DEPARTMENT OF HEALTH AND HUMAN SERVICES

Fiscal Year 2021

Indian Health Service

Justification of Estimates for Appropriations Committees

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Indian Health Service
Rockville, MD 20857

FEB 05 2020

I present the Indian Health Service (IHS) Fiscal Year (FY) 2021 Congressional Justification. The FY 2021 budget request supports the President's goal of providing safe, efficient, effective, and high quality health care services. This budget also invests in the Department of Health and Human Services (HHS) Secretary's priority to enhance the health and well-being of Americans, providing a patient-centered system with an emphasis on bolstering direct medical services and expanding our efforts to improve medical quality at all IHS facilities.

This FY 2021 budget submission continues support for our critical work in providing a comprehensive health service delivery system managed by the IHS, Tribes, Tribal Organizations, and Urban Indian Organizations in 37 states. Our efforts align with the Administration's priorities and support the HHS's goals to help people live healthy, safe, and productive lives. This budget submission also reflects our continued partnership and consultation with Tribes and conferral with Urban Indian Organizations to address the health care needs of American Indians and Alaska Natives nationwide.

Our FY 2021 budget submission maintains focus on the IHS mission to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level and support for three main goals that are outlined in our strategic plan:

Goal 1: To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people;

Goal 2: To promote excellence and quality through innovation of the Indian health system into an optimally performing organization; and

Goal 3: To strengthen IHS program management and operations.

The Indian health care system faces challenges related to access, quality, management, and operations. This budget, which is aligned with our strategic plan, aims to address these challenges and builds on the progress that we have already made. This budget also supports our critical work in providing a comprehensive health care service delivery system managed by the IHS, Tribes, Tribal Organizations, and Urban Indian Organizations. I am excited about what we will achieve together to improve the health and well-being of American Indians and Alaska Natives.

/Michael D. Weahkee/

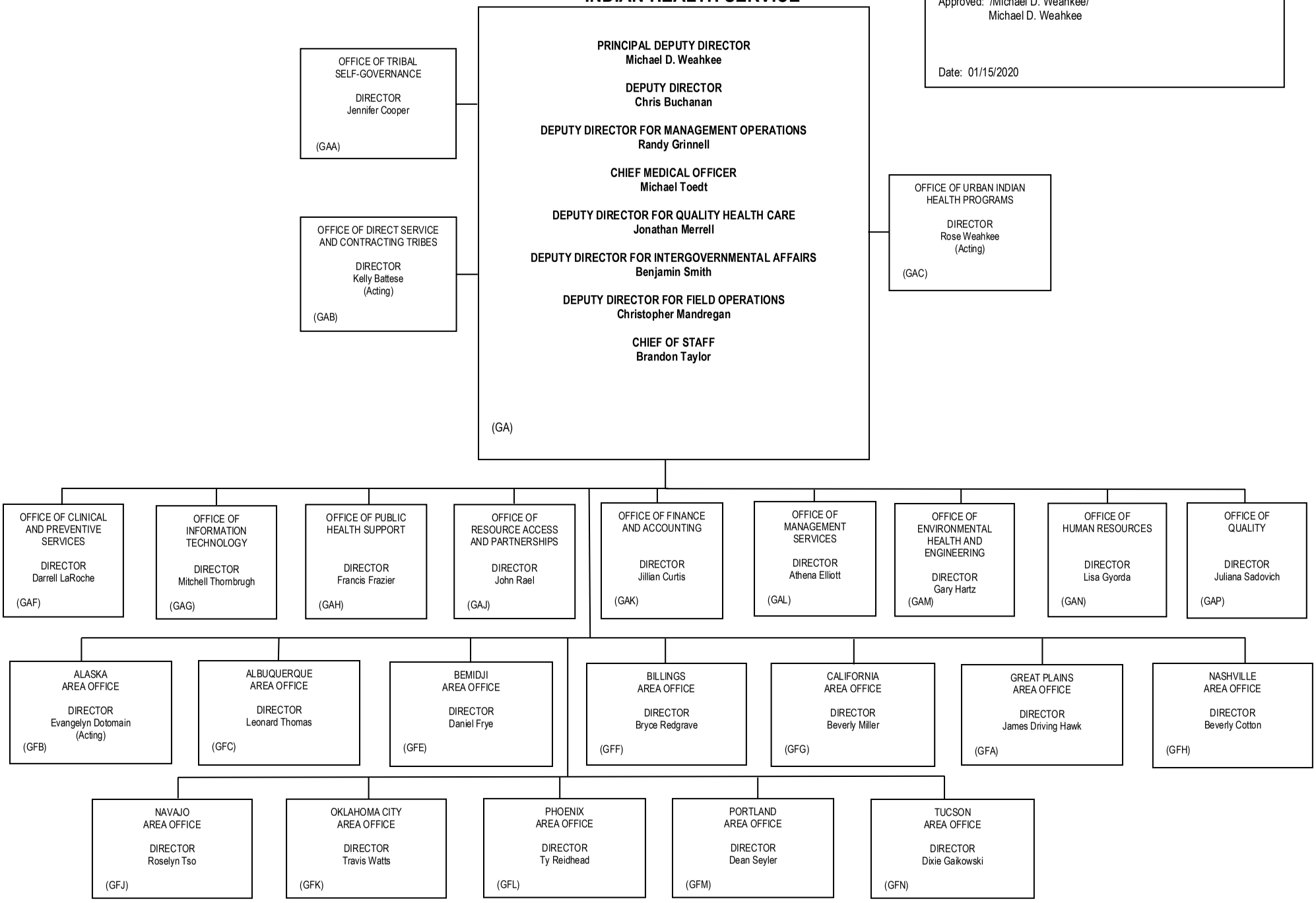
RADM Michael D. Weahkee, MBA, MHSA
Assistant Surgeon General, U.S. Public Health Service
Principal Deputy Director

