2120 L Street, NW, Suite 700
Washington, DC 20037

T 202.822.8282
F 202.296.8834

HOBBSSTRAUS.COM

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GENERAL MEMORANDUM 10-015

Indian Health Service Proposed FY 2011 Budget;
House Interior Appropriations Hearings for Public Witnesses on Indian Programs

On February1, 2010, the President submitted to Congress his proposed FY 2011 budget. In this Memorandum we report on the proposed budget for the Indian Health Service.

The pages numbers in this Memorandum refer to the FY 2011 IHS Budget Justification. FY 2009-2010 appropriations figures in this Memorandum do not include Recovery Act funding.

Hearings. The House Interior, Environment, and Related Agencies Appropriations Subcommittee has set March 23 and 24, 2010, as hearing dates for public witnesses on Indian programs under their jurisdiction (including IHS, BIA, BIE). Persons wanting to testify in person should e-mail the Subcommittee at INApprop.Detailee@mail.house.gov. You should indicate who will testify, the subject of the testimony and contact information. Or you may fax your request to the Subcommittee at 202-225-9069; if you submit your request by fax you should also call the Subcommittee at 202-225-3081 to let them know you are doing this. The deadline to submit a request to testify is March 1, 2010. We expect the Subcommittee will continue its practice of limiting written testimony to four pages.

Representative Norm Dicks (D-WA) is the Chairman of the Interior, Environment and Related Agencies Subcommittee but it is likely he will leave that position to become Chairman of the Defense Appropriations Subcommittee – a position that is open due to the death of its Chairman, Representative John Murtha. We do not know whether Representative Dicks will still be the Chairman of the Interior Subcommittee by the time the March 23-24 hearings take place.

FUNDING OVERVIEW

While the President had announced that he would propose a funding freeze for most domestic non-security programs, such a freeze was not applied to the Indian Health Service.

The Administration requested an 8.7 percent increase for the IHS over the FY 2010 enacted level. The Administration recommended increases for: Contract Health Services; Contract Support Costs; Indian Health Care Improvement Fund; Chronic Care Initiative; Alcohol and Substance Abuse; Third Party Collections for Urban Indian Health Clinics; Health Care Facilities Construction; and Health Information Technology.

Built-in Costs. The Administration requested $175.6 million for built-in costs consisting of: $24.4 million for pay costs (1.4 percent civilian and commissioned

officers); $60 million for inflation (3.3 percent medical, 1.5 percent non-medical); $52.5 million for population growth (1.5 percent); and staffing for new facilities ($38.8 million).

For FY 2010 the pay raises were 2 percent for civilians and 2.9 percent for commissioned officers; medical inflation was funded at 3 percent and non-medical inflation at 1 percent.

Staffing of New Facilities. As mentioned above, the proposed budget includes $38.8 million for the staffing and operating costs for the following new facilities: $8.9 million for the Absentee Shawnee Health Center in Little Axe, OK; $8.4 million for the New Town, ND Elbowoods Health Center; $6.5 million for the Carl Albert Hospital in Ada, OK; $3.0 million for the Lake County Tribal Health Center in CA; $2 million or the Cheyenne River Eagle Butte Health Center; and $9.8 million as a place holder for two joint venture projects.

LEGISLATIVE PROVISIONS

Restriction of IHS Funds in Alaska to Regional Native Organizations. The Administration proposes to not include the provision, enacted as part of FY 2010 Interior Appropriations (PL 111-88), that provides that IHS funds for Alaska be made available only to regional Alaska Native health organizations (with some exceptions). PL 111-88 reads:

> 419(a) Notwithstanding any other provision of law and until October 1, 2011, 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 Athasbascan Tribal Governments, and the Native Village Eyak shall be treated as Alaska Native regional health entities to which funds may be disbursed under this section.

The budget justification states that the language would not be included as it "restricts Self-Determination for Tribes" (CJ-23). However, since the language from the FY 2010 Interior Appropriations Act extends through FY 2011, it would need to be specifically repealed in order to meet the Administration's proposal.

Contract Support Costs Cap. The proposed budget, consistent with previous appropriations acts, would continue a statutory cap on IHS contract support costs – $444,332,000.

IDEA Data Collection Language. The proposed budget would continue language to authorize the BIA to collect data from the IHS and tribes regarding disabled children in order to assist with the implementation of the Individuals with Disabilities Education Act (IDEA):

> *Provided further*, That the Bureau of Indian Affairs may collect from the Indian Health Service and 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.

