FY 2013.

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The SDPI grant program provides funding for diabetes treatment and prevention through 404 Indian Health Service, Tribal and Urban (I/T/U) Indian health grant programs. Now in its 14th year, the SDPI operates with a budget of $150 million per year (through FY 2013). 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 IHS DDTP is to develop, document, and sustain a public health effort to prevent and control diabetes in American Indians and Alaska Natives (AI/ANs). This mission is accomplished by promoting collaborative strategies for the prevention of diabetes and its complications to AI/ANs through its extensive diabetes network. The diabetes network consists of a national program office, Area Diabetes Consultants in each of the 12 IHS Areas, 19 Model Diabetes programs in 23 different IHS and Tribal sites, and 336 local SDPI Community-directed grants and sub-grants, and 68 Diabetes Prevention (DP) and Healthy Heart (HH) Initiatives in I/T/U sites.

This extensive diabetes network supports the SDPI grant programs by providing comprehensive diabetes surveillance, research translation, promotion of quality assurance and improvement activities, technical support, resource and best practices information, and develops and distributes American Indian specific diabetes education materials and training. The IHS combines both clinical and public health approaches to address the problem of diabetes and its complications.

Target Audience: American Indians and Alaska Natives
Diabetes and its complications are major contributors to death and disability in every Tribal community. AI/ANs have the highest age-adjusted rate of diagnosed diabetes (16.0%) among all racial and ethnic groups in the United States - roughly twice the rate of the general population

(7.7%). In some AI/AN communities more than half of adults aged 18 and older have diagnosed diabetes, with prevalence rates reaching as high as 60 per cent. Once found mainly in older adults, the disease increasingly affects AI/AN youth, threatening the health, well-being, and quality of life of future generations.

Diabetes is the fourth leading cause of death among AI/ANs, and the diabetes mortality rate among AI/ANs is 3 to 4 times that of non-AI/ANs. AI/ANs have the highest rate of premature deaths from heart disease of all races, with 35 percent of deaths from heart disease classified as premature; the rate is nearly 2.5 times that for whites. The complications of diabetes lead to much higher incidence rates of blindness, vascular insufficiency leading to amputation, and kidney failure leading to dialysis than in the general U.S. population. However, since 1999, the incidence of kidney failure leading to dialysis has declined 18 percent among the AI/AN population with diabetes over age 45 years (a 29 percent decrease was seen in those aged 45-64 years and a 13 percent decrease in those aged 65 years and older). This improvement was seen despite the continued rise in diabetes prevalence in the same time period and was attributed to the reduction in risk factors and improvements in diabetes care practices in Indian communities as shown by the yearly IHS Diabetes Care and Outcomes Audit.

Allocation Method
In the Balanced Budget Act of 1997, Congress instructed the IHS to use SDPI funds to "establish grants for the prevention and treatment of diabetes" to address the growing problem of diabetes in AI/ANs. The entities eligible to receive these grants included IHS programs, Tribes and Tribal organizations, and urban Indian organizations.

In accordance with legislative intent, the IHS distributed this funding to over 400 entities through a process that included Tribal consultation, development of a formula for distribution of funds, and a formal grant application and administrative process.

Strategy
The SDPI brought Tribes together to work toward a common purpose and share information and lessons learned. The Tribal Leaders Diabetes Committee (TLDC) established in 1998, reviews information on the SDPI progress and provides recommendations on diabetes-related issues to the IHS Director. Through collaborations and partnerships with federal agencies, private organizations and an extensive I/T/U network, DDTP undertook one of the most strategic diabetes treatment and prevention efforts and demonstrated the ability to design, manage, and measure a complex, long-term project to address this chronic condition.

Because of the significant costs associated with treating diabetes, the Tribes and urban Indian organizations have had to make choices about how to best use their local SDPI funding to address the primary, secondary and tertiary prevention of diabetes in AI/AN communities. A study published by the American Diabetes Association in 2007 on the economic burden of diabetes in the U.S. estimated that it costs $11,744 per year to care for one person with diabetes compared with $5,095 per year for persons without diabetes. A recent IHS analysis, supported by the SDPI, demonstrated that in the Indian health system it costs $7,003 per year to care for an AI/AN person with diabetes compared with $2,205 for an AI/AN person without diabetes, a three-fold difference. Among AI/ANs with diabetes, those who also have cardiovascular disease (CVD) cost $12,693 per year, a two-fold increase.

SDPI: Three Major Components
As directed by Congress and Tribal consultation, the SDPI consists of three major components: 1) Community-directed programs, 2) Diabetes and Cardiovascular Disease Prevention

Demonstration Projects that have now transitioned to the Diabetes Prevention and Healthy Heart (DP/HH) Initiatives, and 3) Diabetes Data and program delivery infrastructure.

1) Community-directed Programs

The Community-directed component provides over $116 million per year in grants and sub-grants for local diabetes treatment and prevention services at 363 I/T/U health programs in 34 states. Each of the communities served by the Community-directed programs is unique in that its diabetes treatment and prevention needs and priorities are defined locally. They use these priorities to design and implement interventions that best address the problem of diabetes in local communities across the lifespan.

The Consolidated Appropriations Act of 2001 established statutory authority for SDPI to implement a best practices approach to diabetes treatment and prevention. The SDPI has incorporated these Indian Health Diabetes Best Practices into the Community-directed grant application process use throughout AI/AN communities. Grant programs are required to document the use of at least one Diabetes Best Practice, corresponding evaluation measures, and progress in achieving program objectives in order to enhance accountability.

Each of the current 20 Indian Health Diabetes Best Practices provides: 1) guidelines, 2) key recommendations, 3) direction for how to monitor progress and outcomes, including key measures, 4) specific recommendations for clinical settings, communities, and organizations, 5) instructions on how to evaluate and sustain a program, 6) additional tools, including web-based resources, exemplary programs, and program experts to contact for assistance, and 7) specific suggestions for improving programs and overall accountability in the Indian health system.

In September 2010 IHS implemented a new competitive grant application process for the Community-directed grants. A total of 363 grant and sub-grants were awarded. The Community-directed programs continue capacity building efforts to provide quality diabetes prevention and care services guided by the Diabetes Best Practices.

Impact of the Community-directed Programs

These programs have employed successful, proven strategies to address key areas of diabetes treatment and prevention, based on IHS Standards of Care and the Indian Health Diabetes Best Practices, including activities and services in the following areas:

- *Providing quality care for people with diabetes*
    - 64% more grant programs have diabetes teams (94% in 2010 compared with only 30% in 1997);
- *Reducing the risk for diabetes in youth and adults*
    - 68% more grant programs have type 2 diabetes prevention programs for youth (74% in 2010 compared with only 6% in 1997);
- *Nutrition*
    - 50% more grant programs offer nutrition services for adults (89% in 2010 compared with only 39% in 1997);
- *Physical activity*
    - 71% more grant programs offer community walking and running programs (91% in 2010 compared with only 20% in 1997);
- *Weight management*
    - 57% more grant programs offer adult weight management programs (76% in 2010 compared with only 19% in 1997);
- *Behavior change*

- 70% more grant programs offer organized diabetes education activities (95% in 2010 compared with only 25% in 1997).

Key clinical outcome measures have improved among AI/AN people with diabetes each year since the SDPI was created. These improvements not only enhance the quality of life of people with diabetes, but also help the Indian health system realize cost savings. Highlighted below are important improvements in clinical outcomes (based on the IHS Diabetes Audit) since the inception of the SDPI Community-directed programs.

- *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 11% from 9.00% in 1996 to 8.00% in 2011, nearing the A1C goal for most patients of less than 7%.

- *Improving Blood Lipid Levels*
  Average total cholesterol in IHS patients with diabetes decreased 16% from 204 mg/dL in 1997 to 171.94 mg/dL in 2011. Average LDL cholesterol (i.e., "bad" cholesterol) declined 20% from 118 mg/dL in 1998 to 94.21 mg/dL in 2011, surpassing the goal of less than 100 mg/dL

- *Improving Kidney Function*
  The prevalence of proteinuria (the presence of protein in the urine, which is a sign of kidney dysfunction) decreased 10%, from 25% in 1997 to about 15% in 2007. At the same time, use of ACE inhibitors to slow the progression of diabetes-related kidney disease increased 31% from 42% in 1997 to 73% in 2008in patients served by IHS.

2) Diabetes Prevention and Healthy Heart Demonstration Projects

In the 2002 reauthorization of the SDPI, Congress directed the IHS to use additional funding to plan a new competitive grant program to address diabetes prevention and cardiovascular risk reduction. A significant increase in Congressional funding for SDPI beginning in 2004 enabled the IHS to translate research-based diabetes prevention and cardiovascular risk reduction strategies into AI/AN communities. Sixty-six Demonstration Projects were funded to focus on primary prevention of type 2 diabetes in those adults at risk for developing diabetes (36 programs) and reduction of cardiovascular risk in adults diagnosed with type 2 diabetes (30 programs) to I/T/U health programs for six years.

Diabetes Prevention (DP) Demonstration Program
The goal of the Diabetes Prevention Program was to translate the NIH Diabetes Prevention Program (DPP) study's 16-session lifestyle intervention curriculum in a diverse set of AI/AN communities. Specific objectives included: 1) prevent onset of diabetes through modest weight loss in people with pre-diabetes, and 2) achieve changes in clinical and behavioral characteristics of participants that support diabetes risk reduction. Programs developed culturally appropriate adaptations and strategies to promote recruitement, retention and successful patient outcomes.

The DP Demonstration Program successfully achieved its objective of translating the NIH DPP in AI/AN community settings. The DP participants who completed the follow-up assessment had a significantly reduced 8-year risk of developing diabetes. These results were similar to the results that were achieved by the NIH DPP lifestyle intervention group study participants, which is a much higher rate of success compared to other translational projects. In addition, the DP participants achieved significant weight loss, lower blood sugar levels, improved consumption of

healthy foods, increased physical activity, improved blood pressure and blood lipid levels, and improved health-related quality of life following participation in the program.

Healthy Heart (HH) Demonstration Project

The HH Demonstration Project was created to demonstrate reduction of cardiovascular disease factors in adults with diabetes by implementing intensive, clinic-based case management interventions in AI/AN health programs using current standards of care. Specific objectives included: 1) controlling the key cardiovascular risk factors – blood sugar, blood pressure, and blood lipids, and 2) achieving changes in weight, body mass index (BMI), waist circumferences, and heart health-related behaviors such as aspirin use, smoking cessation, healthy eating, and physical activity.

The HH Project achieved its objective of applying intensive case management and patient education to reduce cardiovascular disease risk factors among AI/ANs with diabetes. Participants who completed the follow-up assessment had significantly reduced their 10-year risk of developing coronary heart disease. They achieved significant improvements in meeting goals for control of blood pressure, blood glucose, improved lipid profiles, weight, BMI, and waist circumference. The HH Project has led to significant reductions in diabetes-related complications, reductions in the costs of care, and improved quality of life for people with diabetes.

Transition to DP/HH Initiatives

In September 2010, as a result of a new competitive grant application process, the IHS awarded 68 cooperative agreements to previous and new sites to continue to implement the Diabetes Prevention and Healthy Heart Initiatives to begin the work of implementing successful activities from the Demonstration Projects and of disseminating the best practices, lessons learned, and share resources developed from the experience of the Demonstration Projects during their 6-year project period. The DP/HH Initiative recipients will continue to evaluate their progress and will receive technical assistance as they implement program activities.

3) Diabetes Data and Program Delivery Infrastructure

The IHS has used administrative funding from the SDPI to strengthen the diabetes data infrastructure of the Indian health system by improving diabetes surveillance and evaluation capabilities. SDPI supports the IHS Diabetes Data infrastructure in the development and implementation of the IHS Electronic Health Record, and the IHS Diabetes Management System (a software program that is part of the RPMS system) in all 12 IHS Areas. As a result, the Indian health system is better able to identify and track AI/ANs with diabetes and improve clinical care and services. The improvements in diabetes surveillance will allow for the measurement of the long-term outcomes of age-specific prevalence of diabetes and of CVD in people with diagnosed diabetes. These improvements facilitate program management and accountability. Technical assistance, provider networks, clinical monitoring, and grant evaluation activities at the Headquarters and Area office levels have also been strengthened.

Facilities associated with SDPI programs participate in the annual IHS Diabetes Care and Outcomes Audit. The Diabetes Audit is the cornerstone of the IHS DDTP diabetes care surveillance system, tracking annual performance on 59 diabetes care and health outcome measures that are based on the IHS Standards of Care for People with Diabetes. Data collection for the Diabetes Audit follows a standardized protocol to ensure statistical integrity and comparability of measures over time. In 2008, submission of data by participating facilities was substantially improved by the creation of the Web Audit, a set of internet-based tools for data entry, review and analysis of the data. This process utilizes modern technology and enhances

both DDTP as well as SDPI grant program's ability to monitor trends and gather important data on diabetes care outcomes. The 2011 Diabetes Audit included a review of 92,949 patient charts, a sample representing care to 141,884 patients with diabetes, at 335 I/T/U health facilities. More data were collected in the 2011 audit year than ever before. This enables IHS and the SDPI programs to monitor and evaluate yearly performance at the local, regional, and national levels.

Diabetes clinical practice has become more complex including an increasing number of guidelines issued by national organizations. The IHS DDTP has developed a variety of clinical tools and resources to assist Indian health clinicians in caring for an increasing number of medically complex patients. The DDTP has sought to review and compile this information and provide it in easily accessed, online web-based formats. The DDTP "Diabetes LEARN" (Linked Education and Resource Network) is a virtual repository of diabetes information addressing training and resource needs of a multigenerational workforce in diverse settings who often work in geographically isolated settings and/or have limited time and budgets. Diabetes LEARN is a cost-efficient model to provide training and evidence-based, peer reviewed information that is frequently updated and tailored to meet the audiences' needs.

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. The evaluation of SDPI and diabetes clinical measures suggests that population-level diabetes-related health is better among AI/AN patients since the implementation of SDPI. SDPI outcome measures have demonstrated improvement in FY 2011. Modifications to program activities, including increased accountability and evaluation, will be implemented in FY 2011-2013 and will contribute to improved performance outcome measures in subsequent years. Continual efforts to improve blood glucose, blood pressure and cholesterol values will further reduce microvascular as well as macrovascular complications.

