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GENERAL MEMORANDUM 12-009

Indian Health Service Fiscal Year 2012 Appropriations, PL 112-74

On December 23, 2011, President Obama signed HR 2055 as Public Law 112-74 the Consolidated Appropriations Act, 2012, an Act which includes FY 2012 funding for what would normally be nine separate appropriations bills. Included in the Act is funding for programs under the Interior, Environment, and Related Agencies Appropriations bill (Division E of the Act). *In this Memorandum we report on FY 2012 appropriations for the Indian Health Service (IHS).* The Conference Report is House Report 112-331. Previous to this signing, the IHS and most other federal programs had been funded under a Continuing Resolution during FY 2012 at their FY 2011 level minus 1.5 percent.

Under the Act, Congress applied several across-the-board reductions which vary by appropriations sections. Programs, projects, and activities as detailed in the Act, accompanying reports, or President's budget under Interior, Environment and Related Agencies have an across-the-board reduction of 0.16 percent. *Figures in this Memorandum do not reflect the 0.16 percent reduction.*

The Conference report states with regard to consideration of Appropriations Committee report language (there was a House but no Senate Committee report):

> Language contained in House Report 112-151 providing specific guidance to agencies regarding the administration of appropriated funds and any corresponding reporting requirements carries the same emphasis as the language included in this explanatory statement and should be complied with unless specifically addressed to the contrary herein.
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> In instances where the House report speaks more broadly to policy issues or offers views that are subject to interpretation, such views remain those of the House and do not reflect the views of the conferees unless otherwise repeated in this statement.

FUNDING OVERVIEW

The President's request of a 14.1 percent increase in the FY 2012 IHS budget was not realized, although relative to other federal agencies the IHS fared better than most. (Most domestic non-security programs are proposed by the Administration for a five-year funding freeze.) The FY 2012 IHS appropriations are 5.8 percent more than the FY 2011 appropriations. Much of the increase is in the form of staffing for new facilities and health facility construction which are not really program increases. However, there is a real program increase for Contract Support Costs.

Congress did *not* provide the Administration's requested increases for pay costs for Commissioned Officers ($4.1 million); inflation ($155 million – 3.6 percent medical and 1.5 percent non-medical inflation rates); and population growth ($96.6 million – 1.3 percent growth rate). These costs – totaling $255 million – will need to be absorbed from existing program funds. (We note that there also was no funding for built-in costs for the IHS in FY 2011 except for pay raises for Commissioned Officers.)

There is no funding for IHS/tribal employee pay raises as funding for federal civilian employees is frozen.

Decreases. The Administration proposed, and Congress approved, funding decreases of $5.9 million from grants: Health Promotion/Disease Prevention ($1.1 million); National Congress of American Indians' healthy youth lifestyles initiative ($1 million); Institute for Healthcare Improvement chronic care ($835,000); Elder Health Long Term Care ($700,000); Children and Youth ($600,000); Women's Health ($600,000); Domestic Violence/Sexual Assault Grant to Urban Programs ($524,000); National Indian Health Board ($500,000); and National Native American EMS Association ($90,000). An additional $1.1 million in grant reduction is to be absorbed by the IHS. The House report directs the IHS to continue its cooperative agreement with the National Indian Health Board from within existing funds.

In addition, a reduction of $16 million was enacted for sanitation facilities construction.

Staffing of New Facilities. The Act (Services and Facilities accounts combined) includes $63 million for the staffing and operating costs for the following new facilities: $2,487,000 for the Carl Albert Hospital in Ada, OK; $1,088,000 for the Lake County Tribal Health Center in Lakeport, CA; $7,315,000 for the Elbowoods Health Center in New Town, ND; $24,672,000 for the Cheyenne River Health Center in Eagle Butte, SD; $8,981,000 for the Absentee Shawnee Health Center in Little Axe, OK; $8,665,000 for the Cherokee Nation Vinita Health Center in Vinita, OK; and $9,843,000 as a joint venture placeholder for two facilities.

Increases. Increases above the FY 2011 level are $65 million for Contact Health Services ($845 million total); $74.5 million for Contract Support Costs ($472 million total); $12 million for the Indian Health Care Improvement Fund ($57.5 million total), and $3.4 million for Health Information Technology Security ($176 million total for Health Information Technology in Hospitals and Clinics account). Lack of funding for inflation will partially offset these program increases.

LEGISLATIVE PROVISIONS

Extension of the Restriction of IHS Funds in Alaska to Regional Native Organizations. Congress extended until October 1, 2013, 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). The Administration had proposed to not extend this provision. The Act reads:

> 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 Eyak shall be treated as Alaska Native regional health entities to which funds may be disbursed under this section.