Prohibition on Implementing Eligibility Regulations. The prohibition on the implementation of the eligibility regulations published on September 16, 1987, would be continued.

Services for non-Indians. The provision that allows the IHS and tribal facilities to extend health care services to non-Indians, subject to charges, would be continued. The provision states:

> 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.

Assessments by DHHS. The Administration again proposes to eliminate the provision that has been in the Interior appropriations act for a number of years which provides that no IHS funds can be used for any assessments or charges by DHHS "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". The Administration states that the provision "restricts the Department's flexibility in managing overall resources for the Agency" (CJ-22).

Limitation on No-Bid Contracts. The Administration proposes to continue the provision from FY 2010 regarding the use of no-bid contracts. The provision specifically exempts Indian Self-Determination agreements and reads:

> Sec. 416. None of the funds appropriated or otherwise made available by this Act to executive branch agencies may be used to enter into any Federal contract unless such contract is entered into in accordance with the requirements of the Federal Property and Administrative Service Act of 1949 (41 U.S.C. 253) or chapter 137 of title 10, United States Code, and the Federal Acquisition Regulations, unless:
>
> (1) Federal law specifically authorizes a contract to be entered into without regard for these requirements, including formula grants for States, or federally recognized Indian tribes; or
>
> (2) such contract is authorized by the Indian Self-Determination and Education and Assistance Act (Public Law 93-638, 25 U.S.C. 450 et seq., as amended) or by any other Federal laws that specifically authorize a contract within an Indian tribe as defined in section 4(e) of that Act (25 U.S.C. 450b(3)); or
>
> (3) Such contract was awarded prior to the date of enactment of this Act.

FUNDING FOR INDIAN HEALTH SERVICES

FY 2009 Enacted	$3,190,956,000
FY 2010 Enacted	$3,657,618,000
FY 2011 Admin. Request	$3,961,187,000

SPECIAL DIABETES PROGRAM FOR INDIANS

While the entitlement funding for the Special Diabetes Program for Indians (SDPI) is not part of the IHS appropriations process, those funds are administered through the IHS. The SDPI is currently funded through FY 2011 at $150 million annually (PL 110-275). For information regarding pending legislation that would raise the annual funding for the SDPI program to $200 million, see our General Memorandum 09-123 (October 2, 2009).

HOSPITALS AND CLINICS

FY 2009 Enacted	$1,597,777,000
FY 2010 Enacted	$1,754,383,000
FY 2011 Admin. Request	$1,893,292,000

Built-In Costs. $88.4 million is for built-in costs, including $29.2 million for the staffing of new facilities. The budget justification shows $3.7 million in costs to be absorbed.

Staffing of New Facilities. Within the total, the following amounts are for the staffing and operation of new facilities: $5.52 million for Absentee Shawnee Health Center; $4.04 million for Carl Albert Hospital; $1.95 million for Lake County, CA Health Center; $6.44 million for the New Town, ND Health Center; $1.42 million for the Cheyenne River Health Center; and a $9.8 million placeholder for joint venture projects.

Indian Health Care Improvement Fund. The Administration proposed $44 million for the Indian Health Care Improvement Fund (IHCIF), $1.5 million below the FY 2010 level but $30 million over the FY 2009 enacted level. The IHS describes its current evaluation of the methodology and data sources utilized to distribute the ICHIF:

> The IHCIF methodology compares the current funding of health care delivery sites relative to a benchmark cost for a standard benefits package. The formula allocates funds to sites with the lowest scores.
>
> The benchmark considers site user counts, population health status, prevailing health care costs, and an estimate for Medicare and Medicaid funding. In FY 2010, the IHS, in consultation with Tribes, is evaluating allocation of the Indian Health Care Improvement Fund. The evaluation consists of two complementary parts: (1) a technical work group to evaluate and update data and identify technical improvements to the computations; and (2) a process with Tribal leaders to consider whether the formula itself needs to be changed. Stage one is underway. Statisticians and analysts from IHS and tribal operated programs are assessing measures, data definitions, collection/reporting, and alternative data which may improve accuracy and precision. This stage will be completed in February 2010 in time to allocate FY 2010 IHCIF funding. In stage 2, policy level issues and recommendations to alter the structure of the allocation formula will be considered. Proposed changes to the formula will be subject to full tribal consultation before potential implementation in FY 2011.
>
> This budget increase will increase health care in communities with the greatest unmet needs as evidenced by per capita funding, expanded ambulatory services, higher utilization rates, and more persons served. (CJ-63-64)

Epidemiology Centers. The proposed budget would provide $5.29 million for the 12 Epidemiology Centers, which is $208,000 over the FY 2010 level. The funding will, according to the budget document, help pay for inflation for 12 cooperative agreements, including the new center for the California Rural Health Board. Each Epidemiology Center would be funded at approximately $407,000 each.