FY 2011 Outcomes: Diabetes

1.	Poor Glycemic Control:	Proportion of patients with diagnosed diabetes that have poor glycemic control (A1C>9.5).	Target exceeded for 2011; will be discontinued for 2013
2.	Ideal Glycemic Control:	Proportion of patients with diagnosed diabetes with ideal glycemic control (A1C<7.0).	Target exceeded
3.	Blood Pressure Control:	Proportion of patients with diagnosed diabetes that have achieved blood pressure control (<130/80).	Target exceeded.
4.	Dyslipidemia Assessment	Proportion of patients with diagnosed diabetes assessed for Dyslipidemia (LDL cholesterol).	Target exceeded

The implementation of the SDPI program has been a complex process that has demonstrated success in improving quality diabetes care. Significant challenges remain, such as: significant numbers of vacancies for professional health care positions in rural areas, inadequate space to set-up programs and conduct program activities, decreased access to clinical services in rural areas, and additional needs for training and technical assistance. In addition, secular trends in diabetes and obesity prevalence, as well as difficult to change risk factors in families and communities, continue to pose challenges.

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

- January 2000 Interim Report to Congress on SDPI
- December 2004 Interim Report to Congress on SDPI
- 2007 SDPI Report to Congress: On the Path To A Healthier Future
- The 2011 SDPI Report to Congress is currently under Agency review.

FUNDING HISTORY

Fiscal Year	Amount
2008 Enacted	$150,000,000
2009 Omnibus	$150,000,000
2010 Enacted	$150,000,000
2011 Enacted	$150,000,000
2012 Enacted	$150,000,000

BUDGET

The FY 2013 budget for Special Diabetes Program for Indians is $150,000,000, consistent with the recent extension (H.R. 4994) through FY 2013. The distribution of funding has remained the same since 2004 after Tribal consultation and is illustrated below:

Special Diabetes Program for Indians – Total Yearly Costs 2004-2011

CATEGORY	Percentage of the total	(Dollars in Millions)
Original Diabetes Grants – now called Community-directed Diabetes Programs (363 Tribal and IHS grants and sub-grants in FY 2010)	69.9%	$104.8
Administration of Community-directed SDPI grants (Includes administrative funds to IHS Areas, Tribal Leaders Diabetes Committee, Div of Diabetes, Grants Operations, evaluation support contracts, etc.)	2.7%	4.1
Urban Indian Health Program community-directed diabetes programs (34 grants) ($7.4M allocated to 34 grants; remaining amount redistributed within existing grants)	5 %	7.5
Diabetes Prevention & Healthy Heart Initiatives (68 grants)	15.5%	23.2
Administration of Demonstration Project Diabetes Grants (Includes administrative funds 1) to support the DP/HH Initiatives coordinating center; 2) to support the limited dissemination activities; 3) to HQ; 4) to support contracts, etc.)	2.8%	4.1
Funds to strengthen the Data Infrastructure of IHS	3.4%	5.2
Native Diabetes Wellness Center (CDC)	0.7%	1.0
TOTAL:	**100%**	**$150.0**

The following tables show the accomplishments in terms of outputs and outcomes as well as the estimated change in performance. Most measures showed improvement in FY 2011. Modifications to program activities, including increased accountability and evaluation, are being implemented in FY 2011-2013 which will contribute to improved performance on outcome measures in subsequent years.

Outputs and Outcomes

Measure	Year and Most Recent Result/ Target for Recent Result/ (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 Target +/- FY 2012 Target
Diabetes: A1c Measured[1]: Proportion of patients who have had an A1c test. IHS-All	FY 2011: 83.0% No target; collected for context	Discontinued in FY 2012	N/A	N/A
Tribally Operated Health Programs	FY 2011: 82.2% No target; collected for context	Discontinued in FY 2012	N/A	N/A
1: **Diabetes: Poor Glycemic Control**: Proportion of patients with diagnosed diabetes that have poor glycemic control (A1C > 9.5). IHS-All[2,3]	FY 2011: 19%/19.1% Target: 20%/19.4% (Target Exceeded)	18.6%	Discontinued in FY 2013	N/A
1: Tribally Operated Health Programs	FY 2011:15.2% Target: 16.2% (Target Exceeded)	14.8%	Discontinued in FY 2013	N/A
2: **Diabetes: Ideal Glycemic Control**: Proportion of patients with diagnosed diabetes with ideal glycemic control (A1c <7.0) IHS-All[3]	FY 2011: 37%/31.9% Target: 36%/30.2% (Target Exceeded)	32.7%	31.3%	-1.4%
2: Tribally Operated Health Programs	FY 2011: 35.0% Target: 33.1% (Target Exceeded)	35.8%	34.3%	-1.5%
3: **Diabetes: Blood Pressure Control**: Proportion of patients with diagnosed diabetes that have achieved blood pressure control (<130/80). IHS-All[3]	FY 2011: 39%/37.8% Target: 39%/35.9% (Target Exceeded)	38.7%	37.0%	-1.7%
3: Tribally Operated Health Programs	FY 2011: 35.7% Target: 35.0% (Target Exceeded)	36.6%	35.0%	-1.6%
4: **Diabetes: Dyslipidemia Assessment:** Proportion of patients with diagnosed diabetes assessed for Dyslipidemia (LDL cholesterol). IHS-All[3]	FY 2011: 77%/68.7% Target: 76/%/63.3% (Target Exceeded))	70.3%	67.3%	-3.0%
4: Tribally Operated Health Programs	FY 2011: 68.4% Target: 63.3% (Target Exceeded)	70.0%	67.0%	-3.0

[1]*There is no measure or goal; this information is provided for context.*
[2]*ForPoor Glycemic Control, a reduction in the rate represents improvement.*
[3]*First figure in results column is Diabetes audit data for which data is not currently available; second is from the Clinical Reporting System.*

FY 2013 Mandatory State/Formula Grants

CFDA No. 93.442 / Special Diabetes Program for Indians Community-Directed Grant Programs by State and FY 2011 Annual Financial Assistance Awards						
State	State Name	Total # Grant Programs	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request	Difference +/- 2012
AK	Alaska	25	$8,927,252	$8,927,252	$8,927,252	$0
AL	Alabama	1	201,191	201,191	201,191	$0
AZ	Arizona	32	25,964,591	25,964,591	25,964,591	$0
CA	California	41	8,698,479	8,698,479	8,698,479	$0
CO	Colorado	3	728,212	728,212	728,212	$0
CT	Connecticut	2	197,399	197,399	197,399	$0
FL	Florida	2	515,077	515,077	515,077	$0
IA	Iowa	1	254,197	254,197	254,197	$0
ID	Idaho	4	760,150	760,150	760,150	$0
IL	Illinois	1	226,282	226,282	226,282	$0
KS	Kansas	7	660,186	660,186	660,186	$0
LA	Louisiana	4	307,288	307,288	307,288	$0
MA	Massachusetts	2	68,142	68,142	68,142	$0
ME	Maine	5	445,865	445,865	445,865	$0
MI	Michigan	13	2,128,707	2,128,707	2,128,707	$0
MN	Minnesota	13	3,287,642	3,287,642	3,287,642	$0
MS	Mississippi	1	1,022,920	1,022,920	1,022,920	$0
MT	Montana	17	5,512,348	5,512,348	5,512,348	$0
NE	Nebraska	5	1,590,573	1,590,573	1,590,573	$0
NV	Nevada	15	3,260,719	3,260,719	3,260,719	$0
NM	New Mexico	31	6,938,491	6,938,491	6,938,491	$0
NY	New York	4	1,185,398	1,185,398	1,185,398	$0
NC	North Carolina	1	1,198,729	1,198,729	1,198,729	$0
ND	North Dakota	7	2,643,997	2,643,997	2,643,997	$0
OK	Oklahoma	33	17,592,178	17,592,178	17,592,178	$0
OR	Oregon	14	1,799,861	1,799,861	1,799,861	$0
RI	Rhode Island	1	98,109	98,109	98,109	$0
SC	South Carolina	1	137,023	137,023	137,023	$0
SD	South Dakota	14	5,439,117	5,439,117	5,439,117	$0
TN	Tennessee	2	79,915	79,915	79,915	$0
TX	Texas	4	584,689	584,689	589,689	$0
UT	Utah	7	1,449,293	1,449,293	1,449,293	$0
WA	Washington	34	3,892,836	3,892,836	3,892,836	$0
WI	Wisconsin	13	3,062,885	3,062,885	3,062,885	$0
WY	Wyoming	3	747,878	747,878	747,878	$0
Funds Pending Distribution*			**483,210**	**297,383**	**297,383**	**$0**

CFDA No. 93.442 / Special Diabetes Program for Indians Community-Directed Grant Programs by State and FY 2011 Annual Financial Assistance Awards						
State	State Name	Total # Grant Programs	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request	Difference +/- 2012
	TOTAL	**364***** (IHS, Tribal & Urban grants and sub-grantees)	**$111,607,619**	**$111,793,446**	**$111,793,446**	**$0**
	Indian Tribes	**286 primary grants and sub-grants**	**$91,713,631**			
	Total States	**#35 states**	**$111,607,619**			

*Funds pending distribution in FY 2011 due to disapproved applications or no application submitted for 10 sites.
**For FY 2011, 364 grants and sub-grants received financial assistance awards compared to 384 original SDPI grants in 1998.

CFDA No. 93.442 / Special Diabetes Program for Indians Diabetes Prevention (DP) and Healthy Heart (HH) Initiative Grants by State and FY 2011 Annual Financial Assistance Awards						
	State	Total # DP and HH Initiatives	Total FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request	Difference +/- 2012
AK	Alaska	5	$1,694,200	$1,694,200	$1,694,200	$0
AZ	Arizona	6	2,163,900	2,163,900	2,163,900	$0
CA	California	11	3,388,500	3,388,500	3,388,500	$0
ID	Idaho	1	324,300	324,300	324,300	$0
KS	Kansas	1	397,000	397,000	397,000	$0
MI	Michigan	2	648,600	648,600	648,600	$0
MN	Minnesota	4	1,297,200	1,297,200	1,297,200	$0
MS	Mississippi	1	397,000	397,000	397,000	$0
MT	Montana	2	648,600	648,600	648,600	$0
NC	North Carolina	1	324,300	324,300	324,300	$0
NE	Nebraska	2	648,600	648,600	648,600	$0
NM	New Mexico	5	1,766,900	1,766,900	1,766,900	$0
NY	New York	2	648,600	648,600	648,600	$0
OK	Oklahoma	8	2,957,900	2,957,900	2,957,900	$0
OR	Oregon	2	794,000	794,000	794,000	$0
SD	South Dakota	8	2,667,100	2,667,100	2,667,100	$0
UT	Utah	1	397,000	397,000	397,000	$0
WA	Washington	5	1,694,200	1,694,200	1,694,200	$0
WI	Wisconsin	1	324,300	324,300	324,300	$0
	Total	**68**	**$23,182,200**	**$23,182,200**	**$23,182,200**	**$0**
	Indian Tribes	**61 primary and sub-grant sites**				

CFDA No. 93.442 / Special Diabetes Program for Indians Diabetes Prevention (DP) and Healthy Heart (HH) Initiative Grants by State and FY 2011 Annual Financial Assistance Awards						
	State	Total # DP and HH Initiatives	Total FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request	Difference +/- 2012
	Total States	**#9 States**	**$23,182,200**			

Size of Awards

CFDA No. 93.443 / SDPI Community-directed Grant Programs			
(whole dollars)	FY 2011 Enacted	FY 2012 Enacted	FY2013 Request
Number of Awards	364 (includes sub-grants)	364 (includes sub-grants)	364 (includes sub-grants)
Average Award	$306,614	$306,614	$306,614
Range of Awards	$12,549 - $6,483,988	$12,549 - $6,483,988	$12,549 - $6,483,988

CFDA No. 93.443 / SDPI Diabetes Prevention / Healthy Heart Initiative Grants			
(whole dollars)	FY 2011 Enacted	FY 2012 Enacted	FY2013 Request
Number of Awards	68	68	68
Average Award	$324,300	$324,300	$324,300
Range of Awards	$137,500 – $397,000	$137,500 – $397,000	$137,500 – $397,000

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

FACILITIES

(Dollars in Thousands)

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Budget Request	FY 2013 +/- FY 2012
BA	$403,647	$440,346	$443,502	+$3,156
M&I	*$53,807*	*$53,721*	*$55,470*	*+$1,749*
Sanitation	*$95,665*	*$79,582*	*$79,582*	*+$0*
HCFC	*$39,156*	*$85,048*	*$81,489*	*-$3,559*
FEHS	*$192,701*	*$199,413*	*$204,379*	*+$4,966*
Equipment	*$22,618*	*$22,582*	*$22,582*	*+$0*
Quarters	$6,288	$7,500	$7,500	+$0
FTE*	1,165	1,175	1,185	+5

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

SUMMARY OF THE BUDGET REQUEST

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

BUDGET AUTHORITY

The FY 2013 budget submission for Facilities of $443,502,000 is an increase of $3,156,000 over the FY 2012 enacted level of $440,346,000. This budget request includes the following changes compared to FY 2012:

Maintenance & Improvement +$1,749,000 – Provides for maintenance, repair, and improvement of health care facilities. Specific objectives and program priorities to address the condition of facilities include:

- Providing routine maintenance and repairs to upkeep facilities at their current conditions;
- Achieving compliance with buildings and grounds accreditation standards of the Joint Commission or other applicable accreditation bodies;
- Providing improvements to facilities for enhanced patient care through larger M&I projects to reduce the Backlog of Essential Maintenance, Alteration and Repair (BEMAR), currently reported at over $427 million for all IHS and reporting Tribal facilities;
- Ensuring that health care facilities meet building codes and standards; and
- Ensuring compliance with executive orders and public laws relative to building requirements, e.g., sustainability, energy conservation, seismic, environmental, handicapped accessibility, and security.

Health Care Facilities Construction -$3,559,000 – Provides funding for continued progress on construction of replacement facilities in progress. The FY 2013 request will fund the following:

- San Carlos Health Center, San Carlos, Arizona, to complete construction of the facility; with equipment and staff quarters remaining to be completed; and
- Kayenta Health Center, Kayenta, Arizona, to continue construction.

Facilities and Environmental Health Support +$4,966,000 – Provides for:

- Staffing and Operating Costs at Newly Constructed Facilities; and
- Personnel who provide facilities and environmental health services throughout the IHS and operating costs associated with provision of those services and activities.

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

(Dollars in Thousands)

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request	FY 2013 +/- FY 2012
BA	$53,807	$53,721	$55,470	+$1,749
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 2013 Authorization.....Permanent

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

Maintenance and Improvement (M&I) funds are the primary source of funding to maintain, repair, and improve existing IHS facilities and Tribal health care facilities which are used to deliver and support healthcare services. M&I funding goes to federal, government-owned buildings and Tribally-owned space where healthcare services are provided pursuant to contracts or compacts executed under the provisions of the Indian Self-Determination and Education Assistance Act (P.L. 93-638). M&I funds are necessary to achieve and maintain accreditation, to meet building codes and standards, to maintain and repair the physical condition of 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 deliver health care in direct support of the IHS mission and priorities.