Contract Support Costs Cap. The Act, consistent with previous appropriations acts, continues a statutory cap on IHS Contract Support Costs – $472,193,000.

Contract Support Limitation. The Act, consistent with the Interior Appropriations acts for FYs 1999-2011, 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:

IDEA Data Collection Language. The Act continues 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, is 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, is continued. The provision states:

> Provided, 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. Bill language is continued 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 has held the provision would restrict the Department's flexibility in managing overall resources for the Agency.

Limitation on No-Bid Contracts. The Act continues 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 Chapter 33 of title 41 United States 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(e)); or
>
> (3) Such contract was awarded prior to the date of enactment of this Act.

FUNDING FOR INDIAN HEALTH SERVICES

FY 2011 Enacted	$3,665,273,000
FY 2012 Admin. Request	$4,166,139,000
FY 2012 Enacted	$3,872,377,000

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 2013 at $150 million annually (PL 111-309).

HOSPITALS AND CLINICS

FY 2011 Enacted	$1,762,865,000
FY 2012 Admin. Request	$1,963,886,000
FY 2012 Enacted	$1,813,868,000

Built-In Costs. No funding was provided for built-in costs (Commissioned Officer pay increase, inflation and population growth) for which the Administration had requested $98 million. Funding is provided for staffing of new facilities.

Indian Health Care Improvement Fund. The Act includes $57.5 million for the Indian Health Care Improvement Fund (IHCIF), which is $12 million above the FY 2011 level and $3 million over the Administration's request. The IHS has been in consultation with tribes regarding the possible changes in the IHCIF formula. On November 25, 2011, IHS Director Roubideaux wrote tribal leaders informing them of her decisions relating to the IHCIF. In that letter the IHS Director said the following:

- No change will be made to the IHCIF formula until all programs reach at least 55 percent of their estimated level of need
- Data and technical improvements to the formula are approved and the IHS will continue to evaluate whether a prototype Medicaid spending index would be a possible replacement for the existing 25 percent alternate resource factor
- The IHCIF will not be expanded to include new services authorized by the Indian Health Care Improvement Act until funding is made available for those services (i.e., long term care).

Requested increases for Epidemiology Centers ($1 million), the Chronic Care Initiative ($2.5 million) and Business Operations Support ($6 million) were not approved. The Administration proposed $10 million for a Domestic Violence Initiative; bill language does not specify an amount for this purpose but states that funding made available for the methamphetamine and suicide prevention and treatment and the domestic violence prevention initiatives are to be allocated at the discretion of the Director.

For *Health Information Technology,* the Act provides $3.4 million of the $4 million requested increase for security maintenance. The Act states that $4 million of the total is to be allocated at the discretion of the Director. The total HIT budget under Hospitals and Clinics is $176 million.

DENTAL SERVICES

FY 2011 Enacted	$152,634,000
FY 2012 Admin. Request	$170,859,000
FY 2012 Enacted	$159,696,000

The Conference report directs the IHS to update Congress, at least annually, on the progress of the Early Childhood Caries initiative. The report also noted that the IHS has now provided Congress with a schedule for implementation of the Electronic Dental Record system as requested in the House report.

Built-In Costs. No funding was provided for built-in costs (Commissioned Officer pay increase, inflation and population growth) for which the Administration had requested $11.1 million. Funding is provided for staffing of new facilities.

MENTAL HEALTH

FY 2011 Enacted	$72,786,000
FY 2012 Admin. Request	$81,117,000
FY 2012 Enacted	$75,710,000

Built-In Costs. No funding was provided for built-in costs (Commissioned Officer pay increase, inflation and population growth) for which the Administration had requested $4.4 million. Funding is provided for staffing of new facilities.

The Act does not include the Administration's proposed $1 million increase to implement Section 723 of the Indian Health Care Improvement Act which authorizes demonstration telemental health projects targeting prevention of youth suicide.

ALCOHOL AND SUBSTANCE ABUSE

FY 2011 Enacted	$194,409,000
FY 2012 Admin. Request	$211,693,000
FY 2012 Enacted	$194,608,608

Built-In Costs. No funding was provided for built-in costs (Commissioned Officer pay increase, inflation and population growth) for which the Administration had requested $13.1 million. Funding is provided for staffing of new facilities.

The Act does not include the proposed increase of $4 million for competitive grants to expand access to and improve the quality of substance abuse treatment programs.