Domestic Violence Initiative. The budget proposes Act $10 million for the Domestic Violence Initiative, the same as in FY 2010.

Bill language provides that the funds are to be allocated at the discretion of the IHS Director and are to remain available until expended. The IHS notes that on December 16, 2009, it sent out a Dear Tribal Leader Letter describing the Director's decision on allocation of funding for the Domestic Violence Initiative.

Chronic Care Initiative. The budget proposes a $2.5 million increase for the Chronic Care Initiative. Of that amount, $1.5 million would be for efforts to prevent and treat obesity ($1.25 million to test and evaluate intervention by pediatricians and primary care teams in medical office and school-based health centers settings and $250,000 for a I/T/U staff Healthy Weight for Life Workgroup to facilitate "marketing, implementation and evaluation of the Health Weight for Life Strategy".

The remaining $1 million would be for efforts to reduce smoking rates through provider training, clinic-based, cessation programs and public education.

Headquarters Health Information Technology (HIT). The Administration proposes a $4 million increase for a total of $134.8 million. Bill language provides that the increase would be allocated at the discretion of the IHS Director. The Budget Justification describes the bill language specifying the HIT Headquarters funds as follows:

> Language still needed to ensure funds are used for necessary administrative and management functions associated with IHS residual. The IHS residual, i.e., amount of funding identified with those functions which cannot legally be delegated to Indian Tribes, has increased since initial Tribal shares tables were established in the mid-1990s. For example, new mandates for personnel and IT security have been issued for Federal government agencies since that time. This language will ensure that the total amount is used for these functions. (CJ-21)

The IHS notes that the increase will be used for "health information technology security maintenance and enhancements". The budget justification further states:

> The Resource and Patient Management System (RPMS) has been the health information solution for IHS since the mid-1980s. RPMS is an integrated suite of approximately 60 clinical, business, and infrastructure packages that support the delivery of high quality health care services across Indian country. Nationwide there are approximately 170 installations of RPMS that serve up to 400 facilities. Many of these are self-governing Tribal or Urban programs that use RPMS for administrative or workload reporting, provide limited clinical services, or use proprietary systems for clinical care. The full Electronic Health Record (EHR) version of RPMS has been installed on 100 systems and implemented at some 222 hospitals and clinics. All Federal IHS facilities use the RPMS EHR; the majority of Tribal and Urban programs do as well. IHS considers the deployment

of the EHR software to be essentially complete, though IHS continues to accept requests for support from self-governing Tribal and Urban programs that are still selecting their HIT solutions. The focus in 2010 and 2011 will be on optimizing EHR utilization for Meaningful Use, especially on inpatient units, as well as extending EHR access to dozens of remote Village Clinics in the Alaskan bush. (CJ-75)

DENTAL SERVICES

FY 2009 Enacted	$141,936,000
FY 2010 Enacted	$152,634,000
FY 2011 Admin. Request	$161,262,000

Built-in Costs. $8.6 million is proposed for built-in costs, including $3.3 million for the staffing of new facilities.

Staffing of New Facilities. Within the total, the following amounts are for the staffing and operation of new facilities: $1.47 million for Absentee Shawnee Health Center; $836,000 for Carl Albert Hospital; $195,000 for Lake County, CA Health Center; $614,00 for the New Town, ND Health Center; and $238,000 for the Cheyenne River Health Center.

MENTAL HEALTH

FY 2009 Enacted	$67,748,000
FY 2010 Enacted	$72,786,000
FY 2011 Admin. Request	$77,076,000

Built-in Costs. $4.3 million is proposed for built-in costs, including $1.7 million for the staffing of new facilities.

Staffing of New Facilities. Within the total, the following amounts are for the staffing and operation of new facilities: $785,000 for Absentee Shawnee Health Center; $564,000 for Carl Albert Hospital; and $353,000 for Lake County, CA Health Center.