Maintaining reliable and efficient buildings is increasingly challenging as existing facilities age and additional space is added into the real property inventory. Many of IHS and Tribal facilities are old, operate at or beyond capacity, and are not designed to be utilized efficiently in the context of modern healthcare delivery. As existing health care facilities continue to age, they can become less efficient and the operational and maintenance costs increase. The average age for IHS-owned healthcare facilities is 32 years, whereas the average age including recapitalization of private-sector hospital plant is 9 to 10 years. The IHS has not had the resources to recapitalize facilities on a routine basis.

The physical condition of IHS-owned and many Tribally-owned facilities is evaluated through a series of condition surveys. These surveys, together with routine observations by facilities personnel, identify facility, fire-life-safety, and program deficiencies make up the Backlog of Essential Maintenance, Alteration, and Repair (BEMAR). The BEMAR is a measure of the condition of facilities and establishes priorities for larger M&I projects. Adequate M&I funding is essential to correct the deficiencies and keep the BEMAR to an acceptable level. The current BEMAR for all IHS and reporting Tribal facilities as of October 1, 2011 is $427,044,000.

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 upkeep the facility in its current condition. Funding allocation is formula based. The Building Research Board of the National Academy of Sciences (NAS) (*Committing to the Cost of Ownership - Maintenance and Repair of Public Buildings, 1990*) 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.

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

- 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 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 the Indian Health Service.

FUNDING HISTORY

Fiscal Year	Amount
2008 Enacted	$52,889,000
2009 Recovery Act	$100,000,000
2009 Omnibus	$53,915,000
2010 Enacted	$53,915,000
2011 Enacted	$53,807,000
2012 Enacted	$53,721,000

BUDGET REQUEST

The FY 2013 budget request for Maintenance and Improvement of $55,470,000 is an increase of $1,749,000 over the FY 2012 enacted level of $53,721,000.

+$1,749,000 to fund a program increase.

The increase will be used to provide routine maintenance funding for Federal and Tribal healthcare facilities supported under this budget activity. The space supported increases by approximately three percent annually with the construction of new and expanded Federal and Tribal healthcare facilities.

The budget request will be used as follows:

- $3 million will be allocated for environmental compliance projects and $500,000 for demolition projects.
- Approximately $51.9 million will be allocated to sustain the condition of federal and tribal health care facilities buildings.
- Limited funding will be available for projects that improve the condition of the facilities or make improvements to support healthcare delivery.

This level of funding will allow the IHS to maintain the condition of the IHS real property portfolio at, or slightly below, the existing level. The array of benefits achieved through timely investments in facilities maintenance and repair includes mission attainment, compliance with regulations, improved facility condition, efficient operations, and implementing stakeholder-driven initiatives.

Adequate funds are not available to fully achieve the goals of the Energy Policy Act of 2005; Executive Order 13423, "Strengthening Federal Environmental, Energy, and Transportation Management"; the Energy Independence and Security Act of 2007; and Executive Order 13514, "Federal Leadership in Environmental, Energy and Economic Performance."

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

GRANT AWARDS – This program has no Grant Awards.

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

(Dollars in Thousands)

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request	FY 2013 +/- FY 2012
BA	$95,665	$79,582	$79,582	+$0
FTE*	136	136	136	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 2013 Authorization.....Permanent

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

Sanitation Facilities Construction (SFC) is an integral component of the Indian Health Service (IHS) disease prevention activities. The IHS has carried out the program since 1959 using funds appropriated for SFC to provide potable water and waste disposal facilities for American Indian and Alaska Native (AI/AN) people. As a result, the rates for infant mortality, the mortality rate for gastroenteritis and other environmentally-related diseases have been dramatically reduced by about 80 percent since 1973. IHS physicians and health professionals credit many of these health status improvements to IHS's provision of water supplies, sewage disposal facilities, development of solid waste sites, and provision of technical assistance to Indian water and sewer utility organizations. It is important to note that 12 percent, or over 48,000 AI/AN homes, are without access to safe water or adequate wastewater disposal facilities and those individuals who live in the homes are still at an extremely high risk for gastrointestinal disease and respiratory disease at rates similar to developing countries. Many of these homes without service are very remote and may have limited access to health care which increases the importance of improving environmental conditions in the home as part of a comprehensive public health program.

The four types of sanitation facilities projects funded through IHS are (1) projects to serve new or like-new housing, such as Indian homes being constructed or rehabilitated by the BIA-Home Improvement Program (HIP), Tribes, individual homeowners, or other nonprofit organizations, (2) projects to serve existing housing, (3) special projects (studies, training, or other needs related to sanitation facilities construction), and (4) emergency projects. Projects that serve new or like-new housing are funded based on a priority classification system. Projects that serve existing housing are annually prioritized as described below with Tribal input, then funded in priority order.

SFC projects can be managed by the IHS directly (Direct Service) or they can be managed by Tribes that elect to use the Title I or Title V authorization under P.L. 93-638, the Indian Self-

Determination and Education Assistance Act. Sanitation facilities projects are carried out cooperatively with the Tribes who are to be served by the facilities. Projects start with a Tribal Project Proposal and are funded and implemented through execution of an agreement between the Tribe and IHS. In these agreements the Tribes also agree to assume ownership responsibilities, including operation and maintenance. The overall SFC goals, eligibility criteria, and project funding priorities remain the same, regardless of the delivery methods chosen by a Tribe. More than 70 percent of all sanitation facilities construction is performed by Indian Tribes/firms.

The Indian Health Care Improvement Act (Title III, Section 302(g) 1 and 2 of P.L.94-437) directs the IHS to identify the universe of sanitation facilities needs for existing Indian homes by documenting deficiencies and then proposing projects to address those needs. Types of projects range from those providing new and existing homes their first services such as water wells and onsite wastewater systems or by connections to community water and wastewater facilities. The universe of need also includes projects to upgrade existing water supply and waste disposal facilities and projects to improve sanitation facilities operation and maintenance capabilities in Indian country. As of November 2011, the list of all projects to correct documented sanitation project deficiencies totaled almost $3.1 billion with those projects considered economically and technically feasible totaling almost $1.46 billion. Typically, projects with exceptionally high capital costs are considered economically infeasible if their cost per home exceeds an established allowable unit cost per home for a particular geographical area. Technical feasibility relates to operability and sustainability of the proposed system.

As of the end of FY 2011, there were about 231,000 or approximately 60 percent of AI/AN homes in need of sanitation facilities, including 9 percent or nearly 33,000 AI/AN homes without potable water. Maximum health benefits will be realized by addressing existing sanitation needs identified in the backlog and by providing sanitation facilities for new homes when they are constructed.

In 2011, the IHS provided service to 21,984 AI/AN homes. Projects that provide sanitation facilities to homes are selected for funding in priority order each year from the Sanitation Deficiency System (SDS) inventory of all needs in Indian Country. The SDS is an inventory of the sanitation deficiencies of American Indian and Alaska Native communities; those sanitation deficiencies include needed water, sewer, and solid waste facilities for existing American Indian and Alaska Native homes. Project selection is driven by objective evaluation criteria that include health impact, existing deficiency level, adequacy of previous service, capital cost, local Tribal priority, operations and maintenance capacity of receiving entity, availability of contributions from non-IHS sources, and other conditions that are locally determined. The SDS priority position of each unfunded project is reevaluated with the Tribes in each Area annually. In most years, the SFC program has exceeded all national performance measures, IHS, Departmental and program assessment performance measures.

An efficiency measure based on the average project duration is used in evaluating SFC expertise in advancing project discipline. The goal for Sanitation Facilities Construction projects completed during calendar 2011 and the years thereafter is that the average project duration from the execution of the Project Memorandum of Agreement (MOA) to the Construction Completion date as tracked by the Sanitation Facilities Project Data System shall be 4 years or less. Project duration is the average length of time to complete project construction from the time the project is funded and is a measure of actual performance since the project schedule is under a project manager's control. This time length had been slowly increasing from 2.5 years in 1993 to over 4 years at the end of 2007. Several factors have contributed to this growth in project duration including increased administrative requirements, more involved environmental reviews, increased

complexity of designs and decreases in staff resources. Reductions in the length of time a project takes to complete will yield cost savings in both construction inflation costs and project related staffing costs. In 2007, the average length of time to complete a project increased to 4.1 years but with the implementation of a robust project management program the time to complete projects has been reduced to 3.53 years by CY 2010. This decrease is a program success because it occurred at a time when construction budgets increased by 80 percent due to the American Recovery and Reinvestment Act, increasing need for SFC.

FUNDING HISTORY

Fiscal Year	Amount
2008 Enacted	$94,253,000
2009 Recovery Act	$68,000,000
2009 Omnibus	$95,857,000
2010 Enacted	$95,857,000
2011 Enacted	$95,665,000
2012 Enacted	$79,582,000

BUDGET REQUEST

The FY 2013 budget request for Sanitation Facilities Construction of $79,582,000 is the same as FY 2012 enacted level of $79,582,000.

This level of funding will be allocated as follows, with projects budgeted to include full costs for pre-planning, design, construction costs, and associated overhead:

1) A portion of the total FY 2013 SFC appropriation will be reserved to serve new and like-new homes. Some of these funds may also be used for sanitation facilities for the individual homes of the disabled or sick with a physician referral indicating an immediate medical need for adequate sanitation facilities in their home. As needed, amounts to serve new and like-new homes will be established by Headquarters after reviewing Area requests. Priority will be given to projects intended to provide sanitation facilities for the first time to homes in categories B, C, and D (new homes and homes receiving major renovation bringing the homes up to like new condition) under the BIA Housing Improvement Program (HIP). (NOTE: Homes in BIA/HIP Category A are considered existing homes. Category A homes needing service will be included in the SDS.)

   The amount allocated to each Area for projects to serve other new/like-new homes will be used as a basis for determining the Area's pro-rata share of remaining funds for serving such housing.

2) Up to $48,000,000 of the SFC appropriation in FY 2013 will be distributed to the Areas for prioritized projects to serve existing homes, based on a formula that considers, among other factors, the cost of facilities to serve existing homes that: (a) have not received sanitation facilities for the first time; or (b) are served by substandard sanitation facilities (water and/or sewer). Another distribution formula element is a weight factor that favors Areas with larger numbers of (AI/AN) homes without water supply or sewer facilities, or without both.

3) Up to $5,000,000 will be used for projects to clean up and replace open dumps on Indian lands pursuant to the Indian Lands Open Dump Cleanup Act of 1994.

4) Up to $2,000,000 will be reserved at IHS Headquarters. Of this amount, $1,000,000 will be used for special projects and for distribution to all Areas as needed to address water supply and waste disposal emergencies caused by natural disasters or other unanticipated situations that require immediate attention to minimize potential threats to public health. Emergency and special funds remaining at the end of the fiscal year may be distributed to the Areas to address the Sanitation Deficiency System (SDS) priority list of needs. The remaining $1,000,000 is for funding special projects to do several things. Up to $500,000 will be used in 3 Areas a year to collect homeowner data and other demographic information to strengthen verification mechanisms within the SFC Community Deficiency Profiles (CDP) in SDS in an effort to increase transparency, accuracy, and accountability of the CDP data. This data initiative began in 2010 and will be funded over 4 years to collect this data in all 12 IHS Areas. An amount up to $500,000 will be used for improving data collection systems, providing technical assistance and training for users, as well as for covering the costs of a national automated computer aided drafting contract and to fund an Alaska Native and American Indian Water Resource Center. The Water Resource Center will develop teaching materials and techniques for homeowners and communities to improve usage and support in a way that promotes health. The need is for a five-year funding stream at $250,000 annually, in partnership with the Alaska Native Tribal Health Consortium to develop a teaching system that can be used IHS wide.

The IHS appropriated funds will not be used to provide sanitation facilities for new homes funded with grants by the housing programs of the Department of Housing and Urban Development (DHUD). These DHUD housing grant programs for new homes should incorporate funding for the sanitation facilities necessary for the homes.

OUTPUTS AND OUTCOMES

Measure	Year and Most Recent Result/ Target for Recent Result/ (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 Target +/- FY 2012 Target
(35) SFC-1: Sanitation Improvement: Number of new or like-new and existing AI/AN homes provided with sanitation facilities.	FY 2011: 21,984 Target: 18,600 (Target Exceeded)	15,500	15,000	-500
SFC-E: Track average project duration from the Project Memorandum of Agreement (MOA) execution to construction completion. *(Efficiency)*	FY 2010: 3.5 years Target: 4.0 years (Target Exceeded)	4.0 years	4.0 years	0
SFC-3: Percentage of AI/AN homes with sanitation facilities	FY 2011: 91% Target: 90% (Target Exceeded)	90%	90%	N/A

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 2011 Enacted	FY 2012 Enacted	FY 2013 Request	FY 2013 +/- FY 2012
BA	$39,156	$85,048	$81,489	-$3,559
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 2013 Authorization.....Permanent

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The IHS Health Care Facilities Construction (HCFC) funds provide optimum availability of functional, modern IHS and tribally operated health care facilities and, where no suitable housing alternative is available, staff housing. The IHS is authorized to construct health care facilities and staff quarters; renovate/construct youth substance abuse treatment centers; support Tribal construction of facilities under the Joint Venture Construction Program; provide construction funding for Tribal small ambulatory care facilities projects; and provide funding to provide 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 Health and Human Services Strategic goal to transform health care. The health care facilities constructed by the IHS ensure access to quality, culturally competent care for one of the poorest and most vulnerable populations in the United States, American Indians and Alaska Natives (AI/AN). The focus of the IHS health service programs provided in these facilities is on prevention and the delivery of comprehensive primary care in a community setting.

Health care facilities construction is funded based on a national list of priorities for construction projects. During FY 1990, in consultation with the Tribes, the IHS revised its Health Facilities Construction Priority System (HFCPS) methodology. The HFCPS ranks proposals using factors reflecting the total amount of space needed; age and condition of the existing facility, if any; degree of isolation of the population to be served in the proposed facility; and availability of alternate health care resources. The health facilities projects remaining on the HFCPS, including those partially funded, total approximately $2.5 billion.

The Joint Venture Construction Program (JVCP) allows IHS to enter into agreements with Tribes that construct their own health facilities. Through this competitive process, applicants can and do fund equipment for the projects. Upon completion by the respective Tribe, IHS requests Congressional appropriations for staffing and operations based on the Tribes' projected dates of completion and opening. Between FY 2001 and FY 2011, sixteen joint venture project

agreements signed by IHS and Tribes were initiated and eight have been completed. The JVCP continues to receive strong support by Tribes based upon the 55 positive responses to the FY 2009 congressionally directed solicitation for the JVCP FY 2010-FY 2012 cycle. The IHS will continue to work on the applications received for the FY 2010-FY 2012 cycle in accordance with ongoing construction projects and appropriation levels.