CONTRACT HEALTH SERVICES

FY 2011 Enacted	$779,927,000
FY 2012 Admin. Request	$948,646,000
FY 2012 Enacted	$844,927,000

The Act provides a $65 million increase over FY 2011; the Administration had requested an increase of $89.6 million.

Built-In Costs. No funding was provided for built-in costs (inflation and population growth) for which the Administration had requested $79.7 million.

The IHS also noted in its FY 2012 Budget Justification that the demand for Contract Health Services, which always exceeds the available funding, will be even more in demand as five hospitals have been or are planned to be replaced by ambulatory health centers with no inpatient services. Those health centers will be required to purchase inpatient care from the private sector using Contract Health Services funding.

Catastrophic Emergency Health Fund (CHEF). Within the total CHS amount is $51.5 million for CHEF, $6.5 million below the FY 2011 level.

PUBLIC HEALTH NURSING

FY 2011 Enacted	$63,943,000
FY 2012 Admin. Request	$70,613,000
FY 2012 Enacted	$66,739,000

Built-In Costs. No funding was provided for built-in costs (Commissioned Officer pay increase, inflation and population growth) for which the Administration had requested $9.3 million. Funding is provided for staffing of new facilities.

HEALTH EDUCATION

FY 2011 Enacted	$16,649,000
FY 2012 Admin. Request	$18,190,000
FY 2012 Enacted	$17,084,000

Built-In Costs. No funding was provided for built-in costs (Commissioned Officer pay increase, inflation and population growth) for which the Administration had requested $1.07 million. Funding is provided for staffing of new facilities.

IHS reports that the number of patient visits in which health education was provided has tripled from FY 2004 to FY 2010. The funding supports 23 IHS health education field positions and 75 tribal health education staff. Areas of emphasis in FY 2012 are to strengthen the development of standardized nationwide patient and health education programs through the integration of IHS Patient Educating Protocols throughout the system and to increase health education literacy.

COMMUNITY HEALTH REPRESENTATIVES

FY 2011 Enacted	$61,505,000
FY 2012 Admin. Request	$65,746,000
FY 2012 Enacted	$61,505,000

Built-In Costs. No funding was provided for built-in costs (Commissioned Officer pay increase, inflation and population growth) for which the Administration had requested $4.1 million. Funding is provided for staffing of new facilities.

All but three of the 264 Community Health Representatives programs are administered by tribes under the authority of the Indian Self-Determination and Education Assistance Act. The programs train and support 1,600 community health paraprofessionals to provide preventive and direct health care.

VIRAL HEPATITIS/HEMOPHILUS INFLUENZA
IMMUNIZATION PROGRAMS IN ALASKA

FY 2011 Enacted	$1,930,000
FY 2012 Admin. Request	$2,064,000
FY 2012 Enacted	$1,930,000

Built-In Costs. No funding was provided for built-in costs (Commissioned Officer pay increase, inflation and population growth) for which the Administration had requested $130,000.

The IHS stated in its budget submission that it intends to increase to 3.5 days its outpatient clinic at the Alaska Native Medical Center in order to focus on the increased number of cases of chronic Hepatitis C. Because many patients have primary care givers outside Anchorage, the IHS plans to have "a venue for the education/training of providers utilizing the established statewide Tribal Health System telehealth system (video-conferencing)" in order to assist in the cure and management hepatitis and liver disease patients. Regional field clinics are conducted at 13 sites in Alaska.

URBAN INDIAN HEALTH

FY 2011 Enacted	$43,053,000
FY 2012 Admin. Request	$46,745,000
FY 2012 Enacted	$43,053,000

Built-In Costs. No funding was provided for built-in costs (Commissioned Officer pay increase, inflation and population growth) for which the Administration had requested $2.6 million.

The Act does not provide the proposed $1 million increase for competitive grants to assist urban Indian clinics in improving third party collections.

INDIAN HEALTH PROFESSIONS

FY 2011 Enacted	$40,661,000
FY 2012 Admin. Request	$42,016,000
FY 2012 Enacted	$40,661,000

Built-In Costs. No funding was provided for built-in costs (Commissioned Officer pay increase and inflation) for which the Administration had requested $1.27 million.

Bill language allows for up to $36 million to be utilized for the Loan Repayment Program – IHS Area Offices and Service Units are authorized to provide supplemental funds. The House report directs the IHS to report to Congress within 90 days of enactment on the status of its plans to implement recent recommendations on ways to increase the recruitment and retention of health care professionals in the IHS system.