THIS PAGE INTENTIONALLY LEFT BLANK

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE

Approved: /Michael D. Weahkee/
Michael D. Weahkee

Date: 01/15/2020



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

THIS PAGE INTENTIONALLY LEFT BLANK

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2021 Performance Budget Submission to Congress

TABLE OF CONTENTS

Significant Items in Committee Reports

Operating Division-Specific Requirements

Self Determination

Non-Recurring Expense Fund

THIS PAGE INTENTIONALLY LEFT BLANK

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2021 Performance Budget Submission to Congress

TABLE OF CONTENTS

Executive Summary

THIS PAGE INTENTIONALLY LEFT BLANK

INTRODUCTION AND MISSION
Indian Health Service

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

The IHS provides comprehensive primary health care and disease prevention services to approximately 2.6 million American Indians and Alaska Natives through a network of over 605 hospitals, clinics, and health stations on or near Indian reservations. Facilities are predominantly located in rural primary care settings and are managed by IHS, Tribal, and urban Indian health programs.

United States Government and Indian Nations

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

Indian Health Service and Its Partnership with Tribes

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

The Indian Self-Determination and Education Assistance Act of 1975 (ISDEAA), as amended, and the Indian Health Care Improvement Act of 1976 (IHCIA), as amended, provided new opportunities for the IHS and Tribes to deliver quality and accessible health care.

The IHCIA includes specific authorizations such as improvements for urban Indian health programs, Indian health professions programs, and the authority to collect from Medicare and Medicaid and other third-party insurers for services rendered at IHS or Tribal facilities. Under the ISDEAA, many Tribes have assumed the administrative and programmatic roles previously carried out by the Federal Government. Tribes currently administer over half of IHS resources through ISDEAA contracts and compacts. The IHS directly administers the remaining resources and manages programs where Tribes have chosen not to contract or compact health programs.

INDIAN HEALTH SERVICE
Fiscal Year 2021 Budget Submission to Congress

Overview of Budget

The fiscal year (FY) 2021 Indian Health Service (IHS or Agency) Budget supports the Agency's three strategic goals: 1) ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native (AI/AN) people; 2) promote excellence and quality through innovation of the Indian health system into an optimally performing organization; and 3) strengthen IHS program management and operations. These goals guide the strategies and objectives IHS will carry out to achieve the agency mission to raise the physical, mental, social, and spiritual health of AI/ANs to the highest level. The Budget conveys the Administration's strong support of health care needs of AI/ANs, and includes key proposals to improve the management and operations of HIS, and recruit and retain quality health care professionals. The Budget directly supports the President's agenda to address the Nation's priorities through careful investments of taxpayer resources and furthers the Administration's initiative to end the HIV epidemic in America.

The Budget invests in the new Department of Health and Human Services (HHS) *Improving Maternal Health in America Initiative* to reduce maternal mortality and morbidity. Specifically, HHS is developing a cross-agency approach to improve maternal health focused on four strategic goals to1) Achieve Healthy Outcomes for All Women of Reproductive Age by improving prevention and treatment, 2) Achieve Healthy Pregnancies and Births by prioritizing quality improvement, 3) Achieve Healthy Futures by optimizing post-partum health, and 4) Improve Data and Bolster Research to inform future interventions.

The Budget also supports the HHS Secretary's priorities[1] to combat the opioid crisis (e.g., by increasing access to treatment and reducing opioid overdose-related deaths through prevention, treatment, and recovery services); transform the nation's healthcare system to a value-based system (e.g., enhanced focus on patient control over health information through interoperable and accessible health information technology.

The IHS provides a wide range of clinical, public health, community, and facilities infrastructure services to approximately 2.6 million AI/ANs who are members of 574 federally recognized tribes in 37 states. Comprehensive primary health care and disease prevention services are provided through a network of over 605 hospitals, clinics, and health stations on or near Indian reservations. These facilities are predominately primary care settings and are managed by IHS, tribal, and urban (I/T/U) Indian health programs.