FUNDING HISTORY

Fiscal Year	Amount
2008 Enacted	$36,584,000
2009 Recovery Act	$227,000,000
2009 Omnibus	$40,000,000
2010 Enacted	$29,234,000
2011 Enacted	$39,156,000
2012 Enacted	$85,048,000

BUDGET REQUEST

The FY 2013 budget request for Health Care Facilities Construction of $81,489,000 is a decrease of $3,559,000 below the FY 2012 enacted level of $85,048,000.

The FY 2013 request of $81,489,000 will be allocated to the following projects:

- San Carlos Health Center, San Carlos, Arizona, to complete construction of the facility; with equipment and staff quarters remaining to be completed and,
- Kayenta Health Center, Kayenta, AZ to continue construction.

The Agency is committed to the most effective and transparent use of resources provided in FY 2013 to continue construction on the above health facilities projects which are many months into construction.

San Carlos Health Center, San Carlos, AZ $41,489,000
This facility will provide an expanded level of health care services specifically designed to meet the health care needs of the San Carlos Service Unit's projected user population of 12,985, generating approximately 50,000 primary care provider visits and 128,000 outpatient visits annually (projections to 2015 based on actual FY 2008 population figures). The existing hospital at San Carlos will be replaced with a modern 16,721 gross square meters (GSM) health center that will have alternative rural hospital capabilities. The replacement facility will be a modern, technologically advanced facility with the required staff to provide improved access to quality, culturally competent care for AI/AN who are among the most vulnerable populations in the United States. The health care programs and services provided include 8 low risk nursing care beds and 2 birthing beds for a total of 10 beds. New services provided by the facility will be a two-bed low risk birthing unit, physical therapy, telemedicine, podiatry, ultrasound, ambulatory procedures, CT Scanning, and mammography. The project will also include the construction of 43 new staff housing units. The FY 2013 funds will complete the facility, but the equipment will not be installed and quarters for this facility will not be completed. The balance required in the following year to complete this project totals $22,453,000.

Kayenta Health Center, Kayenta, AZ $40,000,000
The proposed new Kayenta replacement health center will provide space to support a modern and adequately staffed health care delivery program that will improve access to quality, culturally

competent care for AI/AN who are among the most vulnerable populations in the United States. The proposed 16,638 gross square meters (GSM) new health center has been planned for a projected user population of 19,253, generating approximately 54,000 primary care provider visits and 107,000 outpatient visits annually. This facility will ensure availability to the medical services needed to maintain and promote the health status and overall quality of life for the residents of the service area. The health care programs and services provided at this facility include a level III emergency and urgent care unit with the support of the Tribal emergency medical services (EMS); a 10-bed short stay nursing unit that provides sub-acute care; a three-bed low-risk birthing center, which will allow this health center to function as an IHS alternative rural hospital. Additionally, this health center will have comprehensive ambulatory care, ancillary services, preventive community health services, behavioral health services, service unit administration, and facility support services. The existing facility will be disposed of in accordance with established regulations and procedures after the replacement health center is operational. The FY 2013 funds will continue construction. The balance required in the following years to complete this project totals $71,682,000.

OUTPUTS AND OUTCOMES

Measure	Year and Most Recent Result/ Target for Recent Result/ (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 Target +/- FY 2012 Target
36 Health Care Facility Construction: Number of health care facilities construction projects completed.	FY 2011: 1 Target: 1 (Target Met)	1	2*	+1
HCFC-9: Percent of the YPLL rate within 7 years of opening the new facility (Outcome)	N/A	Discontinue but consolidate in FY 2012	N/A	N/A
HCFC-11: Access to Care: Increasing Access to Care at completed, congressionally appropriated, priority Health Care Facilities	N/A	Discontinue in FY 2012	N/A	N/A
HCFC-E Health Care Facilities Construction: Percent of health care facilities construction projects completed on time.	FY 2011: 100% Target:100% (Target Met)	Discontinue	N/A	N/A
HCFC-E Health Care Facilities Construction: Energy consumption in Leadership in Energy and Environmental Design (LEED) certified IHS health care facilities compared to the industry energy consumption standard for comparable facilities.			Set Baseline	NA

* The two health care facility scheduled to be completed in FY 2013 are Nome, Alaska and Barrow, Alaska.

GRANTS AWARDS -- Program has no grants awards.

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

FACILITIES AND ENVIRONMENTAL HEALTH SUPPORT

(Dollars in Thousands)

	FY 2011 Enacted		FY 2012 Enacted		FY 2013 Request		FY 2013 +/- FY 2012	
	FTE	Funds	FTE	Funds	FTE	Funds	FTE*	Funds
BA	1,029	$192,701	1,039	$199,413	1,044	$204,379		+$4,966
FS	*550*	*$107,303*	*558*	*$113,545*	*563*	*$117,636*	*5*	*$4,091*
EHS	*407*	*$69,058*	*409*	*$69,703*	*409*	*$70,513*	*0*	*$810*
OEHE	*72*	*$16,340*	*72*	*$16,165*	*72*	*$16,230*	*0*	*$65*

*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 2013 Authorization.....Permanent

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

SUMMARY OF PROGRAMS

Facilities and Environmental Health Support programs provide an extensive array of real property, health care facilities and staff quarters construction, maintenance and operation services, as well as community and institutional environmental health, injury prevention, and sanitation facilities construction services. The programs both directly and indirectly support all of the IHS facilities performance measures and improved access to quality health services. The Facilities Appropriation programs are managed to ensure accountability and transparency at IHS Headquarters and Area Offices by the Office of Environmental Health and Engineering (OEHE). At the Service Unit and field levels, OEHE staff work directly with Tribes and individuals to promote and provide access to improvements in public health through surveillance, education, intervention activities, construction of sanitation facilities and health care facilities.

This activity has three sub-activities to align program and functions and is summarized below:

1. Facilities Support (FS) provides funding for staff and management activities to support operation and maintenance of real property and building systems; medical equipment technical support; and planning, design, of new and replacement facilities projects.
2. Environmental Health Support (EHS) provides funding for staff and management activities in support of sanitation facilities construction, and environmental health services activities.
3. Office of Environmental Health and Engineering Support (OEHE) provides funding for headquarters management activities and for real property asset management across the IHS facilities and environmental health programs, including technical services and support for capital investments, construction contracting and management of new and replacement facilities, budget formulation, and long range planning, national policy development and implementation and liaison with the Department of Health and Human Services (HHS), Congress, Tribes, and other Federal agencies.

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

FUNDING HISTORY

Fiscal Year	Amount
2008 Enacted	$169,638,000
2009 Omnibus	$178,329,000
2010 Enacted	$193,087,000
2011 Enacted	$192,701,000
2012 Enacted	$199,413,000

BUDGET REQUEST

The FY 2013 budget request for Facilities and Environmental Health Support of $204,379,000 is an increase of $4,966,000 over the FY 2012 enacted level of $199,413,000.

- +$4,456,000 to fund Staffing and Operating Cost at Newly Constructed Facilities. These funds allow IHS to expand provision of health care in those areas where capacity has been expanded to address critical health care needs.
- +510,000 to cover federal Commissioned Officer pay costs.

Staff for New Facility[1]	Amount	FTE/Tribal Positions	
		Facilities Support	Environmental Health Support
Chickasaw Nation Health Clinic (JV), Ardmore, OK	$774,000	4	
Cherokee Nation Health Center (JV), Vinita, OK	$220,000	1	
Chickasaw Nation Health Clinic (JV), Tishomingo, OK	$541,000	3	
Southcentral Foundation Valley Primary Care Center (JV), Wasilla, AK	$1,029,000	4	
Tanana Chief Conference Interior Health Center (JV), Fairbanks, AK	$773,000	2	1
Norton Sound Regional Hospital, Nome, AK	$1,119,000	3	2
Grand Total:	**$4,456,000**	**17**	**3**

1) FACILITIES SUPPORT

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

Facilities Support 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 by (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.

[1] These FTE increases include employees at Tribally operated facilities, only.

The IHS owns approximately 956,000 square meters of facilities (buildings and structures) and 736 hectares of Federal and trust land. The nature of space varies from sophisticated medical centers to residential units and utility plants. Facilities range in age from less than one year to more than 159 years with an average age greater than 32 years. A professional and fully-staffed workforce is essential to ensure effective and efficient operations. Typical staff functions funded may include: (1) 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; (2) specialized clinical engineers and technicians that maintain and service medical equipment; (3) realty staff that manages the real property requirements and quarters; and (4) facilities planning and construction-monitoring components that assist in the planning and construction projects.

In addition, this sub-activity 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. IHS reduced the energy related utility consumption for IHS managed facilities from 2,149,000 British Thermal Units per Square Meter (BTU/SM) in 2003 to 1,852,000 BTU/SM in 2011 which is a 13.8 percent reduction. These efforts help stem the growth in utility costs. During the period FY 2003 through FY 2011, total utility costs have increased 44 percent from $15.5 million to $22.4 million and total utility costs per Gross Square Meters (GSM) increased 64 percent from $25/GSM to $41/GSM. The IHS continues to aggressively investigate options to reduce energy costs. However, adequate funds are not available to fully achieve the goals of the Energy Policy Act of 2005; Executive Order 13423, "Strengthening Federal Environmental, Energy, and Transportation Management"; the Energy Independence and Security Act of 2007; and Executive Order 13514, "Federal Leadership in Environmental, Energy and Economic Performance."

2) ENVIRONMENTAL HEALTH SUPPORT

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The Environmental Health Support Account 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. American Indians and Alaska Natives (AI/AN) face hazards in their environment that affect their health status, including: communities in remote/isolated locations; severe climatic conditions; limited availability of safe housing; lack of safe water supply; and lack of public health and safety legislation.

Two programs are funded by the Environmental Health Support Account. The **Sanitation Facilities Construction Program (SFC)** staff manages and provides professional engineering services to construct over 400 sanitation projects annually at a total cost of over $190 million. The program manages annual project funding that includes contributions from Tribes, States, and other Federal agencies. Services funded include management of staff; pre-planning; consultation with Tribes; coordination with other Federal, State, and local governmental entities; identifying supplemental funding outside of IHS; developing local policies and guidelines with Tribal consultation; developing agreements with Tribes and others for each project; providing project design, project construction; assuring environmental and historical preservation procedures are followed; and assisting Tribes where the Tribes provide construction management. Consistent with the 1994 Congressional set aside for "…tribal training on the operation and maintenance of

sanitation facilities," $1 million of these support funds are used for technical assistance, training, and guidance to Indian families and communities regarding the operation and maintenance of essential water supply and sewage disposal facilities. In accordance with the Indian Health Care Improvement Act (Title III, Section 302(g) 1 and 2 of P.L. 94-437), the staff annually updates its inventory of sanitation facilities deficiencies for existing Indian occupied homes. 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 (P.L. 103-399). Both of these inventories are widely used by other governmental agencies in their evaluation and funding of sanitation projects.

The **Environmental Health Services Program (EHS)** includes the specialty areas of injury prevention and institutional environmental health. The EHS identifies environmental hazards and risk factors in Tribal communities and proposes control measures to prevent adverse health effects. These measures include monitoring and investigating disease and injury in Tribal communities; identifying environmental hazards in community facilities such as food service establishments, Head Start centers, community water supply systems, and health care facilities; and providing training, technical assistance, and project funding, primarily through competitive cooperative agreements, to develop the capacity of Tribal communities to address their environmental health issues. The IHS **Injury Prevention Program** has been instrumental in reducing the injury mortality rate of AI/AN by 58 percent since it moved from an "education only" focus to a public health approach in the 1970's. Treatment of injuries cost an estimated $350,000,000 per year in direct health care costs to IHS, Tribes, and contract care facilities. The Injury Prevention Program has developed effective strategies and initiatives to reduce the devastating burden of injuries experienced by AI/AN. The IHS **Institutional Environmental Health Program (IEH)** identifies environmental hazards and risk factors in the built environment and proposes control measures to prevent adverse health effects in health care and other community facilities and to support health care accreditation. Maintaining accreditation ensures that IHS continues to have access to third party funding. The IHS IEH Program developed and maintains an incident reporting system (WebCident) to prepare required Occupational Safety and Health Administration logs, identify and document hazardous conditions, and develop targeted prevention strategies.

Tribal Health Programs: Area, District and Service Unit environmental health personnel work with Tribes/Tribal organizations to encourage maximum participation in planning health services delivery programs. They provide training and technical assistance to the Tribal officials who carry out administrative/management responsibilities associated with operation of federally supported programs.

OUTPUTS AND OUTCOMES

Measure	Year and Most Recent Result/ Target for Recent Result/ (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 Target +/- FY 2012 Target
Injury Intervention: Occupant Protection Use (Output)	FY2011: 57% National Baseline Target: Establish a national baseline measure for all Tribal Injury Prevention Cooperative Agreement	Implement proven or promising strategies to increase the national seatbelt use rate.	Determine interim measure of national seatbelt use rate.	N/A

Measure	Year and Most Recent Result/ Target for Recent Result/ (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 Target +/- FY 2012 Target
	sites.(Target Met)			
Environmental Surveillance: Identification and control of environmental health risk factors (Output)	FY2011: 4.6% National Baseline Target: Establish a national baseline measure for food risk factor deficiencies.	**Areas will implement comprehensive interventions targeted at improving the national food risk factor deficiency measure.**	Determine interim measure of national food risk factor deficiencies.	N/A

GRANT AWARDS

In 2011, the Injury Prevention Program awarded $2.4 Million in cooperative agreements to 33 Tribal programs to create Tribal Injury Prevention Programs where there were none or to continue those that were previously funded. Seven Tribal programs were awarded $70,000 to implement proven or promising motor vehicle or elder fall injury interventions.

3) OFFICE OF ENVIRONMENTAL HEALTH AND ENGINEERING SUPPORT

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The Office of Environmental Health and Engineering Support activity 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 includes national policy development and implementation, budget formulation, project review and approval, congressional report preparation, quality assurance (internal control reviews, Federal Managers Financial Integrity Act activities and other oversight), technical assistance (consultation and training), long range planning, meetings (with HHS, Tribes, and other Federal agencies), and recruitment and retention. Typical direct support functions performed by OEHE personnel who serve as project officers for health care facilities construction projects are: reviewing and/or writing technical justification documents, participating in design reviews and site surveys, conducting onsite inspections, and monitoring project funding status, etc. In addition, these positions support new 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 Support funds personnel and activities to develop, maintain, and utilize data systems to distribute resources to Area offices for facilities and environmental health activities.
Also, technical guidance, information, and training were provided throughout the IHS system in support of the Facilities Appropriation. Some of the activities and accomplishments include review and approval of Program Justification Documents and Program of Requirements; announcement, review and approval of Joint Venture and Small Ambulatory projects; and awarding and monitoring contracts for health care facilities construction. OEHE coordinates construction, environmental health, and real property activities among 12 Area Offices to ensure program consistency, to ensure the most effective use of resources across IHS and to support field

programs through budget preparation and required reporting, thus ensuring the most effective use of resources to improve access to quality health care services.