ALCOHOL AND SUBSTANCE ABUSE

FY 2009 Enacted	$183,769,000
FY 2010 Enacted	$194,409,000
FY 2011 Admin. Request	$205,770,000

Built-in Costs. $7.4 million is proposed for built-in costs.

Suicide and Methamphetamine Treatment and Prevention Initiative. The Administration proposes to continue the methamphetamine and suicide prevention and treatment initiative at the $16.4 million level. Bill language provides that the funds are to be allocated at the discretion of the IHS Director. Last year Congress expressed concern regarding the lack of a plan on the distribution of these funds from past years, and the IHS notes that on November 20, 2009, it submitted a report to Congress regarding its distribution plan for this initiative.

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CONTRACT HEALTH SERVICES

FY 2009 Enacted	$634,477,000
FY 2010 Enacted	$779,347,000
FY 2011 Admin. Request	$862,765,000

Built-in Costs. $37.4 million is proposed for built-in costs.

Program Increase. The program increase of $46 million ($5 million of which is for CHEF) will, according to the IHS, cover approximately 23 percent of denied cases. Priority 1 and some priority II cases will be covered:

> This increase will allow IHS to cover CHS cases that may otherwise go unfunded. The program estimates that the increase will cover approximately 23 percent of denied cases, based on FY 2008 data. Based on historical information, it is unlikely all CHS cases will be funded.
>
> The increase will enable the CHS program to cover priority I cases, and some priority II. This request will increase the average patient daily load (ADPL) by 22 patients and fund an additional 47,511 outpatient visits (see outputs table). This increase will support the Mammography and Colorectal Cancer Screening Performance Measures. In addition, the estimated number of one way trips is 68,353, an increase of 3,064 above the 2010 budget. The increase will allow IHS to fund a greater number of trips although the rising costs of both ground and air transportation continues to be a challenge because many AI/ANs live in remote areas of the country.
>
> The estimated number of dental services will be 130,750, an increase of 6,415 above the FY 2010 Enacted budget. The rising cost of health care services, transportation, and demand for CHS play a critical role in the number of services that the program can purchase. (CJ-99)

CHEF. Within the total amount is $53 million for the Catastrophic Health Emergency Fund (CHEF), a $5 million increase over the FY 2010 enacted level and $23.5 million above the FY 2009 amount. The increase is expected to fund an additional 200 high cost cases.

PUBLIC HEALTH NURSING

FY 2009 Enacted	$59,885,000
FY 2010 Enacted	$64,071,000
FY 2011 Admin. Request	$67,571,000

Built-in Costs. $3.5 million is proposed for built-in costs, including the staffing of new facilities.

Staffing of New Facilities. Within the total, the following amounts are for the staffing and operation of new facilities: $453,000 for Absentee Shawnee Health Center; $303,000 for Carl Albert Hospital; $235,000 for Lake County, CA Health Center; $230,00 for the New Town, ND Health Center; and $93,000 for the Cheyenne River Health Center.

HEALTH EDUCATION

FY 2009 Enacted	$15,723,000
FY 2010 Enacted	$16,682,000
FY 2011 Admin. Request	$17,489,000

Built-in Costs. $807,000 is proposed for built-in costs, including the staffing of new facilities.

Staffing of New Facilities. Within the total, there is $106,000 for the Carl Albert Hospital and $86,000 for the New Town, ND Health Center.

COMMUNITY HEALTH REPRESENTATIVES

FY 2009 Enacted	$57,796,000
FY 2010 Enacted	$61,628,000
FY 2011 Admin. Request	$63,991,000

Built-in Costs. $2.4 million is proposed for built-in costs.

All but 3 of the 264 CHR programs are administered by tribes under the authority of the Indian Self-Determination and Education Assistance Act. The programs train and support community health para-professionals to provide preventive and direct health care.

VIRAL HEPATITIS/HEMOPHILUS INFLUENZA IMMUNIZATION PROGRAMS IN ALASKA

FY 2009 Enacted	$1,823,000
FY 2010 Enacted	$1,934,000
FY 2011 Admin. Request	$2,009,000

Built-in costs. $75,000 is proposed for built-in costs.