The Act allows funds collected on defaults from the loan repayment and health professions scholarship programs to be used to recruit health professionals for Indian communities:

> 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 2011 Enacted	$2,581,000
FY 2012 Admin. Request	$2,762,000
FY 2012 Enacted	$2,581,000

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. The IHS estimated 27 awards in FY 2012 (one more than in FY 2011). The Act does not provide the $176,000 requested for inflation.

DIRECT OPERATIONS

FY 2011 Enacted	$68,583,000
FY 2012 Admin. Request	$73,636,000
FY 2012 Enacted	$71,768,000

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. Tribal Shares funding for Title I contracts and Title V compacts are also included.

Built-In Costs. No funding was provided for built-in costs (Commissioned Officer pay increase and inflation) for which the Administration had requested $1.5 million.

Program Increase. The Administration proposed in its budget submission a program increase of $3.4 million for the following purposes (of which Congress provided $3.1 million):

> Program expansion will fund: (a) continuing investments to improve the IHS' capacity for providing oversight and accountability in key administrative areas such as property, financial, and human resources management; (b) addressing unfunded mandates for national initiatives associated with privacy requirements, facilities, and personnel security; and (c) for improving responsiveness to external authorities such as OMB and Congress, including but not limited to the implementation and continuing accountability for new permanent authorities of the reauthorization of the Indian Health Care Improvement Act. Recent congressional oversight as well as reports issued by the General Accountability Office and the Office of Inspector General demonstrate the importance of making improvements in these areas. (CJ-127)

SELF-GOVERNANCE

FY 2011 Enacted	$6,054,000
FY 2012 Admin. Request	$6,329,000
FY 2012 Enacted	$6,054,000

The budget justification this year did not, as in the past, break down Self-Governance funding in the categories of those monies that fund the Office of Self-Governance and those that act as a shortfall reserve.

The Self-Governance budget supports, among other things, implementation of the IHS Tribal Self-Governance Program and funds tribal shares required under Self-Governance.

The IHS projects that in FY 2012 approximately $1.5 billion will be transferred to support 108 tribal compacts and 129 funding agreements.

The Act does not provide the $263,000 proposed to cover inflation costs.

CONTRACT SUPPORT COSTS

FY 20101 Enacted	$397,693,000
FY 2012 Admin. Request	$461,837,000
FY 2012 Enacted	$472,193,000

The Act provides a $73.5 million increase for Contract Support Costs. That amount would cover the $13.1 million IHS estimated in its budget submission would be needed to cover inflation costs and also provide a $60 million program increase.

The Administration, in proposing in its budget submission a program increase of $50 million, explained that it intended to use the entire increase for existing contracts and compacts:

> Contract Support Costs: +$50,000,000 will be applied against projected CSC shortfalls of $171 million (FY 2012) associated with ongoing 329 contracts and compacts. After applying the FY 2012 funding allocation for CSC, the IHS projects that the FY 2012 CSC shortfall will be approximately $153 million. The projected CSC Level of Need Funded after applying the increase will be 75 percent, a 3.49 percent decrease from FY2010 funding.
>
> Unfunded CSC associated with program increases and new staffing continues to be the greatest factor contributing to increased CSC shortfalls in recent years. The CSC need associated with program increases included in the FY 2012 budget and the CSC need associated with new or expanded programs assumed by Tribes and Tribal Organizations in FY 2012 is projected to be approximately $34 million. Therefore, the projected CSC LNF is not expected to change much between FY 2011 and 2012.
>
> The budget request represents the amount of CSC funding that will be allocated among the contracting/compacting Tribes. Although the budget request represents an increase in CSC funding, the LNF may not increase. The LNF decreases when the overall CSC need rises more quickly than the funding for CSC. IHS addresses the difference between CSC funding and CSC need in the shortfall report, which is required by Congress to inform them of the difference. (CJ-135)

Indian Self-Determination (ISD) Fund. The Act authorizes up to $10 million of the total CSC funds for an Indian Self-Determination Fund. The IHS may allocate funds to the ISD Fund to support new or expanded self-determination contracts, grants, self-governance compacts or annual funding agreements. It remains to be seen whether the IHS, in light of the significant funding increase for CSC, will use some of the appropriated funds for the ISD Fund.

Cap on Contract Support Costs. Consistent with past Appropriations acts, the Act continues 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 $472,193,000 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.

Contract Support Limitation. The Act, consistent with the Interior Appropriations Acts for FYs 1999-2011 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. 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, and 112-10 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 2011 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.