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

GRANT AWARDS – This program has no grant awards.

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

(Dollars in Thousands)

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request	FY 2013 +/- FY 2012
BA	$22,618	$22,582	$22,582	+$0
FTE	0	0	0	0

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

FY 2013 Authorization.....Permanent

Allocation Method.....Direct Federal, P.L. 93-638 Self Determination contracts and Self-Governance compacts for replacement medical equipment that is formula based; Equipment funds for Tribally-constructed health care facilities are competitively allocated; and TRANSAM and ambulance purchase programs are Federally managed.

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

Equipment funds are used for maintenance, replacement, and the purchase of new medical equipment at IHS and Tribal health care facilities. It directly supports the Agency's priorities by: (1) renewing and strengthening our partnership with Tribes; and (2) improving the quality of and access to care.

Accurate clinical diagnosis and effective therapeutic procedures depend in large part on health care providers using modern and effective medical equipment to assure the best possible health outcomes. The IHS and Tribal health programs manage laboratory, x-ray, patient monitoring, pharmacy, and biomedical equipment valued at approximately $320 million. With today's medical devices having an average life expectancy of approximately 6 years, medical equipment replacement is a continual process necessary to replace worn out equipment or provide equipment with newer technology to enhance the speed and accuracy of diagnosis and treatment.

Equipment Funds Allocation Method
The IHS Equipment funds are allocated in three categories: Tribally-constructed health care facilities, TRANSAM and ambulance programs, and new and replacement equipment:

- Tribally-Constructed Health Care Facilities – The IHS provides medical equipment funds to support the initial purchase of equipment for Tribally-constructed health care facilities. $5 million is set aside annually for competitive awards to Tribes and Tribal organizations that construct new or expand health care facilities space using non-IHS funding sources. As a result, approximately 500,000 patients will be treated with updated medical equipment.

- TRANSAM and Ambulance Programs – Equipment funds are also used to acquire new and like-new excess medical equipment from the Department of Defense (DoD) or other sources through the TRANSAM (i.e., Transfer of DoD Excess Medical and Other Supplies to Native

Americans) program and to procure ambulances for IHS and Tribal emergency medical services programs. Currently IHS sets aside $500,000 for Ambulances and $500,000 for TRANSAM annually. Under the TRANSAM program, excess equipment and supplies, annual estimated value of $4 million, are acquired for distribution to the Tribes.

- New and Replacement Equipment – The balance, $16.6 million, of equipment funds are allocated to IHS and Tribal health care facilities to purchase new medical equipment, including replacement of existing equipment used in diagnosing and treatment of illnesses. The funding allocation is formula based.

FUNDING HISTORY

Fiscal Year	Amount
2008 Enacted	$21,282,000
2009 Recovery Act	$20,000,000
2009 Omnibus	$22,067,000
2010 Enacted	$22,664,000
2011 Enacted	$22,618,000
2012 Enacted	$22,582,000

BUDGET REQUEST

The FY 2013 budget request for Equipment of $22,582,000 is the same as FY 2012 enacted level of $22,582,000.

The budget request will provide:
- Approximately $16.6 million for new and routine replacement medical equipment to over 1,500 federally and Tribally-operated healthcare facilities.
- Approximately $5 million for new medical equipment in Tribally-constructed healthcare facilities.
- Approximately $500,000 for the TRANSAM and $500,000 for ambulance programs.

IHS and Tribal healthcare facilities take into account the medical equipment life cycle, acquisition costs, maintenance requirements, intensity of use, and new technologies to prioritize the procurement of new and replacement medical equipment. Emerging medical equipment technologies, telemedicine, and electronic health records have a profound impact on the quality of healthcare. Equipment funds are used to address the most pressing medical equipment needs while incorporating new medical equipment advances.

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

GRANT AWARDS – This program has no Grant Awards.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Facilities: 75-0391-0-1-551
PERSONNEL QUARTERS/QUARTERS RETURN FUNDS*

(Dollars in Thousands)

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request	FY 2013 +/- FY 2012
BA	$6,288	$7,500	$7,500	+$0
FTE**	25	25	25	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 for Tribal staff.

Authorizing Legislation .....Public Law 98-473, Sec. 320 as amended

FY 2013 Authorization.....Permanent

Allocation Method.....Federal Direct

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

Staff quarters operation, maintenance, and improvement costs are funded with Quarters Return (QR) funds. QR funds are collected from tenants of quarters associated with IHS owned quarters. These funds will be used for the operation, management, and general maintenance of quarters, including maintenance personnel services, security guard services, repairs to housing units and associated grounds, purchase of materials, supplies, and household appliances/equipment (stoves, water heaters, furnaces, etc.). In certain situations, Maintenance and Improvement funds may be used, in conjunction with QR funds, to ensure adequate quarters maintenance; e.g., locations with few quarters where QR funds are not enough to pay for all required maintenance costs.

FUNDING HISTORY

Fiscal Year	Amount
2008 Enacted	$6,288,000
2009 Enacted	$6,288,000
2010 Enacted	$6,288,000
2011 Enacted	$6,288,000
2012 Enacted	$7,500,000

BUDGET REQUEST

The FY 2013 budget request of collections for Quarters of $7,500,000 is the same as the FY 2012 enacted level of $7,500,000 for anticipated collections.

Rental rates are established in accordance with OMB Circular A-45.

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

GRANT AWARDS – This program has no Grant Awards.

FY 2013 BUDGET SUBMISSION
INDIAN HEALTH SERVICE
OBJECT CLASSIFICATION
(Dollars in Thousands)

Object Class	FY 2012 Enacted	FY 2013 Estimate	FY 13 +/- FY 2012
DIRECT OBLIGATIONS			
Personnel Compensation:			
Full-Time Permanent(11.0)……	439,337	448,555	9,218
Other than Full-Time Permanent(11.3)…….	25,132	25,610	478
Other Personnel Comp.(11.5)……	60,220	61,352	1,132
Military Personnel Comp (11.7)……	101,673	104,380	2,707
Special Personal Services Payments (11.8)……	273	274	1
Subtotal, Personnel Compensation...……	626,635	640,171	13,536
Civilian Personnel Benefits(12.1)…….	152,239	155,350	3,111
Military Personnel Benefits (12.2)	42,336	43,449	1,113
Benefits to Former Personnel(13.0)…….	9,973	10,099	126
Subtotal, Pay Costs……	**831,183**	**849,069**	**17,886**
Travel(21.0)……	43,577	44,855	1,278
Transportation of Things(22.0)……	9,792	9,854	62
Rental Payments to GSA(23.1)…….	15,051	15,138	87
Rental Payments to Others(23.2)……..	1,319	1,355	36
Communications, Utilities and			
Miscellaneous Charges(23.3……	27,006	27,340	334
Printing and Reproduction(24.0)……..	539	535	(4)
Other Contractual Services:			
Advisory and Assistance Services(25.1)…….	12,012	12,137	125
Other Services(25.2)……	157,439	168,603	11,164
Purchases from Govt. Accts.(25.3)……	63,871	64,211	340
Operation and Maintenance of Facilities(25.4)…..	10,802	11,784	982
Research and Development Contracts(25.5)…….	13	14	1
Medical Care(25.6)……	458,056	498,574	40,518
Operation and Maintenance of Equipment(25.7)…	15,631	16,511	880
Subsistence and Support of Persons(25.8)…….	14,553	14,303	(250)
Subtotal, Other Contractual Current.....……	**732,377**	**786,137**	**53,760**
Supplies and Materials(26.0)……	149,519	153,449	3,930
Equipment (31.0)……	22,905	23,562	657
Land & Structures (32.0)……	17,436	17,822	386
Investments & Loans (33.0)……	0	0	0
Grants, Subsidies, & Contributions (41.0)……	2,454,465	2,491,993	37,528
Insurance Claims & Indemnities (42.0)……	1,297	1,306	9
Interest & Dividends (43.0)……	61	61	0
**Subtotal Non-Pay Costs.....…… **	**3,475,344**	**3,573,407**	**98,063**
Total, Direct Obligations……	**4,306,527**	**4,422,476**	**115,949**

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

Object Class	FY 2012 Enacted	FY 2013 Estimate	Increase or Decrease
Personnel Compensation:			
Full-Time Permanent (11.0)	439,337	448,555	9,218
Other than Full-Time Permanent (11.3)	25,132	25,610	478
Other Personnel Comp. (11.5)	60,220	61,352	1,132
Military Personnel Comp. (11.7)	101,673	104,380	2,707
Special Personnel Services Payments (11.8)	273	274	1
Subtotal, Personnel Compensation	626,635	640,171	13,536
Civilian Personnel Benefits (12.1)	152,239	155,350	3,111
Millitary Personnel Benefits (12.2)	42,336	43,449	1,113
Benefits to Former Personnel (13.0)	9,973	10,099	126
Total, Pay Costs	**831,183**	**849,069**	**17,886**
Travel (21.0)	12,675	12,789	114
Transportation of Things (22.0)	9,792	9,854	62
Rental Payments to Others (23.2)	1,319	1,355	36
Communications, Utilities & Misc. Charges (23.3)	27,006	27,640	634
Printing and Reproduction (24.0)	539	535	(4)
Other Contractual Services:			
Advisory and Assistance Services (25.1)	12,012	12,137	125
Other Services (25.2)	157,439	168,603	11,164
Purchases from Govt. Accts. (25.3)	63,871	64,211	340
Operation and Maintenance of Facilities (25.4)	10,802	11,784	982
Operation and Maintenance of Equipment (25.7)	15,631	16,511	880
Subsistance and Support of Persons (25.8)	14,553	14,303	(250)
Subtotal, Other Contractual	274,308	287,549	13,241
Supplies and Materials (26.0)	149,519	143,449	(6,070)
Total, Non-Pay Costs	**475,158**	**483,171**	**8,013**
Total Salaries & Expenses	1,306,341	1,332,240	25,899
Direct FTE	9,285	9,421	136

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

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request
Headquarters			
Sub-Total, Headquarters	471	490	510
Area Offices			
Aberdeen Area Office	1,998	2,013	2,028
Alaska Area Office	523	527	531
Albuquerque Area Office	1,046	1,054	1,062
Bemidji Area Office	513	517	521
Billings Area Office	959	966	973
California Area Office	95	96	96
Nashville Area Office	170	171	173
Navajo Area Office	4,426	4,458	4,493
Oklahoma City Area Office	1,673	1,685	1,698
Phoenix Area Office	2,622	2,641	2,661
Portland Area Office	533	537	541
Tucson Area Office	456	459	463
Sub-Total, Area Offices	15,014	15,124	15,240
Trust Funds (Gift)	23	23	23
TOTAL FTES	15,508	15,637	15,773

Average GS Grade

2009.....	8.1
2010.....	8.1
2011.....	8.1

INDIAN HEALTH SERVICE

DETAIL OF PERMANENT POSITIONS

(Dollars in Thousands)

	FY 2011 Enacted	FY 2012 Estimate	FY 203 Estimate
Total - ES's.....	18	18	18
Total - ES Salaries.....	$3,035	$3,084	$3,099
GS/GM-15.....	419	426	431
GS/GM-14.....	399	382	386
GS/GM-13.....	410	416	421
GS-12.....	914	928	939
GS-11.....	1,287	1,307	1,322
GS-10.....	559	568	574
GS-9.....	1,315	1,336	1,350
GS-8.....	327	332	336
GS-7.....	1,033	1,049	1,061
GS-6.....	1,327	1,348	1,363
GS-5.....	2,212	2,247	2,272
GS-4.....	1,171	1,189	1,203
GS-3.....	203	206	208
GS-2.....	46	47	47
GS-1.....	1	1	1
Subtotal.....	11,623	11,782	11,913
Total - GS Salaries.....	$629,479	$636,204	$649,271
Assistant Surgeon General CO-08.....	1	1	1
Assistant Surgeon General CO-07.....	7	7	7
Director Grade CO-06.....	468	476	478
Senior Grade CO-05.....	573	583	585
Full Grade CO-04.....	563	573	575
Senior Assistant Grade CO-03.....	354	392	393
Assistant Grade CO-02.....	63	104	104
Junior Grade CO-01.....	13	35	35
Subtotal.....	2,042	2,172	2,177
Total - CO Salaries	$140,350	$144,009	$147,801
Ungraded.....	1,324	1,324	1,324
Total - Ungraded Salaries	$47,380	$47,886	$48,870
Trust Funds (Gift)	23	23	23
Average ES level.....	ES-02		
Average ES salary.....	$169		
Average GS grade.....	8.1		
Average GS salary.....	$54		

INDIAN HEALTH SERVICE
PROGRAMS FOR PROPOSED ELIMINATION

The Indian Health Service FY 2013 budget request does not include any programs for proposed elimination.