The IHS meets the annual statutory requirement to consult with, and solicit the participation of, AI/AN Tribes and tribal organizations in the development of the budget for IHS. Likewise, IHS confers with urban Indian organizations. The consultation and confer input informs the IHS budget formulation process. The core of the agency's formulation process consists of the priorities and recommendations developed in consultation with Tribes through this independent annual budget process led by the National Tribal Budget Formulation Workgroup.[2] IHS is strongly committed to this process and it ensures that the IHS budget is relevant to the health needs and priorities of AI/ANs. The tribal priorities identified in the

[1] https://www.hhs.gov/about/leadership/secretary/priorities/index.html

[2] The requirements for consultation are contained in statutes and various Presidential Executive orders including the: Indian Self-Determination and Education Assistance Act, Public Law (P.L.) 93-638 as amended; Indian Health Care Improvement Act, P.L. 94-437, as amended; Memorandum to the Heads of Executive Departments and Agencies from President William J. Clinton, April 29, 1994; Presidential Executive Order 13084, Consultation and Coordination with Indian Tribal Governments, May 14, 1998; Presidential Executive Order 13175, Consultation and Coordination with Indian Tribal Governments, November 6, 2000; and Presidential Memorandum, Government-to-Government Relationship with Tribal Governments, September 23, 2004.

consultation process are also instrumental to inform senior officials of other U.S. Department of Health and Human Services (HHS) agencies of the health needs of the AI/AN population, so that they have the opportunity to reflect those priorities in the Department's budget requests. The tribal budget consultation process is a key component of the *IHS strategic objectives to build, strengthen, and sustain collaborative relationships (Objective 1.2); improve communication within the organization, with Tribes, Urban Indian Organizations, and other stakeholders, and with the general public (Objective 3.1); and secure and effectively manage the assets and resources (Objective 3.2); objectives that advance the IHS mission*.

Summary of Budget Submission

The total discretionary budget authority for IHS is $6.4 billion, an increase of $185 million[3] above the FY 2020 Enacted. Major changes include:

- Current Services (fixed costs): +$42.4 million to address increases in costs for medical inflation. Unfunded, these costs reduce IHS's buying power and reduce funds available for patient care and oversight.

- Staffing and Operating Costs for Newly-Constructed Health Care Facilities: +$36.6 million for staffing of four newly-constructed health care facilities built through the Joint Venture Construction Program. These funds will allow new facilities to expand the provision of health care in areas where the existing capacity is overextended.

- New Tribe: +$2.6 million to fund direct health care services for the Little Shell Tribe of Chippewa Indians in Montana which was federally recognized on December 20, 2019.

- Electronic Health Record Modernization: +$117.0 million for Electronic Health Record (EHR) system modernization. The Department of Veterans Affairs (VA) announced changes to discontinue use and support for the VA Information Systems and Technology Architecture (VistA). To avoid negatively impacting IHS and tribal programs, which are reliant on VistA for the core of IHS's current EHR – the Resource and Patient Management System (RPMS), IHS must pursue modernization of its Health Information Technology (HIT) and its EHR. This project will continue work begun in FY 2019 to augment, upgrade, or replace the IHS EHR system with a modern system capable of support for the delivery of care, revenue generation, and interoperability.

- ISDEAA Section 105(*l*) Leases: +$101.0 million for compensation of reasonable operating costs associated with facilities leased or owned by Tribes and Tribal organizations for carrying out health programs under ISDEAA contracts and compacts as required by 25 U.S.C. § 5324(*l*). The Budget proposes a new indefinite discretionary appropriation account, Payments for Tribal Leases, and reforms to improve management of lease payments.

- HIV, HCV, and Sexually Transmitted Disease (STD) Initiative: +$27.0 million to enhance HIV testing and linkages to care in support of the Ending the HIV Epidemic: A Plan for America. The Initiative would also provide treatment and case management services to prevent and treat HCV infection due to injection drug use and fund data collection to measure outcomes. This funding will also provide overall support for STD data surveillance and enhancements and provides supplementary resources for Tribal Epidemiology Centers (TECs).

[3] Increase based on the FY 2020 CBO score for Contract Support Costs of $820 million.

- Quality and Oversight: +$4.9 million for continued progress and focus on quality and IHS administrative and management oversight. To ensure a culture of reliability is developed and sustained, and that systems and processes are performed as intended consistently over time, IHS must invest in a program of national quality improvement and oversight. With these investments, IHS can better provide consistent quality and evidence-based care across its system with a focus on clinical excellence and patient-centered care. HIS's goal is to provide satisfying, efficient, and effective care to our patients and honor the Nation's commitment to AI/ANs. These funds will provide key resources for the Office of Quality to build out its national capabilities, enforce consistency in quality across the IHS system, and improve access and analysis of program and administrative data.

- Recruitment and Retention: +$11.5 million to support of a range of recruitment and retention strategies aimed to enhance and support the mission of the IHS. Initiatives include providing housing subsidies and Title 38 compensation to more eligible providers, increaseing the number of IHS Loan Repayment, Scholarship awards, and supplemental loan repayment, and support for the expansion of IHS recruitment and outreach activities.

- Improving Maternal Health in America: +$5 million to provide new funding to support IHS preventative, perinatal, and postpartum care; address the needs of pregnant women with opioid or other substance use disorder; and improve quality services and health outcomes in order to reduce maternal morbidity by 50 percent.

- Maximizing Technology to Increase Access to Care: +$2.9 million for the expansion of the Telebehavioral Health Center of Excellence, which will increase access to health care services. This funding will expand the capabilities of the Center to assist with accessing a wider variety of care by IHS patients in rural or isolated locations.