The IHS states with regard to plans for FY 2011:

> Planned activities for FY 2011 include focused clinical and research activities in persons with chronic hepatitis B infection, and the continuance of clinical and research activities in persons with hepatitis C, nonalcoholic fatty liver disease, autoimmune and other liver diseases.
>
> The Immunization program will continue to be involved with the State Immunization Registry (VacTrAK) rollout and will work with our Tribal partners across the state to contribute data. VacTrAK includes a 2-way exchange of immunization data to improve the accuracy and completeness of immunization records and prevent over-vaccination and missed opportunities to vaccinate. (CJ-122)

URBAN INDIAN HEALTH

FY 2009 Enacted	$36,189,000
FY 2010 Enacted	$43,139,000
FY 2011 Admin. Request	$45,502,000

Built-in costs. $1.4 million is proposed for built-in costs.

Program Increase. The Administration proposes a $1 million increase for "competitive grants to assist urban Indian clinics in improving third party collections. The grants will be used for training, on site technical assistance, and off-site technical assistance via conference calls and webinars. Additional program support will increase revenue and services for the AI/AN populations served." (CJ-127).

INDIAN HEALTH PROFESSIONS

FY 2009 Enacted	$37,500,000
FY 2010 Enacted	$40,743,000
FY 2011 Admin. Request	$41,413,000

Built-in Costs. Of the total amount, $670,000 is proposed for built-in costs for the loan repayment program. Funding for other programs would remain at their FY 2009 levels.

The Indian Health Professions programs and their funding levels are: Scholarship Program (Section 104 Health Professions Scholarships; Section 103 Health Professions Preparatory Scholarships) $15.8 million; Loan Repayment Program, $20.9 million; Extern Program, $1.2 million; Quentin N. Burdick American Indians into Nursing Program, $1.7 million; INMED Program, $1.1 million; and Indians into Psychology Program, $0.7 million.

Bill language allows for up to $36 million to be utilized for the loan repayment program. New bill language proposes to use funds collected from defaults from the loan repayment and health professions scholarship programs to recruit health professionals for Indian communities. Bill language states:

> Provided further, That the amounts collected by the Federal Government as authorized by sections 104 and 108 of the Indian Health Care Improvement Act (25 U.S.C. 1613a and 1616a) during the preceding fiscal year for breach of contracts shall be deposited to the Fund authorized by section 108A of the Act (25 U.S.C. 1616a-1) and shall remain available until expended and, notwithstanding section 108A(c) of the Act (25 U.S.C. 1616a-1(c)), funds shall be available to make new awards under the loan repayment and scholarship programs under sections 104 and 108 of the Act (25 U.S.C. 1613a and 1616a)

TRIBAL MANAGEMENT

FY 2009 Enacted	$2,586,000
FY 2010 Enacted	$2,586,000
FY 2011 Admin. Request	$2,669,000

Funding is for new and continuation grants for the purpose of evaluating the feasibility of contracting the IHS programs, developing tribal management capabilities, and evaluating health services. IHS expects the $83,000 increase will fund one or two more grants in FY 2011, for an approximate total of 32 awards.

DIRECT OPERATIONS

FY 2009 Enacted	$65,345,000
FY 2010 Enacted	$68,720,000
FY 2011 Admin. Request	$69,845,000

The IHS stated in its budget submission that 56.5 percent of the Direct Operations budget would go to Headquarters and 43.5 percent to the 12 area offices. Funding for Tribal Shares for Title I contracts and Title V compacts is also included.

Built-in Costs. $1 million is proposed for built-in costs.

SELF-GOVERNANCE

FY 2009 Enacted	$6,004,000
FY 2010 Enacted	$6,066,000
FY 2011 Admin. Request	$6,201,003

Of the $6.2 million requested by the Administration, $3 million would be for the operating budget of the Office of Self-Governance and $3.2 million would fund a shortfall reserve. Reserve funds are to be used (1) to ensure that funding of tribal shares under Self-Governance Compacting does not adversely impact non-Self-Governance tribes, (2) for Self-Governance costs incurred as a result of special circumstances, and (3) to support special projects that enhance Self-Governance activities.

The IHS projects that in FY 2011 approximately $1.28 billion will be transferred to support 133 tribal compacts and 154 funding agreements.

Built-in Costs. $135,000 is proposed for built-in costs.