INDIAN HEALTH SERVICE
Summary of Reimbursements, Assessments, and Purchases
FY 2011

REVISED:CLB:12-14-11

		Object Class								FY 2011	FY 2012	FY 2013
		11.1 & 12.1	21.0	22.0	23.2 & 23.3	24.0	25.3	26.0	31.0	Actual	Estimate	Estimate
Type of Funding	**Reimbursement for Services Purchased within HHS**											
SSF	Service & Supply Fund				98,330		17,055,000			17,055,000	15,936,000	15,960,000
SSF	HHS Consolidated Acquisition System (HCAS) Operations and Maintenance						3,318,000			3,318,000	2,652,000	2,652,000
SSF	Unified Financial Management System (UFMS) Operations and Maintenance						5,896,000			5,896,000	5,735,000	5,735,000
SSF	UFMS Assessment and Upgrade (Under JFA as of FY 10)						0					
	Subtotal SSF	0	0	0	98,330	0	26,269,000	0	0	26,269,000	24,323,000	24,347,000
OS TAP	Audit Resolution						60,000			20,045	64,000	66,000
OS TAP	Web Communications						2,272,000			2,272,119	2,287,000	2,739,000
OS TAP	Web Crawler						6,000			6,000	6,000	6,000
OS TAP	Small Business Center						169,000			169,282	176,000	179,000
OS TAP	Tracking Accountability Government Grants System						122,000			121,810	194,000	178,000
OS TAP	Departmental Contract Information System						285,000			290,523	439,000	459,000
OS TAP	Acquisition Integration Modernization						259,000			259,000	259,000	227,000
OS TAP	High Performing Organizations and Competitive Sourcing Reporting						53,000			52,042	49,000	49,000
OS TAP	Commissioned Corps Force Management						7,611,000			427,929	7,121,000	7,239,000
OS TAP	Human Resource Services						2,495,000			2,619,350	2,034,000	2,034,000
OS TAP	HHS NET						649,000			641,199	399,000	406,000
OS TAP	HSPD-12						2,361,000			2,243,690	2,764,000	2,994,000
OS TAP	OGC Claims						398,000			286,650	406,000	413,000
OS TAP	EEO Investigations (new for non-psc in FY11)						373,000			359,458	283,000	283,000
OS TAP	EEO Services (new for non-psc in FY11)						0			0	6,000	6,000
OS TAP	Strategic Resourcing (new for non-psc in FY11)						65,000			64,738	64,000	95,000
	Subtotal Non-PSC	0	0	0	0	0	17,178,000	0	0	9,833,835	16,551,000	17,373,000
JFA	UFMS Assessment and Upgrade (under JFA as of FY 10)						1,543,043			1,543,043	2,275,238	2,275,238
JFA	Office of General Counsel	535,860	43,144	16		697	384,309	1,196	18,633	996,393	1,251,473	1,271,497
JFA	OGC Ethics Program						333,000			102,355	343,000	343,000
JFA	HSPD-12 Implementation						101,866			13,130	101,866	101,866
JFA	HCAS						0			0	0	0
JFA	HHS Enterprise						0			0	0	0
JFA *	Legislatively Mandated Initiatives and Emerging Technologies (formerly part of HHS Enterprise)						1,438,025			1,438,025	2,501,599	2,751,474
JFA	IT Access for the Disabled						0			0	0	0
JFA	Regional Health Administrators						308,010			308,010	388,999	388,999
JFA	Motor Vehicle Management Information System						8,000			8,000	8,400	8,400
JFA	Secretarial Protective Operations Staff						0			0	0	0
JFA	(Environmental) Compliance and Process Tracking System						0			0	0	0
JFA	Health Services Research Library						868,216			868,216	910,392	952,567
JFA	Office of Global Health Affairs						13,404			13,404	13,404	13,404
JFA *	CFO Financial Statement Audit						535,000			535,000	555,000	566,000
JFA *	Regions Together Initiative									0	0	0
JFA	Media Monitoring and Analysis						59,322			45,960	61,695	64,163
	Subtotal JFA Assessments	535,860	43,144	16	0	697	5,592,195	1,196	18,633	5,871,536	8,411,066	8,736,608
	Government-wide Administrative Functions											
JFA	Tri-Council (CFOC, CIOC, PEC)						59,898			59,898	60,737	61,708
JFA *	Government-wide E-Gov Initiatives (formerly part of HHS Enterprise)									342,023	351,866	351,866
JFA	Federal Employment Services						71,205			71,205	71,205	72,344
JFA	President's Council on Bioethics						22,800			22,800	22,800	22,800
	Subtotal, GAF	0	0	0	0	0	153,903	0	0	495,926	506,608	508,718
	Grand Total	535,860	43,144	16	98,330	697	49,193,098	1,196	18,633	42,470,297	49,791,674	50,965,326

* New

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

FY 2013 HHS Enterprise Information Technology and Government-Wide E-Gov Initiatives

OPDIV Allocation Statement:

The **IHS** will use **$880,952.00** of its **FY 2013** budget to support Department-wide enterprise information technology and government-wide E-Government initiatives. Operating Divisions help to finance specific HHS enterprise information technology programs and initiatives, identified through the HHS Information Technology Capital Planning and Investment Control process, and the government-wide E-Government initiatives. The HHS enterprise initiatives meet cross-functional criteria and are approved by the HHS IT Investment Review Board based on funding availability and business case benefits. Development is collaborative in nature and achieves HHS enterprise-wide goals that produce common technology, promote common standards, and enable data and system interoperability.

Of the amount specified above, **$271,518.00** is allocated to developmental government-wide E-Government initiatives for **FY 2013**. This amount supports these government-wide E-Government initiatives as follows:

FY 2013 Developmental E-Gov Initiatives*	
Line of Business - Human Resources	$29,783.00
Line of Business - Grants Management	$1,209.00
Line of Business - Financial	$18,064.00
Line of Business - Budget Formulation and Execution	$13,263.00
Disaster Assistance Improvement Plan	$12,208.00
Federal Health Architecture	$100,019.00
Integrated Acquisition Environment-Grants and Loans	$96,972.00
Line of Business - Geospatial	$0.00
FY 2013 Developmental E-Gov Initiatives Total	**$271,518.00**

* Specific levels presented here are subject to change, as redistributions to meet changes in resource demands are assessed.

Prospective benefits from these initiatives are:

Lines of Business-Human Resources Management: Provides standardized and interoperable HR solutions utilizing common core functionality to support the strategic management of Human Capital

Lines of Business-Grants Management: Supports end-to-end grants management activities promoting improved customer service; decision making; financial management processes; efficiency of reporting procedure; and, post-award closeout actions. The Administration for Children and Families (ACF), is a GMLOB consortia lead, which has allowed ACF to take on customers external to HHS. These additional agency users have allowed HHS to reduce overhead costs for internal HHS users. Additionally,

NIH is an internally HHS-designated Center of Excellence. This effort has allowed HHS agencies using the NIH system to reduce grants management costs. Both efforts have allowed HHS to achieve economies of scale and efficiencies, as well as streamlining and standardization of grants processes, thus reducing overall HHS costs for grants management systems and processes.

Lines of Business –Financial Management: Supports efficient and improved business performance while ensuring integrity in accountability, financial controls and mission effectiveness by enhancing process improvements; achieving cost savings; standardizing business processes and data models; promoting seamless data exchanges between Federal agencies; and, strengthening internal controls.

Lines of Business-Budget Formulation and Execution: Allows sharing across the Federal government of common budget formulation and execution practices and processes resulting in improved practices within HHS.

Disaster Assistance Improvement Plan (DAIP): The DAIP, managed by Department of Homeland Security, assists agencies with active disaster assistance programs such as HHS to reduce the burden on other federal agencies which routinely provide logistical help and other critical management or organizational support during disasters.

Lines of Business-Federal Health Architecture: Creates a consistent Federal framework that improves coordination and collaboration on national Health Information Technology (HIT) Solutions; improves efficiency, standardization, reliability and availability to improve the exchange of comprehensive health information solutions, including health care delivery; and, to provide appropriate patient access to improved health data. HHS works closely with federal partners, state, local and tribal governments, including clients, consultants, collaborators and stakeholders who benefit directly from common vocabularies and technology standards through increased information sharing, increased efficiency, decreased technical support burdens and decreased costs.

In addition, **$609,434.00** is allocated to ongoing government-wide E-Government initiatives for **FY 2013**. This amount supports these government-wide E-Government initiatives as follows:

FY 2013 Ongoing E-Gov Initiatives*	
E-Rule Making	$11,912.00
GovBenefits	$37,339.00
Integrated Acquisition Environment	$469,986.00
Grants.gov	$90,197.00
FY 2013 Ongoing E-Gov Initiatives Total	**$609,434.00**

* Specific levels presented here are subject to change, as redistributions to meet changes in resource demands are assessed.

FY 2012 House Report No. 112-151 (July 19, 2011)

Dental Health -- The Committee understands that two of the four top leadership positions within the Division of Oral Health, including the Director's position, are vacant. An additional dentist is on detail outside of the Division. The Committee is concerned about the vacancies because the lack of staff undermines recent recruitment gains of dentists. The Committee urges the Service to fill the vacancies expeditiously. (p. 98)

Action taken or to be taken
The Division of Oral Health Director position is a priority position to be filled as soon as possible in 2012. Recruitment was delayed on this position in 2011 in part due to IHS budget uncertainties, and turnover in Headquarters program management positions that support and accomplish national workforce recruitment. The Dental Leadership position descriptions have been revised to more accurately reflect national oversight and tribal management support roles. Recent improvements in the IHS human resource hiring systems will more likely result in quality candidates from which to make a permanent selection in the next 3 months.

Contract Support Costs -- The Committee recommends $573,761,000 for contract support costs, $176,068,000 above the fiscal year 2011 enacted level and $111,924,000 above the budget request. Two recent court cases found that the Bureau of Indian Affairs was legally obligated to pay the full amount of all contract support costs that it had contractually agreed with Indian tribes to pay, and limitations on the overall contract support cost appropriation does not overcome the Bureau's obligation to pay said costs. The Committee believes that both the Bureau and the Indian Health Service should pay all contract support costs for which it has contractually agreed and directs the Service to include the full cost of the contract support obligations in its fiscal year 2013 budget submission. (p. 98)

Action taken or to be taken
The United States has appealed the issue of contract support costs (CSC) obligations to the Supreme Court in the case of *Salazar v. Ramah Navajo Chapter*. The Supreme Court has agreed to review the decision of the Tenth Circuit Court of Appeals, which held that the government is liable for 100% of the CSC incurred by Indian tribes under their contracts with the Bureau of Indian Affairs (BIA), even though the appropriations authorized by Congress for CSC are insufficient to fund the full costs of all contracting tribes. The Supreme Court's decision, which is likely to be issued by July 2012, is expected to resolve the issue for both BIA and the Indian Health Service (IHS). Contrary to the Tenth Circuit's decision, the Federal Circuit Court of Appeals ruled in favor of IHS on this issue, holding that express limitations in the annual appropriations acts limit the government's obligation to fund CSC to the amounts appropriated in the acts. *Arctic Slope Native Ass'n Ltd. v. Sebelius*, 629 F.3d 1296 (Fed. Cir. 2010). The Supreme Court has agreed to review the issue, in part, to resolve the split between the courts of appeals. Because the Supreme Court is considering the matter, IHS will submit its fiscal year 2013 budget using the same approach as in prior years.

IHS Construction Backlog -- The Committee notes that joint venture programs have been proven successful as a means of reducing the IHS construction backlog, for example, at the Carl Albert Hospital in Ada, Oklahoma. The Committee is encouraged by the success of this project and urges the IHS to use this project as a model for future joint venture programs. Furthermore, the Committee directs the Service

to provide thorough outreach to tribal governments encouraging them to develop joint venture initiatives for the construction of IHS projects. (p. 99)

Action taken or to be taken

In the 10 years the Joint Venture Construction Program (JVCP) has been in operation IHS and Tribes have successfully completed seven outpatient health centers and one inpatient hospital, have six facilities currently under construction and two facilities under design pending start of construction. The JVCP has consistently received strong Tribal support based upon the 55 responses to the FY 2009 congressionally directed solicitation for the JVCP FY 2010-2012 cycle. Of the seven priority applicants notified of acceptance into the JVCP in FY2010 and FY2011, six have signed agreements and the seventh is finalizing the planning documents. The remaining three applicants (FY2012 announcements) of the top 10 in the current cycle will be soon notified to initiate planning for these highly ranked JVCP health facilities construction projects. IHS will continue to work in partnership with Tribes participating in the JVCP to estimate completion dates and will request funding for staffing packages in our budget submissions to Congress.

Department of Health & Human Services
Indian Health Service
Number of Service Units and Facilities
Operated by IHS and Tribes, October 1, 2011

Type of Facility	TOTAL	IHS Total	TRIBAL Total	Title I [a]	Title V [b]	Other [c]
Service Units	**157**	63	94	44	50	0
Hospitals	**45**	29	16	1	15	0
Ambulatory	**607**	**109**	498	116	376	6
Health Centers	320	66	254	78	176	0
School Health Centers	6	2	4	2	2	0
Health Stations	115	41	74	22	52	0
Alaska Village Clinics	166	0	166	14	146	6

[a] Operated under P.L. 93-638, Self Determination Contracts

[b] Operated under P.L. 106-260, Tribal Self-Governance Amendment of 2000

[c] Operated by a local government, not a tribe, for some Alaska Native villages through a standard procurement contract

Indian Health Service
Summary of Inpatient Admissions and Outpatient Visits
Federal and Tribal
FY 2009 Data

Direct Care Admissions

	IHS	Tribal	TOTAL
TOTAL	**27,214**	**23,145**	**50,359**
Aberdeen	3,556		3,556
Alaska		11,674	11,674
Albuquerque	1,436		1,436
Bemidji	409		409
Billings	1,835		1,835
California			*
Nashville		1,253	1,253
Navajo	12,693	3,265	15,958
Oklahoma	1,540	6,731	8,271
Phoenix	5,116	222	5,338
Portland			*
Tucson	629		629

* No direct inpatient facilities in FY 2009

Direct Care Outpatient Visits

	IHS	Tribal	TOTAL
TOTAL	**4,877,082**	**6,901,445**	**11,778,527**
Aberdeen	784,207	96,252	880,459
Alaska	**	1,557,191	1,557,191
Albuquerque	492,727	84,349	577,076
Bemidji	262,472	664,080	926,552
Billings	495,373	120,608	615,981
California	**	505,158	505,158
Nashville	10,128	457,106	467,234
Navajo	1,109,611	442,024	1,551,635
Oklahoma	515,161	1,968,943	2,484,104
Phoenix	789,168	416,792	1,205,960
Portland	278,337	523,075	801,412
Tucson	139,898	65,867	205,765

** No IHS facilities in FY 2009

INDIAN HEALTH SERVICE
Immunization Expenditures

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request	FY 2013 +/- FY 2012
Infants and Children	$12,903,354	$12,903,354	$13,329,165	+$425,811
Adults 65+	$1,786,625	$1,786,625	$1,845,584	+$58,959
HPV vaccine Female 19-26 years))	$9,088,511	$9,088,511	$9,388,432	+$299,921
Adult 19 – 64 years influenza			$3,210,800	$3,210,800
Monitoring	$106,914	$106,914	$110,442	+$3,528
Total:	$23,885,404	$23,885,404	$27,884,423	+$3,999,018

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

The Indian Health Service (IHS) patient care data system does not calculate itemized costs for the treatment of various conditions. Therefore, an indirect method was used for calculating immunization costs based on an estimated patient population and the amount of staff time for required immunizations, as well as the immunization costs not available through the Vaccines for Children program.

Immunization costs were categorized by age groups; infants and children (3 to 27 months of age), and adults ≥ 65 years of age. In addition costs for two specific vaccines – HPV and influenza - were included for two age groups, as well as an estimate of monitoring costs.

By combining these two groups, an estimate of $10,540,043 was calculated for the IHS immunization expenditures in FY 2004 with inflation costs added into the equation. Since then, costs have been iterated using inflation rates and the addition of new expenses, such as the introduction of a new vaccine:

FY 2009 Estimated Costs = FY 2008 cost times 3.8 percent
FY 2010 Estimated Costs = FY 2009 cost times 3.0 percent
FY 2011 Estimated Costs = FY 2010 CR
FY 2012 Estimated Costs = FY 2011 cost times 3.3 percent

For FY 2012, $3,210,800 was added for adult (19 – 64 year old) flu vaccination. The total cost does not include inflation, which may affect future estimated costs. The methodology was calculated based on the following assumptions:

1. 50% coverage of the 19 – 64 year old population (~ 401,349)
2. Cost of a dose of influenza vaccine at $8.00.