- Health Care Facilities Construction: +$106 million will continue to make progress on the Health Care Facilities Priority Projects. These facilities will improve access to medical care and facilitate the collaboration and partnership between tribes and the IHS.

- Staff Quarters: +$20.0 million to fund the replacement and the addition of new staff quarters in isolated and remote locations to enhance and improve the recruitment and retention of quality healthcare professionals.

- Contract Support Costs (CSC): +$35.0 million for the estimated increase in CSC associated with the requested increases in health care programs and services reflected in this budget, which would be transferred to Tribes and Tribal organizations through ISDEAA contracts and compacts, as required by law.

- Program Adjustments: -$163.5 million to maximize funding through Services and Facilities to protect direct patient care services.

Overview of Agency Performance

The IHS Strategic Plan FY 2019-2023 sets the direction of the agency over the next five years and includes a mission and vision statement, three goals, and eight objectives.[1] IHS's strategic goals are focused on: access to care, quality of care, and strengthening management and operations. The FY 2021 budget supports the three IHS strategic goals and improvement of AI/AN health outcomes in some of the following ways:[2]

Goal 1: To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people.

- The Hospitals and Health clinics budget line supports the bulk of the agency's clinical measures, including, maintaining or exceeding targets for childhood and adult immunizations, breast feeding rates, and critical health screenings. *IHS Strategic Plan FY 2019-2023 (IHS SP) Objective 1.3, Increase access to quality health care services; HHS Strategic Plan FY 2018-2022 (HHS SP) Objective 2.2, Prevent, treat, and control communicable diseases and chronic conditions.*
- Funding for dental health maintains access to dental services and preventive procedures such as, dental sealants and topical fluorides. *IHS SP Objective 1.3; HHS SP Objective 2.1, Empower people to make informed choices for healthier living.*
- Funding for the Alcohol and Substance Abuse and Mental Health budgets support five screening measures to promote early intervention. *IHS SP Objective 1.3; HHS SP Objective 2.3, Reduce the impact of mental and substance use disorders through prevention, early intervention, treatment, and recovery support.*
- The Special Diabetes Program for Indians monitors and reports several clinical diabetes care measures. *IHS SP Objective 1.3; HHS SP Objective 2.2.*
- In FY 2021, IHS anticipates the opening of two newly constructed healthcare facilities. *IHS SP Objective 1.3; HHS SP Objective 1.3, Improve Americans' access to healthcare and expand choices of care and service options.*

Goal 2: To promote excellence and quality through innovation of the Indian health system into an optimally performing organization.

- IHS ambulatory care facilities are required to obtain Patient Centered Medical Home (PCMH) certification/designation by December 31, 2021. The PCMH models of care promote care standardization across the agency. *IHS SP Objective 2.1, Create quality improvement capability at all levels of the organization; HHS SP Objective 1.3.*

Goal 3: To strengthen IHS program management and operations.

- IHS, Tribes, Tribal organizations, and urban Indian organizations provide critical health care services. IHS continues to strengthen tribal consultation and urban confer efforts to ensure stakeholders have the opportunity to provide input and are informed of system or policy changes. *IHS SP Objective 3.1, Improve communications within the organization with Tribes, Urban Indian Organizations, and other stakeholders, and with the general public; HHS SP Objective 1.3.*
- IHS continues to improve business processes to inform decision making and strengthen partnerships to maximize patient health care options. *IHS SP Objective 3.2, Secure and effectively manage the assets and resources; HHS SP Objective 1.3.*

---

[1] See the "IHS Strategic Plan FY 2019-2023 Goals and Objectives" diagram at the end of this section. The IHS Strategic Plan FY 2019-2023 is available at: www.ihs.gov/strategicplan.

[2] The IHS Strategic Plan FY 2019-2023 aligns with the HHS Strategic Plan FY 2018-2022. See IHS Strategic Plan FY 2019-2023, Appendix A: HHS Strategic Plan and IHS Strategic Plan Crosswalk, the plans are aligned according to strategic objectives. The IHS FY 2021 budget supports the IHS and HHS Strategic Plan objectives, as referenced in italics below.

- In FY 2021, IHS will continue Electronic Health Record (EHR) system modification efforts will ultimately replace IHS's current medical, health, and billing records systems. The information technology infrastructure is central to management and operations of the health care system. *IHS SP Objective 1.2, Build, strengthen, and sustain collaborative relationships; IHS SP Objective 3.3, Modernize information technology and information systems to support data driven decisions; HHS SP Objective 5.3, Optimize information technology investments to improve process efficiency and enable innovation to advance program mission goals.*

The FY 2021 budget request provides critical support in assuring the availability and expansion of health care services, assuring the quality of services, and in providing operational support for the Indian health care system. In addition to the above referenced budget measures, IHS has implemented the following performance reporting and management processes to monitor agency progress.

Performance Reporting

The IHS budget measures support the agency's strategic goals and objectives and are focused on monitoring population health (clinical measures) and strategies to assess program trends and management (non-clinical measures). The FY 2021 budget includes several budget related measures as reported in each narrative and in the outcomes and outputs tables, evaluation results may also be reported in the narrative sections.