CONTRACT SUPPORT COSTS

FY 2009 Enacted	$282,398,000
FY 2010 Enacted	$398,490,000
FY 2011 Admin.Request	$444,332,000

Program Increase. A program increase of $40 million is proposed. The IHS budget Justification the entire increase is for existing contracts and compacts:

> P.L. 93-638 contracts and compacts that reflect less than full CSC funding at the end of fiscal year 2010. The IHS projects that 280 of the total 329 Tribes and Tribal Organizations with P.L. 93-638 contracts and compacts will have CSC shortfalls at the end of FY 2010. The total CSC shortfall associated with those 280 contracts and compacts is projected to be approximately $109.3 million at the end of FY 2010. The CSC need associated with program increases included in the FY 2011 budget and the CSC need associated with new or expanded programs assumed by Tribes and Tribal Organizations in FY 2011 is projected to be approximately $50 million. Therefore, the projected CSC level of need funded is not expected to change much between FY 2010 and 2011. The $40 million increase will, however, allow continued progress in addressing the CSC needs of tribally operated programs to improve quality of care for AI/ANs. The IHS Manual, Part 6, "Services to Tribal Governments and Tribal Organizations,"

Chapter 3, "Contract Support Costs," Section 6-3.3C, specifies how the CSC funds will be distributed. Fifty percent of the FY 2011 increase for CSC will be allocated to those Tribes with the greatest unfunded level of CSC need in such a way as to raise the minimum level of CSC funded to the highest possible level – a bottom up approach. The remaining 50 percent of the FY 2011 CSC increase will then be allocated to all Tribes who have a CSC shortfall in proportion to their overall share of the CSC. As a result of this allocation, the IHS projects that the FY 2011 CSC shortfall will be approximately $114.8 million.

Built-in Costs. $5.8 million is proposed for built-in costs.

Indian Self-Determination (ISD) Fund. The proposed bill would authorize up to $10 million (up from $5 million from previous years) of the total for the Indian Self-Determination Fund which the IHS may use to support new or expanded self-determination contracts, grants, self-governance compacts or annual funding agreements. The IHS has made it clear that they do not intend to allocate any contract support for new or expanded agreements as long as there is a shortfall for existing agreements unless Congress requires it to do so.

Cap on Contract Support Costs. Consistent with past Appropriations acts, proposed bill language would continue language regarding a cap on contract support costs:

> *Provided further*, That, notwithstanding any other provision of law, of the amounts provided herein, not to exceed $444,332,000 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 2010, 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.

Contract Support Limitation. The Act, consistent with the Interior Appropriations Acts for FYs 1999-2009 attempts to limit the ability of the IHS and BIA to fund past-year shortfalls in contract support funding from remaining unobligated balances for those fiscal years:

> SEC. 409. 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 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 2010 for such purposes, except that for the Bureau of Indian Affairs federally recognized tribes and tribal organizations of federally recognized tribes may use their tribal priority allocations for unmet contract support costs of ongoing contracts, grants, self-governance compacts or annual funding agreements.

FUNDING FOR INDIAN HEALTH FACILITIES

FY 2009 Enacted	$390,168,000
FY 2010 Enacted	$394,757,000
FY 2011 Admin. Request	$445,242,000

MAINTENANCE AND IMPROVEMENT

FY 2009 Enacted	$53,915,000
FY 2010 Enacted	$53,915,000
FY 2011 Admin. Request	$55,523,000

Built-in Costs. $1.6 million is proposed for built-in costs.

Maintenance and Improvement funds are provided to Area offices for distribution to projects in their regions. Funding is for the following purposes: 1) approximately $52 million for routine maintenance; 2) approximately $1 million for major M&I programs on the Backlog of Essential Maintenance (BEMAR) list; 3) approximately $3 million for environmental compliance; and 4) approximately $500,000 for demolition of vacant or obsolete health care facilities replaced through federal funding.

The IHS estimates that as of October 2009, the BEMAR is $476 million.

FACILITIES AND ENVIRONMENTAL HEALTH SUPPORT

FY 2009 Enacted	$178,329,000
FY 2010 Enacted	$193,087,000
FY 2011 Admin. Request	$202,106,000

Built-in costs. $9 million is proposed for built-in costs including staffing of new facilities.

Staffing of New Facilities. Within the total, the following amounts are for the staffing and operation of new facilities: $755,000 for Absentee Shawnee Health Center; $678,000 for Carl Albert Hospital; $305,000 for Lake County, CA Health Center; $1 million for the New Town, ND Health Center; and $244,000 for the Cheyenne River Health Center.