Overall, the estimated costs for these immunizations are affected by:

1. Individuals outside these target groups are regular recipients of immunizations (e.g., HBg and influenza 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. There is not a methodology to estimate indirect costs or administrative overhead associated with the administration of immunizations, or operation of the immunization program.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Drug Control Budget
FY 2013

RESOURCE SUMMARY

	Budget Authority (in Millions)		
	FY 2011 Enacted	**FY 2012 Enacted**	**FY 2013 Request**
Drug Resources by Function			
Prevention	18.755	18.736	18.801
Treatment	77.277	77.403	77.972
Construction	0.000	1.997	0.000
Total Drug Resources by Function	**$96.032**	**$98.136**	**$96.773**
Drug Resources by Decision Unit			
Alcohol and Substance Abuse	91.628	91.566	92.023
Urban Indian Health Program	4.403	4.573	4.750
Facilities Construction	0.000	1.997	0.000
Total Drug Resources by Decision Unit	**$96.032**	**$98.136**	**$96.773**
Drug Resources Personnel Summary			
Total FTEs (direct only)	171	171	171
Drug Resources as a Percent of Budget			
Agency Budget	$ 5,140.234	$ 5,385.744	$5,501.693
Drug Resources Percentage	1.87%	1.82%	1.76%

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.

BUDGET

In FY 2013, IHS requests $96.8 million for its drug control activities. This is $1.4 million less than the FY 2012 Enacted Level.

Alcohol and Substance Abuse
Total FY 2013 Request: $195.4 million
The FY 2013 request includes an increase in current services to support the Alcohol and Substance Abuse Program projected staffing needs in FY 2013. The program will continue to support the Methamphetamine and Suicide Prevention Initiative and substance abuse prevention and treatment initiatives.

Urban Indian Health Program – Alcohol and Substance Abuse Title V Grants
Total FY 2013 Request: $42.9 million
The FY 2013 request includes funding for the Urban Indian Health Program which will be used to continue serving urban American Indians and Alaska Natives 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 (VHA) programs and several have identified joint alcohol and substance abuse initiatives.

ONDCP FUNDING PRIORITIES
In FY 2013, the IHS budget request for its drug control activities supports the Office of National Drug Control Policy's (ONDCP) funding priorities as well as Chapter 3 of the National Drug Control Strategy Integrate Treatment for Substance Use Disorders into Health Care and Expand Support for Recovery: 3.1.B: Increase Addiction Treatment Services Within the Indian Health Service and the Prescription Drug Abuse Prevention Plan, "Epidemic: Responding to America's Prescription Drug Abuse Crisis."

The Prescription Drug Abuse Prevention Plan expands upon the Administration's National Drug Control Strategy which offers a valuable opportunity for IHS to advance its mission by strengthening existing programs to control and reduce substance abuse and eliminate its deleterious effects on the health and safety of AI/AN patients and communities.

In FY 2013, IHS will continue to serve AI/ANs impacted by substance abuse and dependence through its Youth Regional Treatment Centers (YRTCs) and other Federally- and Tribally-operated substance abuse treatment and prevention programs. In addition to those direct services, the IHS Methamphetamine and Suicide Prevention Initiative (MSPI) is a nationally-coordinated demonstration pilot program, focusing on providing targeted methamphetamine and suicide prevention and intervention resources to communities in Indian Country with the greatest need for these programs. There is mutual development and implementation of the MSPI project with Tribes, Tribal programs, and other Federal agencies which now provides support to 127 IHS, Tribal, and Urban Indian health programs nationally. The strategic goal is to support Tribal programs in their prevention, treatment, and infrastructure development as they increasingly are delivering their own services. These programs represent an innovative partnership with IHS to deliver services by and for the communities themselves, with a national support network for ongoing program development and evaluation.

Substance abuse and dependence in all of its forms continue to rank high on the concern list of the Tribal partners. IHS believes that a shift in emphasis to earlier intervention is required to be successful in reducing the consequences of substance abuse and dependence. IHS proposes focusing on intervention earlier with younger high risk and hazardous users and preventing further progression by recognizing and responding to the sequelae of the abuse. IHS promotes expanded health care services such as mental and behavioral health treatment and prevention by

providing training on substance use disorders to IHS, Tribal, and Urban Indian health programs at annual conferences, meetings, and webinars. Continuing Medical Education (CMEs) and Continuing Education Credits (CEUs) are offered in these training opportunities provided to primary care providers with a special focus on emergency clinics and on women and families.

Data from the 2009 National Survey on Drug Use and Health show that the AI/AN population leads all other ethnic groups in past 30-day misuse of prescription-type drugs. In response, IHS has developed and established a number of initiatives to curb substance abuse and dependence. For example, ONDCP has been working with IHS in selected states to share prescription drug information with state prescription drug monitoring programs (PDMPs). IHS has partnered with the North Dakota PDMP and secured $100,000 for the programming required to transmit data to states utilizing the American Society for Automation in Pharmacy versions 4.0 and 4.1 export formats. The resulting agreement included the initialization, testing, troubleshooting, and institution of routine reporting to state PDMPs for all Federal sites within the states of North Dakota, South Dakota, and Minnesota. Because South Dakota does not have a functioning PDMP, IHS facilities in South Dakota are reporting to the North Dakota PDMP. IHS has partnered with the Bureau of Justice Assistance and secured an additional $35,000 to program the three remaining programming solutions: ASAP 1995; ASAP 2005; and version 3.0. These partnerships will bring all IHS facilities operating in states with functioning PDMPs into reporting compliance along with those Tribal and Urban Indian health programs likely to utilize IHS reporting systems by June 1, 2013.

PERFORMANCE

Introduction

This section on the FY 2011 performance of the drug control portion of the IHS Alcohol and Substance Abuse Program is based on agency GPRA documents. IHS has added two program measures to report on the effectiveness of IHS programs that focus on drug abuse. The IHS Alcohol and Substance Abuse Program provides anti-drug abuse activities to raise community awareness and target high-risk groups in addition to educating staff on issues and skills related to substance abuse.

The measures reported in the table provide targets and results from both Tribally-Operated Health Programs and Federally-Administered Health Programs. Currently, Tribally-Operated Health Programs have 17 measures, including alcohol- and health- related performance indicators.

IHS Alcohol and Substance Abuse Program		
Selected Measures of Performance	FY 2011 Target	FY 2011 Achieved
Alcohol-use screening among appropriate female patients	56.1%	57.8%
Accreditation rate for Youth Regional Treatment Centers*	100%	91%
Report on number of Emergency Department patients who receive Substance Use Disorder (SUD) intervention	Baseline	39,496
Report on # SUD services in primary care clinics	Baseline	100,266

* In operation 18 months or more.

Discussion

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

rates of FAS are higher among AI/ANs than the general population. Screening with intervention has been shown to be effective in reducing alcohol misuse in pregnancy and to reduce the incidence of FAS.

The percent of appropriate female patients screened for alcohol-use (fetal alcohol syndrome prevention) was 57.8 percent in FY 2011 which exceeded the FY 2011 performance target. In FY 2012, the target is 58.7 percent for the proportion of women screened for alcohol to prevent FAS. This measure has seen significant increases in results due to increased provider awareness, and an agency emphasis on behavioral health screening.

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. Although the measure improved from 81 percent in FY2010 to 91 percent in FY 2011, the target measure of 100 percent was not met in FY 2011. This was the result of ongoing internal infrastructure challenges with one YRTC program. The program has taken corrective action and is currently scheduled for their CARF site visit in 2012. The FY 2012 performance target for the YRTCs is therefore 100% accreditation certification status.

The IHS provides several training opportunities annually on alcohol and substance abuse issues for its providers at the Advances in Indian Health, Comprehensive Updates in Substance Abuse and Dependence, and National Behavioral Health Conference. The Comprehensive Updates in Substance Abuse and Dependence course is provided twice a year to IHS, Tribal, and Urban Indian primary care providers to enhance professional skills in addiction prevention, intervention, and treatment. The program includes a section on prevention, recognition, and treatment of opioid dependence. The IHS has also hosted over 50 Train-The-Trainer sessions for over 1,000 attendees, and distributed the Alcohol Screening and Brief Intervention (ASBI) Operations Manual and Yale Brief Negotiated interview DVD to over 500 health care facilities. IHS, along with SAMHSA and the Bureau of Indian Affairs and the Bureau of Indian Education, co-sponsored the 2011 Action Summit for Suicide Prevention. The Summit included workshop tracks that offered training to the 800 attendees on methamphetamine enforcement and intervention, clandestine laboratory identification and safety issues, substance abuse and co-occurring disorders and community-based intervention, and drug treatment and wellness courts.

IHS has historically had a problem with obtaining treatment for adult patients in rural and remote areas. Office Based Opioid Therapy (OBOT) has dramatically changed this treatment obstacle. Now many of IHS facilities can provide treatment to patients on-site. From 2002 through 2011, the IHS has provided 29 trainings for OBOT. To date, IHS has trained 200 physicians, and 200 midlevel practitioners in the use of buprenorphine to help deal with this increasing trend. The coursework in these training sessions can be applied to the educational requirements needed to apply for a SAMHSA Drug Abuse Treatment Act (DATA) 2000 waiver. This has fundamentally changed the way IHS practitioners view the problem and interact with AI/AN patients.

To address prescription drug abuse, IHS convened a multidisciplinary pain management taskforce charged with studying the use and abuse of IHS prescribed opioids. The taskforce has developed guidance for IHS facilities, a draft national IHS pain management policy, and is developing web based tools for local facility use. The policy has been completed and is now going through the IHS approval process. The policy describes system controls that must be in place at the IHS Area and facility levels, requires the signing of a pain agreement between the prescriber and the patient, defines what should be done if the agreement is broken, requires urine drug testing and medication counts, mandates a local Chronic Pain Management Review Committee, and

empowers the prescriber to enforce the agreements. The policy requires IHS facilities to join State-operated PDMPs to monitor patients visiting multiple providers. IHS has created an exception to the Health Insurance Portability and Accountability Act (HIPAA) rules to allow IHS to report to PDMPs.

IHS is collaborating with other agencies working in the field of substance disorders such as SAMHSA, VHA, National Institues of Health (NIH), Health Resources and Services Administration (HRSA), and Centers for Medicare and Medicaid Services (CMS) to ensure that the best available information, training, protocols, evaluations, performance measures, and data needs and management skills are incorporated and shared with all agencies and organizations working on substance disorders.

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

Indian Health Service
Indian Self Determination

Indian Health Service Philosophy -- The Indian Health Service (IHS) implements the Indian Self-Determination and Education Assistance Act (ISDEAA), Public Law Number (Pub. L. No.) 93-638, as amended, which recognizes the unique legal and political relationship between the United States and American Indian and Alaska Native peoples. Accordingly, the IHS supports Tribal sovereignty (1) by assisting Tribes in exercising their right to administer IHS health programs, or portions thereof, and (2) by continuing to directly provide services to Tribes that choose the IHS as their health care provider. A Tribal decision to enter or not enter into ISDEAA agreements are equal expressions of self-determination.

Title I Contracts and Title V Self-Governance Compacts – Titles I and V of the ISDEAA provide Tribes the option to exercise the right to self-determination by assuming control and management of programs previously administered by the federal government. Since 1992, the IHS has entered into agreements with Tribes and Tribal organizations to plan, conduct, and administer programs authorized under Section 102 of the Act. Today, approximately $2.5 billion of the Agency's appropriation is under Tribal health administration through Title I contracts and Title V compacts. The IHS and Tribes have entered 232 Title I contracts and Annual Funding Agreements. Under Title V, the IHS is a party to 82 compacts and 107 funding agreements; the Title V program constitutes $1.3 million or 33.2 percent of the IHS budget, and 59.6 percent of federally-recognized Tribes.

IHS and Tribally-Operated Service Unit and Medical Facilities – In recent years, the amount of funding administered under ISDEAA contracts and compacts has nearly doubled with a corresponding increase in services provided and managed by Tribal programs. Tribes have traditionally assumed control of community services, later expanding into providing medical care. For example, Tribes operate nearly all of the Community Health Representative Program and community-based alcohol programs. In addition, the number of Tribally-operated hospitals has increased to over 36 percent of the hospitals funded by IHS. With the increase of ambulatory medical facilities, Tribes continue to expand their provision of health care.

Self-Determination Implementation: Contract Support Cost (CSC) Funding –The 1975 Indian Self-Determination and Education Assistance Act (ISDEAA), Pub. L. 93-638, gave Indian Tribes the authority to contract with the Federal government to operate programs serving their tribal members and other eligible persons and to receive not less than the amount of program funding that the Secretary would have otherwise provided for the direct operation of the program. The Act was further amended; the 1988 amendments identified Contract Support Costs (CSC) and provided that CSC be added to the program amount. CSC are defined as reasonable costs for activities that Tribes and Tribal Organizations must carry out but that the Secretary either did not carry out in her direct operation of the program or provided from resources other than those under contract.

The demand for CSC funding has increased because of the new and expanded programs, services, functions, or activities assumed by Tribes and Tribal organizations under both Titles I and V of the ISDEAA. Tribes and Tribal organizations use this funding to increase their Tribal capacity to professionally manage ISDEAA agreements and the corresponding services in their communities.