IHS reports valid and reliable aggregated clinical measures using a centralized reporting system to meet the Government Performance and Results Act (GPRA) and GPRA Modernization Act (GPRAMA) requirements. IHS annually reports GPRA/GPRAMA clinical measure results. Tribes administer over 63.2 percent of IHS resources through ISDEAA contracts and compacts and may choose to participate in IHS GPRA/GPRAMA performance reporting. Many Tribal programs operate EHR systems that differ from the IHS EHR, Resource and Patient Management System (RPMS).

Since 2002, IHS has reported electronic population level results for GPRA/GPRAMA clinical measures. Over time, as more Tribes assumed responsibility of providing health care for their members and adopted non-RPMS EHR systems, the agency's clinical performance measure results primarily reflected IHS programs. Prior to FY 2018, IHS clinical measure results reflected only RPMS data as non-RPMS data could not be verified or validated for budget-related performance reporting. Beginning in FY 2018, the IHS clinical results were reported from a new system, the Integrated Data Collection System Data Mart (IDCS DM). [3] The IDCS DM provides those Tribes using non-RPMS EHRs the opportunity to report data for GPRA/GPRAMA purposes; reporting is optional for Tribes. The IDCS DM calculates measure results using any data (RPMS, non-RPMS or Fiscal Intermediary) submitted to the IHS National Data Warehouse (NDW) and assures reporting of valid and reliable clinical measure results. The FY 2018 clinical GPRA/GPRAMA measure results are reported from the IDCS DM and reflect aggregated Federal, Tribal, and urban (I/T/U) results. Tribal programs have the option to participate in IDCS DM reporting and aggregated results include participating Tribal programs. The FY 2021 budget request includes anticipated targets based on most recent year results.

[3] The IDCS DM uses all data exported to the NDW, including non-RPMS tribal and urban data. Budget measures previously reported from RPMS cannot be compared to IDCS DM results because: IDCS DM standardizes the use of user population estimates as the denominator for clinical GPRA/GPRAMA measures, and the reporting year changes from July 1-June 30 (GPRA/GPRAMA year) to October 1-September 30 (to match the user population estimate report year).

Performance Management

IHS cascades performance goals and objectives and performance-related metrics agency-wide, and aligns them with the agency's strategic plan. Specific measures cascade from senior executive performance plans to those of subordinate managers and supervisors. From there they cascade into employee performance plans, which ensures that performance of all employees relates to key agency performance objectives. Agency leadership periodically reviews progress in meeting these agency performance objectives, holding regular discussions with senior executives to identify challenges to success and determine feasible solutions. Agency leadership then implements those solutions, making specific adjustments or taking corrective actions that eliminate or minimize obstacles preventing the achievement of desired results. The connection between performance objectives, performance measures, and employee accountability enables agency leadership to direct the efforts of the workforce more accurately, and to make more informed and effective decisions. The impact is greater success in meeting the full array of agency mission requirements.

IHS Strategic Plan FY 2019-2023 Goals and Objectives

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

Program	FY 2019[8] Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020 Enacted
SERVICES				
Clinical Services	**3,748,812**	**3,934,831**	**4,177,800**	**242,969**
Hospitals & Health Clinics	2,178,088	2,324,606	2,432,384	107,778
Electronic Health Record System	0	8,000	125,000	117,000
Dental Services	197,949	210,590	219,380	8,790
Mental Health	101,255	108,933	128,228	19,295
Alcohol & Substance Abuse	234,421	245,603	235,745	-9,858
Purchased/Referred Care	964,819	964,819	964,783	-36
Indian Health Care Improvement Fund	72,280	72,280	72,280	0
Preventive Health	**169,723**	**177,567**	**141,627**	**-35,940**
Public Health Nursing	86,354	91,984	95,353	3,369
Health Education[1]	19,698	20,568	0	-20,568
Community Health Representatives	61,613	62,888	0	-62,888
Community Health[2]	0	0	44,109	44,109
Immunization AK	2,058	2,127	2,165	38
Other Services	**184,655**	**202,807**	**187,686**	**-15,121**
Urban Health	50,533	57,684	49,636	-8,048
Indian Health Professions	56,363	65,314	51,683	-13,631
Tribal Management Grants[3]	2,165	2,465	0	-2,465
Direct Operations	70,788	71,538	81,480	9,942
Self-Governance	4,806	5,806	4,887	-919
TOTAL, SERVICES	**4,103,190**	**4,315,205**	**4,507,113**	**191,908**
FACILITIES	**878,806**	**911,889**	**769,455**	**-142,434**
Maintenance & Improvement	167,527	168,952	167,948	-1,004
Sanitation Facilities Construction	192,033	193,577	192,931	-646
Health Care Facilities Construction	243,480	259,290	124,918	-134,372
Facilities & Environ Health Support	252,060	261,983	259,763	-2,220
Equipment	23,706	28,087	23,895	-4,192
TOTAL, SERVICES & FACILITIES	**4,981,996**	**5,227,094**	**5,276,568**	**49,474**
CONTRACT SUPPORT COSTS[4,7]				
TOTAL, CONTRACT SUPPORT COSTS	**822,227**	**855,000**	**855,000**	**0**
PAYMENTS FOR TRIBAL LEASES[5]				
TOTAL, PAYMENTS FOR TRIBAL LEASES	**0**	**0**	**101,000**	**101,000**
TOTAL, BUDGET AUTHORITY	**5,804,223**	**6,082,094**	**6,232,568**	**150,474**
COLLECTIONS				
Medicare	248,638	248,638	260,253	11,615
Medicaid	807,605	807,605	845,751	38,146
Subtotal, M / M	*1,056,243*	*1,056,243*	*1,106,004*	*49,761*
Private Insurance	109,272	109,272	154,333	45,061
VA Reimbursement	28,062	28,062	8,769	-19,293
Total, M / M / PI	*1,193,577*	*1,193,577*	*1,269,106*	*75,529*
Quarters	8,500	8,500	9,600	1,100
TOTAL, COLLECTIONS	**1,202,077**	**1,202,077**	**1,278,706**	**76,629**
MANDATORY				
Special Diabetes Program for Indians (SDPI)[6]				
Subtotal, Special Diabetes Program for Indians	150,000	150,000	150,000	0
Total, Mandatory	**150,000**	**150,000**	**150,000**	**0**
TOTAL, PROGRAM LEVEL	**7,156,300**	**7,434,171**	**7,661,274**	**227,103**