MEDICAL EQUIPMENT

FY 2009 Enacted	$22,067,000
FY 2010 Enacted	$22,664,000
FY 2011 Admin. Request	$23,711,000

Built-in Costs. $1 million is proposed for built-in costs.

The IHS notes that they expect to distribute the FY 2011 funds as follows: $17.7 million for routine replacement medical equipment to over 1,600 Federally and Tribally-operated health care facilities; $5 million for new medical equipment in tribally-constructed health care facilities; and $1 million for the TRANSAM and ambulance

programs. About $5 million of Recovery Act funds were used to replace 62 ambulances at IHS and tribal emergency medical service programs.

CONSTRUCTION

Construction of Sanitation Facilities

FY 2009 Enacted	$95,857,000
FY 2010 House	$95,857,000
FY 2011 Admin. Request	$97,710,000

Built-in Costs. $1.85 million is proposed for built-in costs.

Distribution of Funds. Four types of sanitation facilities projects are funded by the IHS: 1) projects to serve new or like-new housing; 2) projects to serve existing homes; 3) special projects such as studies, training, or other needs related to sanitation facilities construction; and 4) emergency projects. The IHS sanitation facilities construction funds cannot be used to provide sanitation facilities in HUD-built homes.

The IHS projects that the FY 2011 funds at the requested level would be allocated as follows: 1) $2 million to be reserved at the IHS headquarters for special projects and emergencies, including $1 million for projects in three Areas per year. The projects are to collect homeowner data and other demographic information to strengthen verification mechanics within the Community Deficiency Profiles in an effort to increase transparency, accuracy and accountability of the CDP data; 2) up to $50 million for new and like-new homes; 3) at least $45 million to be distributed to IHS Areas for prioritized projects to serve existing homes; and 4) up to $5 million for projects to clean up and replace open dumps on Indian lands pursuant to the Indian Lands Open Dump Cleanup Act of 1994. (CJ-179-180)

Construction of Health Care Facilities

FY 2009 Enacted	$40,000,000
FY 2010 House	$29,234,000
FY 2011 Admin. Request	$66,192,000.

Health facilities proposed to be funded are: 1) Barrow Hospital in Alaska, $40,192,000; 2) Kayenta Health Center in Arizona, $10 million; and 3) San Carlos Health Center in Arizona, $16 million. Each of these projects will be funded in phases; the FY 2011 amounts are not for complete construction.

OTHER

Transam Equipment, Ambulances, Demolition Fund. The proposed budget would continue funding of up to $500,000 to purchase TRANSAM equipment from the Department of Defense and $500,000 to be deposited in a Demolition Fund to be used for the demolition of vacant and obsolete federal buildings. Funding for the purchase of ambulances would be $2.7 million.

THIRD PARY COLLECTIONS

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Below is the chart from the IHS budget justification regarding third party collections.

	FY 2009 Estimate	FY 2010 Estimate	FY 2011 Estimate
Medicare:			
Federal	$128,293,000	$130,953,000	$130,953000
Tribal[1]	6,986,000	6,986,000	6,986,000
Tribal[2]	34,085,000	34,085,000	34,085,000
Subtotal:	169,364,000	172,024,000	172,024,000
Medicaid:			
Federal	452,824,000	465,276,000	465,276,000
Tribal[1]	22,217,000	22,217,000	22,217,000
Tribal[2]	75,181,000	75,181,000	75,181,000
Subtotal:	550,222,000	562,674,000	537,770,000
Medicare/Medicaid Total:	700,538,000	704,474,000	562,674,000
Private Insurance	94,042,000	90,042,000	94,042,000
TOTAL:	**$813,628,000**	**$828,740,000**	**$828,740,000**
FTE	4,204	4,204	4,204
[1] Represents CMS Tribal collection estimates.			
[2] Represents estimates of Tribal collections due to direct billing that began in FY 2002-05.			

The budget justification states that the estimates in above chart are "based on actual FY 2008 collections and current reimbursement rates. These estimates may change as a result of actual FY 2009 collections, changes to the types of services covered by insurers, and transition of programs from Federal to tribally-operated" (CJ-155). The FY 2010 estimates do not include 2009 Medicare and Medicaid rate increases.

If we may be of further assistance regarding the FY 2011 Indian Health Service appropriations, please contact us at the information below.

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Inquiries may be directed to:
Karen Funk (kfunk@hobbsstraus.com)