Indian Health Service
Self Governance Funded Compacts FY 2011

Compacts by State	IHS Services	IHS Facilities	Contract Support Costs Direct	Contract Support Costs Indirect	Total
Alabama	**$4,019,000**	**$218,000**	**$130,000**	**$648,000**	**$5,015,000**
Poarch Band of Creek Indians	$4,019,000	$218,000	$130,000	$648,000	$5,015,000
Alaska	**$412,460,000**	**$30,871,000**	**$33,409,000**	**$91,664,000**	**$568,404,000**
Alaska Native Tribal Health Consortium	$106,650,000	$20,169,000	$8,958,000	$9,393,000	$145,170,000
Aleutian Pribilof Islands Association, Inc.	$3,377,000	$795,000	$340,000	$1,031,000	$5,543,000
Arctic Slope Native Association	$8,250,000	$70,000	$1,175,000	$2,611,000	$12,106,000
Bristol Bay Area Health Corporation	$22,379,000	$957,000	$2,016,000	$6,933,000	$32,285,000
Chickaloon Native Village	$53,000	$1,000	$10,000	$7,000	$71,000
Chugachmiut	$3,613,000	$82,000	$188,000	$1,579,000	$5,462,000
Copper River Native Association	$2,242,000	$31,000	$207,000	$502,000	$2,982,000
Council of Athabascan Tribal Governments	$1,999,000	$100,000	$69,000	$1,013,000	$3,181,000
Eastern Aleutian Tribes, Inc.	$3,183,000	$25,000	$149,000	$1,148,000	$4,505,000
Kenalitze Indian Tribe	$2,173,000	$5,000	$198,000	$330,000	$2,706,000
Ketchikan Indian Community	$6,801,000	$0	$867,000	$2,508,000	$10,176,000
Knik Traditional Council	$65,000	$1,000	$9,000	$9,000	$84,000
Kodiak Area Native Association	$7,155,000	$91,000	$383,000	$1,326,000	$8,955,000
Maniilaq Association	$27,801,000	$948,000	$2,374,000	$10,585,000	$41,708,000
Metlakatla Indian Community	$6,257,000	$954,000	$400,000	$734,000	$8,345,000
Mount Sanford Tribal Consortium	$789,000	$1,000	$69,000	$183,000	$1,042,000
Native Village of Eklutna	$183,000	$1,000	$5,000	$19,000	$208,000
Native Village of Eyak	$763,000	$18,000	$40,000	$0	$821,000
Norton Sound Health Corporation	$22,717,000	$762,000	$1,697,000	$4,365,000	$29,541,000
Seldovia Village Tribe	$1,709,000	$37,000	$65,000	$489,000	$2,300,000
Southcentral Foundation	$66,127,000	$1,558,000	$4,558,000	$18,964,000	$91,207,000
SouthEast Alaska Regional Health Corporation	$39,125,000	$1,467,000	$3,007,000	$7,264,000	$50,863,000
Tanana Chiefs Conference	$32,133,000	$702,000	$1,679,000	$5,204,000	$39,718,000
Yakutat Tlingit Tribe	$320,000	$3,000	$26,000	$81,000	$430,000
Yukon-Kuskokwim Health Corporation	$46,596,000	$2,093,000	$4,920,000	$15,386,000	$68,995,000
Arizona	**$55,283,000**	**$5,791,000**	**$2,178,000**	**$7,883,000**	**$71,135,000**
Gila River Indian Community	$36,106,000	$4,579,000	$1,508,000	$4,442,000	$46,635,000
Tuba City Health Regional Care Corporation	$12,906,000	$854,000	$572,000	$2,557,000	$16,889,000
Winslow Indian Health Care Center, Inc.	$6,271,000	$358,000	$98,000	$884,000	$7,611,000
California	**$58,306,000**	**$2,499,000**	**$2,199,000**	**$16,271,000**	**$79,275,000**
Consolidated Tribal Health Project, Inc.	$4,307,000	$279,000	$90,000	$1,420,000	$6,096,000
Feather River Tribal Health, Inc.	$5,482,000	$196,000	$140,000	$818,000	$6,636,000
Hoopa Valley Tribe	$5,088,000	$244,000	$224,000	$975,000	$6,531,000
Indian Health Council, Inc.	$8,592,000	$477,000	$236,000	$2,515,000	$11,820,000
Karuk Tribe of California	$2,921,000	$232,000	$81,000	$1,166,000	$4,400,000
Northern Valley Indian Health, Inc.	$2,861,000	$401,000	$61,000	$532,000	$3,855,000
Redding Rancheria	$6,576,000	$119,000	$490,000	$2,416,000	$9,601,000
Riverside-San Bernardino County Indian Health, Inc.	$20,827,000	$471,000	$742,000	$5,863,000	$27,903,000
Susanville Indian Rancheria	$1,652,000	$80,000	$135,000	$566,000	$2,433,000
Connecticut	**$2,475,000**	**$33,000**	**$0**	**$31,000**	**$2,539,000**
Mohegan Tribe of Indians of Connecticut	$2,475,000	$33,000	$0	$31,000	$2,539,000
Florida	**$8,285,000**	**$497,000**	**$218,000**	**$1,069,000**	**$10,069,000**
Seminole Tribe of Florida	$8,285,000	$497,000	$218,000	$1,069,000	$10,069,000
Kansas	**$2,602,000**	**$100,000**	**$5,000**	**$233,000**	**$2,940,000**
Prairie Band of Potawatomi Nation	$2,602,000	$100,000	$5,000	$233,000	$2,940,000
Idaho	**$15,148,000**	**$1,063,000**	**$1,060,000**	**$1,985,000**	**$19,256,000**
Coeur D'Alene Tribe	$5,907,000	$326,000	$630,000	$1,017,000	$7,880,000
Kootenai Tribe of Idaho	$622,000	$33,000	$60,000	$58,000	$773,000
Nez Perce Tribe	$8,619,000	$704,000	$370,000	$910,000	$10,603,000
Louisana	**$1,220,000**	**$94,000**	**$97,000**	**$118,000**	**$1,529,000**
Chitimacha Tribe of Louisana	$1,220,000	$94,000	$97,000	$118,000	$1,529,000
Maine	**$3,279,000**	**$221,000**	**$143,000**	**$701,000**	**$4,344,000**
Penobscot Indian Nation	$3,279,000	$221,000	$143,000	$701,000	$4,344,000
Massachusetts	**$753,000**	**$75,000**	**$178,000**	**$217,000**	**$1,223,000**
Wampanoag Tribe of Gay Head	$753,000	$75,000	$178,000	$217,000	$1,223,000
Michigan	**$24,906,000**	**$1,265,000**	**$1,401,000**	**$2,817,000**	**$30,389,000**
Grand Traverse Band of Ottawa and Chippewa Indians	$2,929,000	$197,000	$55,000	$449,000	$3,630,000
Keweenaw Bay Indian Community	$3,239,000	$295,000	$466,000	$578,000	$4,578,000
Little River Band of Ottawa Indians	$1,972,000	$119,000	$214,000	$349,000	$2,654,000
Sault Ste. Marie Tribe of Chippewa Indians	$16,766,000	$654,000	$666,000	$1,441,000	$19,527,000
Minnesota	**$20,535,000**	**$1,187,000**	**$2,142,000**	**$1,400,000**	**$25,264,000**
Bois Forte Band of Chippewa Indians	$2,756,000	$260,000	$66,000	$474,000	$3,556,000
Fond du Lac Band of Lake Superior Chippewa	$11,849,000	$569,000	$1,038,000	$443,000	$13,899,000
Mille Lacs Band of Ojibwe	$4,234,000	$297,000	$1,023,000	$283,000	$5,837,000
Shakopee Mdewakanton Sioux Community	$1,696,000	$61,000	$15,000	$200,000	$1,972,000
Mississippi	**$17,147,000**	**$1,056,000**	**$1,059,000**	**$1,776,000**	**$21,038,000**
Mississippi Band of Choctaw Indians	$17,147,000	$1,056,000	$1,059,000	$1,776,000	$21,038,000

Compacts by State	IHS Services	IHS Facilities	Contract Support Costs Direct	Contract Support Costs Indirect	Total
Montana	**$21,661,000**	**$1,330,000**	**$1,642,000**	**$3,296,000**	**$27,929,000**
Chippewa Cree Tribe of the Rocky Boy's Reservation	$11,128,000	$713,000	$941,000	$2,092,000	$14,874,000
Confederated Salish and Kootenai Tribes of Flathead	$10,533,000	$617,000	$701,000	$1,204,000	$13,055,000
Nevada	**$20,305,000**	**$968,000**	**$1,273,000**	**$3,485,000**	**$26,031,000**
Duck Valley Shoshone-Paiute Tribe	$6,894,000	$465,000	$661,000	$1,583,000	$9,603,000
Duckwater Shoshone Tribe	$1,053,000	$32,000	$166,000	$757,000	$2,008,000
Ely Shoshone Tribe	$1,269,000	$20,000	$49,000	$260,000	$1,598,000
Las Vegas Paiute Tribe	$4,049,000	$144,000	$109,000	$251,000	$4,553,000
Washoe Tribe of Nevada and California	$5,082,000	$193,000	$202,000	$303,000	$5,780,000
Yerington Paiute Tribe of Nevada	$1,958,000	$114,000	$86,000	$331,000	$2,489,000
New Mexico	**$10,376,000**	**$664,000**	**$554,000**	**$704,000**	**$12,298,000**
Pueblo of Jemez	$3,930,000	$203,000	$354,000	$390,000	$4,877,000
Pueblo of Sandia	$2,066,000	$130,000	$31,000	$89,000	$2,316,000
Taos Pueblo	$4,380,000	$331,000	$169,000	$225,000	$5,105,000
New York	**$7,842,000**	**$328,000**	**$203,000**	**$728,000**	**$9,101,000**
St. Regis Mohawk Tribe	$7,842,000	$328,000	$203,000	$728,000	$9,101,000
North Carolina	**$21,112,000**	**$1,473,000**	**$855,000**	**$3,357,000**	**$26,797,000**
Eastern Band of Cherokee Indians	$21,112,000	$1,473,000	$855,000	$3,357,000	$26,797,000
Oklahoma	**$325,950,660**	**$27,804,340**	**$20,592,000**	**$39,684,000**	**$414,031,000**
Absentee Shawnee Tribe of Oklahoma	$8,246,000	$1,217,000	$751,000	$994,000	$11,208,000
Cherokee Nation	$109,611,000	$9,902,000	$4,592,000	$12,356,000	$136,461,000
Chickasaw Nation	$63,843,000	$8,453,000	$7,364,000	$10,097,000	$89,757,000
Choctaw Nation of Oklahoma	$60,004,000	$4,887,000	$5,385,000	$6,884,000	$77,160,000
Citizen Potawatomi Nation	$13,677,660	$374,340	$699,000	$2,766,000	$17,517,000
Kaw Nation	$1,371,000	$86,000	$181,000	$231,000	$1,869,000
Kickapoo Tribe of Oklahoma	$7,718,000	$100,000	$139,000	$870,000	$8,827,000
Modoc Tribe of Oklahoma	$51,000	$59,000	$4,000	$16,000	$130,000
Muscogee (Creek) Nation	$41,398,000	$1,685,000	$1,051,000	$3,507,000	$47,641,000
Northeastern Tribal Health System	$7,119,000	$861,000	$134,000	$814,000	$8,928,000
Ponca Tribe of Oklahoma	$3,714,000	$62,000	$142,000	$392,000	$4,310,000
Sac and Fox Nation	$7,348,000	$69,000	$116,000	$467,000	$8,000,000
Wyandotte Nation	$1,850,000	$49,000	$34,000	$290,000	$2,223,000
Oregon	**$24,533,000**	**$1,154,000**	**$2,244,000**	**$7,149,000**	**$35,080,000**
Confederated Tribes of Coos, Lower Umpqua and Siuslaw Indians of Oregon	$1,668,000	$80,000	$258,000	$522,000	$2,528,000
Confederated Tribes of Grand Ronde	$6,498,000	$290,000	$478,000	$2,371,000	$9,637,000
Confederated Tribes of Siletz Indians of Oregon	$7,731,000	$209,000	$655,000	$1,804,000	$10,399,000
Confederated Tribes of the Umatilla Reservation	$6,714,000	$473,000	$648,000	$1,625,000	$9,460,000
Coquille Indian Tribe	$1,922,000	$102,000	$205,000	$827,000	$3,056,000
Utah	**$297,000**	**$23,000**	**$8,000**	**$0**	**$328,000**
Utah Navajo Health System, Inc.	$297,000	$23,000	$8,000	$0	$328,000
Washington	**$52,687,000**	**$3,434,000**	**$2,399,000**	**$11,047,000**	**$69,567,000**
Cowlitz Indian Tribe	$2,543,000	$86,000	$17,000	$342,000	$2,988,000
Jamestown S'Klallam Indian Tribe	$925,000	$61,000	$81,000	$284,000	$1,351,000
Kalispel Tribe of Indians	$990,000	$73,000	$19,000	$60,000	$1,142,000
Lower Elwha Klallam Tribe	$1,781,000	$97,000	$95,000	$312,000	$2,285,000
Lummi Indian Nation	$8,248,000	$576,000	$228,000	$1,708,000	$10,760,000
Makah Indian Tribe	$3,800,000	$372,000	$265,000	$921,000	$5,358,000
Muckleshoot Indian Tribe	$6,694,000	$285,000	$168,000	$0	$7,147,000
Nisqually Indian Tribe	$2,298,000	$144,000	$102,000	$566,000	$3,110,000
Port Gamble S'Klallam Tribe	$2,403,000	$135,000	$126,000	$659,000	$3,323,000
Quinault Indian Nation	$5,559,000	$414,000	$171,000	$1,696,000	$7,840,000
Shoalwater Bay Indian Tribe	$1,831,000	$36,000	$259,000	$696,000	$2,822,000
Skokomish Indian Tribe	$2,012,000	$152,000	$103,000	$478,000	$2,745,000
Squaxin Island Indian Tribe	$2,892,000	$166,000	$182,000	$912,000	$4,152,000
Suquamish Tribe	$1,595,000	$58,000	$137,000	$521,000	$2,311,000
Swinomish Indian Tribal Community	$2,183,000	$157,000	$153,000	$704,000	$3,197,000
Tulalip Tribes of Washington	$6,933,000	$622,000	$293,000	$1,188,000	$9,036,000
Wisconsin	**$24,799,000**	**$1,276,000**	**$1,024,000**	**$1,313,000**	**$28,412,000**
Forest County Potawatomi Community	$2,268,000	$204,000	$332,000	$333,000	$3,137,000
Oneida Tribe of Indians of Wisconsin	$19,217,000	$821,000	$273,000	$673,000	$20,984,000
Stockbridge-Munsee Community	$3,314,000	$251,000	$419,000	$307,000	$4,291,000
Grand Total	**$1,135,683,660**	**$83,401,340**	**$75,005,000**	**$197,576,000**	**$1,491,666,000**

Indian Health Service
FY 2011 Self-Governance Funding Agreements
By Area

Area	Program Tribal Shares	Area Tribal Shares	Headqtrs Tribal Shares	Contract Support Costs (Direct)	Contract Support Costs (Indirect)	Total
Alaska	417,830,000	13,877,000	10,846,000	33,803,000	92,048,000	568,404,000
Aberdeen	152,000	128,000				280,000
Albuquerque	8,844,000	1,713,000	482000	554000	705000	12,298,000
Bemidji	68,688,000	3,230,000	2,050,000	4,566,000	5,531,000	84,065,000
Billings	19,561,000	1,955,000	1,475,000	1,642,000	3,296,000	27,929,000
California	54,931,000	3,576,000	2,300,000	2,198,000	16,270,000	79,275,000
Nashville	61,956,000	6,044,000	2,125,000	2,884,000	8,646,000	81,655,000
Navajo	19,015,000	995,000	699,000	678,000	3,441,000	24,828,000
Oklahoma	330,980,000	12,706,000	12,772,000	20,596,000	39,917,000	416,971,000
Phoenix	58,714,000	1,707,000	1,537,000	2,782,000	7,926,000	72,666,000
Portland	88,559,000	6,269,000	3,333,000	5,652,000	20,090,000	123,903,000
Total, IHS	1,129,230,000	52,200,000	37,619,000	75,355,000	197,870,000	1,492,274,000