[1]The Health Education program was proposed for discontinuation as of the FY 2020 Budget.

[2]The budget consolidates HE, CHR, and nationalized CHAP.

[3]The Tribal Management Grants program was proposed for discontinuation as of the FY 2020 Budget.

[4]CSC are maintained as discretionary with a separate, indefinite appropriation.

[5]The Budget requests a new, indefinite discretionary appropriation for section 105(l) ISDEAA (P.L. 93-638) leases .

[6]The Budget requests an extension of the Special Diabetes Program for Indians through FY 2021. The FY2020 Further Consolidated Appropriations Act provides only $96.6 million for SDPI, for activity through May 22nd, 2020. The Budget assumes SDPI will funded at $150 million in FY 2020.

[7] The Congressional Budget Office score for FY 2020 for Contract Support costs is $820,000,000.

[8]Reflects Services account adjustments related to formal reprogramming notifications submitted to Congress in FY 2019. Amounts by "Sub IHS Activity" will continue to be adjusted during the period of availability, which concludes on Sept. 30, 2020, for impacted funds.

INDIAN HEALTH SERVICE
FY 2021 President's Budget
Detail of Changes
(Dollars in Thousands)

Sub IHS Activity	FY 2019 Final 3/	FY 2020 Enacted	FY 2021 President's Budget																	
			Baseline Adjustments					Program Changes												
			Policy Adjustments 4/	Current Services (Medical Inflation)	FY 2021 Staffing for New Facilities	New Tribe 5/	Contract Support Costs	Tribal Clinic Operational Costs (105(l) Leases) 6/	Electronic Health Record (EHR) System	Elimination HIV/HCV	Community Health 7/	Tele Behavioral Health Center	Recruitment and Retention	Quality & Oversight	Improving Maternal HealthIn America	Heath Care Facilities Construction	Staff Quarters	Program Increases/ Adjustments	Subtotal of Changes	President's Budget
SERVICES																				
Hospitals & Health Clinics	2,178,088	2,324,606	0	17,012	24,430		0	(101,000)	0	27,000	(20,000)	0	3,500	0	5,000	0	0	151,836	107,778	**2,432,384**
Electronic Health Record System	0	8,000	17,000	0	0		0	0	100,000	0	0	0	0	0	0	0	0	0	117,000	**125,000**
Dental Services	197,949	210,590	0	1,659	3,808		0	0	0	0	0	0	0	0	0	0	0	3,323	8,790	**219,380**
Mental Health	101,255	108,933	0	961	1,930		0	0	0	0	0	2,910	0	0	0	0	0	13,494	19,295	**128,228**
Alcohol & Substance Abuse	234,421	245,603	0	2,339	586		0	0	0	0	0	0	0	0	0	0	0	(12,783)	(9,858)	**235,745**
Purchased/Referred Care	964,819	964,819	0	9,795	0	2,560	0	0	0	0	0	0	0	0	0	0	0	(12,391)	(36)	**964,783**
Indian Health Care Improvement Fund	72,280	72,280	0	719	0		0	0	0	0	0	0	0	0	0	0	0	(719)	0	**72,280**
Total, Clinical Services	3,748,812	3,934,831	17,000	32,485	30,754	2,560	0	(101,000)	100,000	27,000	(20,000)	2,910	3,500	0	5,000	0	0	142,760	242,969	**4,177,800**
Public Health Nursing	86,354	91,984	0	713	2,047		0	0	0	0	0	0	0	0	0	0	0	609	3,369	**95,353**
Health Education	19,698	20,568	(20,568)	0	109		0	0	0	0	(109)	0	0	0	0	0	0	0	(20,568)	**0**
Community Health Representatives	61,613	62,888	(38,888)	0	0		0	0	0	0	(24,000)	0	0	0	0	0	0	0	(62,888)	**0**
Community Health	0	0	0	0							44,109							0	44,109	**44,109**
Immunization AK	2,058	2,127	0	23	0		0	0	0	0	0	0	0	0	0	0	0	15	38	**2,165**
Total, Preventive Health	169,723	177,567	(59,456)	736	2,156	0	0	0	0	0	20,000	0	0	0	0	0	0	624	(35,940)	**141,627**
Urban Health	50,533	57,684	0	630	0		0	0	0	0	0	0	0	0	0	0	0	(8,678)	(8,048)	**49,636**
Indian Health Professions	56,363	65,314	0	0	0		0	0	0	0	0	0	8,000	0	0	0	0	(21,631)	(13,631)	**51,683**
Tribal Management	2,165	2,465	(2,465)	0	0		0	0	0	0	0	0	0	0	0	0	0	0	(2,465)	**0**
Direct Operations	70,788	71,538	0	44	0		0	0	0	0	0	0	0	4,920	0	0	0	4,978	9,942	**81,480**
Self-Governance	4,806	5,806	0	0	0		0	0	0	0	0	0	0	0	0	0	0	(919)	(919)	**4,887**