Reporting Requirement. The Conference report directs the IHS "to meet its annual CSC reporting requirement due date, and to provide the Committees with current CSC estimates in conjunction with its annual budget submission."

FUNDING FOR INDIAN HEALTH FACILITIES

FY 2011 Enacted	$403,947,000
FY 2012 Admin. Request	$457,669,000
FY 2012 Enacted	$441,052,000

MAINTENANCE AND IMPROVEMENT

FY 2011 Enacted	$53,807,000
FY 2012 Admin. Request	$57,078,000
FY 2012 Enacted	$53,807,000

Built-In Costs. No funding was provided for built-in costs (inflation and population growth) for which the Administration had requested $3.2 million.

Maintenance and Improvement funds are provided to Area offices for distribution to projects in their regions. Funding is for the following purposes: 1) approximately $53 million for routine maintenance; 2) approximately $400,000 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 2010, the BEMAR is $472 million.

FACILITIES AND ENVIRONMENTAL HEALTH SUPPORT

FY 2011 Enacted	$192,701,000
FY 2012 Admin. Request	$210,992,000
FY 2012 Enacted	$199,733,000

Built-In Costs. No funding was provided for built-in costs (Commissioned Officer pay increase, inflation and population growth) for which the Administration had requested $10.9 million. Funding was provided for staffing of new facilities.

MEDICAL EQUIPMENT

FY 2011 Enacted	$22,618,000
FY 2012 Admin. Request	$24,705,000
FY 2012 Enacted	$22,618,000

Built-in Costs. No funding was provided for built-in costs (inflation and population growth) for which the Administration requested $2 million.

The IHS notes that they expect to distribute the FY 2012 funds as follows: $18.7 million for routine replacement medical equipment at 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.

CONSTRUCTION

Construction of Sanitation Facilities

FY 2011 Enacted	$95,665,000
FY 2012 Admin. Request	$79,710,000
FY 2012 Enacted	$79,710,000

The Administration's proposed decrease and Congress' concurrence with it note that Recovery Act funds should lessen the impact of this reduction.

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.

Construction of Health Care Facilities

FY 2011 Enacted	$39,156,000
FY 2012 Admin. Request	$85,184,000
FY 2012 Enacted	$85,184,000

The Act funds health care facilities construction as requested by the Administration: Barrow Hospital in Alaska, $62,184,000; Kayenta Health Center in Arizona, $10 million; San Carlos Health Center in Arizona, $10 million; and a Youth Residential Treatment Center in Hemet, CA, $2 million. In addition, $1 million is requested to assess the feasibility of modular construction for health facilities per a requirement of the Indian Health Care Improvement Act.

OTHER

Transam Equipment, Ambulances, Demolition Fund. The Act continues 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 is $2.7 million.

THIRD PARY COLLECTIONS

Below is the chart from the FY 2012 IHS budget justification regarding third party collections.

	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
Medicare:			
Federal	$133,144,000	$130,804,000	$130,804,000
Tribal[1]	6,986,000	6,986,000	6,986,000
Tribal[2]	52,648,000	57,244,000	57,244,000
Subtotal:	192,748,000	195,034,000	195,034,000
Medicaid:			
Federal	487,263,000	485,275,000	485,275,000
Tribal[1]	22,217,000	22,217,000	22,217,000
Tribal[2]	107,759,000	124,203,000	124,203,000
Subtotal:	617,239,000	631,695,000	631,695,000
Medicare/Medicaid Total:	809,987,000	826,729,000	826,729,000
Private Insurance	81,006,000	81,006,000	81,006,000
TOTAL:	**$890,993,000**	**$907,735,000**	**$907,735,000**
FTE	6,471	6,471	6,471
[1] Represents CMS Tribal collection estimates.			
[2] Represents estimates of Tribal collections due to direct billing that began in FY 2002.			

The IHS states that the FY 2011 and FY 2012 estimates are based primarily on the FY 2010 actual collections and the estimated full year FY 2011 impact of the Calendar Year 2010 Medicare and Medicaid rate changes. IHS further states:

> The CY 2010 rate increase is expected to increase FY 2011 Medicare collections by $2,286,000 and Medicaid collections by $14,456,000. In addition, estimates reflect increased Tribal assumptions of major health care programs that will impact federal collections. IHS will continue to place a high priority of finalizing CY 2011 rates and the development of FY 2010 Medicare cost reports to set future rates." (CJ-137)

If we may be of further assistance regarding FY 2012 Indian Health Service appropriations, please contact us at the information below.

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Inquiries may be directed to:
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