Total, Other Services	184,655	202,807	(2,465)	674	0	0	0	0	0	0	0	0	8,000	4,920	0	0	0	(26,250)	(15,121)	**187,686**
Total, Services	**4,103,190**	**4,315,205**	**(44,921)**	**33,895**	**32,910**	**2,560**	**0**	**(101,000)**	**100,000**	**27,000**	**0**	**2,910**	**11,500**	**4,920**	**5,000**	**0**	**0**	**117,134**	**191,908**	**4,507,113**
FACILITIES																				
Maintenance & Improvement	167,527	168,952	0	1,789	0		0	0	0	0	0	0	0	0	0	0	0	(2,793)	(1,004)	**167,948**
Sanitation Facilities Construction	192,033	193,577	0	1,882	0		0	0	0	0	0	0	0	0	0	0	0	(2,528)	(646)	**192,931**
Health Care Facility Construction	243,480	259,290	0	3,122	0		0	0	0	0	0	0	0	0	0	106,000	20,000	(263,494)	(134,372)	**124,918**
Facility & Environmental Health Support	252,060	261,983	0	1,495	3,679		0	0	0	0	0	0	0	0	0	0	0	(7,394)	(2,220)	**259,763**
Equipment	23,706	28,087	0	257	0		0	0	0	0	0	0	0	0	0	0	0	(4,449)	(4,192)	**23,895**
Total, Facilities	878,806	911,889	0	8,545	3,679	0	0	0	0	0	0	0	0	0	0	106,000	20,000	(280,658)	(142,434)	**769,455**
Total, Services & Facilities	**4,981,996**	**5,227,094**	**(44,921)**	**42,440**	**36,589**	**2,560**	**0**	**(101,000)**	**100,000**	**27,000**	**0**	**2,910**	**11,500**	**4,920**	**5,000**	**106,000**	**20,000**	**(163,524)**	**49,474**	**5,276,568**
CONTRACT SUPPORT COSTS 1/																				
Total, Contract Support Costs	**822,227**	**855,000**	**0**	**0**	**0**		**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**855,000**
SECTION 105(l) LEASES																				
Total Section 105(l) Leases	**0**	**0**	**0**	**0**	**0**		**0**	**101,000**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**101,000**	**101,000**
TOTAL BUDGET AUTHORITY	**5,804,223**	**6,082,094**	**(44,921)**	**42,440**	**36,589**	**2,560**	**0**	**0**	**100,000**	**27,000**	**0**	**2,910**	**11,500**	**4,920**	**5,000**	**106,000**	**20,000**	**(163,524)**	**150,474**	**6,232,568**
MANDATORY																				
Special Diabetes Program for Indians (SDPI) 2/																				
Subtotal, SDPI	150,000	96,575	53,425	0	0		0	0	0	0	0	0	0	0	0	0	0	0	53,425	**150,000**
Total, Mandatory	**150,000**	**96,575**	**53,425**	**0**	**0**		**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**53,425**	**150,000**
TOTAL, IHS APPROPRIATION	**5,954,223**	**6,178,669**	**8,504**	**42,440**	**36,589**	**2,560**	**0**	**0**	**100,000**	**27,000**	**0**	**2,910**	**11,500**	**4,920**	**5,000**	**106,000**	**20,000**	**-163,524**	**203,899**	**6,382,568**

1/ The Congressional Budget Office score for Contract Support Costs for FY 2020 is $820,000,000.
2/ The Further Consolidated Appropriations Act, 2020 P.L. 116-94 provided funding for the SDPI program only through May 22, 2020.
3/ Reflects Services account adjustments related to formal reprogramming notifications submitted to Congress in FY 2019. Amounts by "Sub IHS Activity" will continue to be adjusted during the period of availability, which concludes on Sept. 30, 2020, for impacted funds.
4/ Aligns the FY 2021 President's Budget with policy positions from FY 2020 and maintains the proposed program discontinuation of Tribal Management and the consolidation of Health Education, Community Health Representations, and the National CHAP program.
5/ Provides funding for the Little Shell Tribe of Chippewa of Montana, recognized in the National Defense Authorization Act for Fiscal Year 2020, P.L. 116-92.
6/ Funding for leases under the ISDEAA Section 105(l) program is proposed to be an indefinite discretionary appropriation and is moved from the Hospitals and Health Clinics line item to this new appropriation.
7/ The Community Health program line does not include Alaska CHAP and no funds are redirected from the Hospitals and Health Clinics funding provided for Alaska CHAP program to this line.

INDIAN HEALTH SERVICE
STAFFING and OPERATING COSTS FOR NEWLY-CONSTRUCTED HEALTHCARE FACILITIES
FY 2021 Budget -- Estimates

(Dollars in Thousands)

	Bethel, AK Yukon-Kuskokwim Primary Care Center (JV)		Naytahwaush, MN Naytahwaush Health Center (JV)		Yakutat, AK Yakutat Tlingit Health Center (JV)		El Paso, TX Ysleta Del Sur Health Center (JV)				
Opening Date	April 2021		January 2021		May 2020		May 2020		**TOTAL**		
Sub Sub Activity	Pos	Amount	Pos	Amount	Pos	Amount	Pos	Amount	**FTE**	**Pos**	**AMOUNT**
Hospitals & Health Clinics	72	$13,022	57	$7,446	5	$861	27	$3,101	0	161	$24,430
Dental Health	12	$1,677	8	$1,153	2	$647	3	$331	0	25	$3,808
Mental Health	9	$1,157	4	$415	1	$158	2	$200	0	16	$1,930
Alcohol & Substance Abuse	2	$299	2	$209	0	$0	0	$78	0	4	$586
Purchased/Referred Care	0	$0	0	$0	0	$0	0	$0	0	0	$0
Total, Clinical Services	95	$16,155	71	$9,223	8	$1,666	32	$3,710	0	206	$30,754
Public Health Nursing	4	$659	5	$692	2	$346	2	$350	0	13	$2,047
Health Education[1]	1	$109	0	$0	0	$0	0	$0	0	1	$109
Comm. Health Representatives	0	$0	0	$0	0	$0	0	$0	0	0	$0
Total, Preventive Health	5	$768	5	$692	2	$346	2	$350	0	14	$2,156
Total, Services	100	$16,923	76	$9,915	10	$2,012	34	$4,060	0	220	$32,910
Facilities Support	7	$1,816	2	$758	0	$166	2	$392	0	11	$3,132
Environmental Health Support	2	$355	1	$95	0	$9	0	$88	0	3	$547
Total, FEHS	9	$2,171	3	$853	0	$175	2	$480	0	14	$3,679
Total, Facilities	9	$2,171	3	$853	0	$175	2	$480	0	14	$3,679
Grand Total[2]	**109**	**$19,094**	**79**	**$10,768**	**10**	**$2,187**	**36**	**$4,540**	**0**	**234**	**$36,589**

[1]The Health Education program was proposed for discontinuation in the FY 2020 President's Budget. The FY 2021 budget request includes a prorated restoration amount of $109,000 in Health Education for the Yukon-Kuskokwim Primary Care Center.

[2]Includes Utilities

Statement of Personnel Resources
INDIAN HEALTH SERVICE

	FY 2019 Final	FY 2020 Enacted	FY 2021 PB
Direct:			
Hospitals & Health Clinics	6,158	6,158	6,170
Electronic Health Record	0	0	6
Dental Health	579	579	579
Mental Health	191	191	198
Alcohol & Substance Abuse	242	242	242
Indian Health Care Improvement	0	0	0
Purchased/Referred Care	0	0	0
Total, Clinical Services	7,170	7,170	7,195
Public Health Nursing	201	201	201
Health Education	18	18	0
Community Health Reps	3	3	0
Community Health	0	0	27
Immunization, AK	0	0	0
Total, Preventive Health	222	222	228
Urban Health	7	7	7
Indian Health Professions	24	24	24
Tribal Management	0	0	0
Direct Operations	275	275	287
Self Governance	12	12	12
Total, Other Services	318	318	330
Total, Services	7,710	7,710	7,753
Maint. & Improvement	0	0	0
Sanitation Facilities	119	119	119
Hlth Care Facs Construction	0	0	0
Facil. & Envir. Hlth Support	1,073	1,073	1,073
Equipment	0	0	0
Total, Facilities	1,192	1,192	1,192
Total, Direct FTE	8,902	8,902	8,945
Special Diabetes Program for Indians (SDPI):			
Direct	23	23	23
Reimburseable	106	106	106
Total, Special Diabetes Program for Indians	129	129	129
Reimbursable:			
Buybacks	1,176	1,176	1,176
Medicare	761	761	761
Medicaid	3,648	3,648	3,648
Private Insurance	562	562	562
Quarters	40	40	40
Total, Reimbursable FTE	6,187	6,187	6,187
TOTAL FTE	**15,218**	**15,218**	**15,261**
Total, Civilian FTE	**13,537**	**13,537**	**13,579**
Total, Military FTE	**1,681**	**1,681**	**1,682**

FY 2021 Crosswalk
Budget Authority
Estimated Distribution

(dollars in thousands)

Sub Activity	Federal Health Administration								Tribal Health Administration								FY 2021 PB
	Clinical Services	Preventive Health	Indian Health Professions	Federal Administration	Self-Governance	Special Diabetes Program for Indians	Facilities	TOTAL Federal Health Admini-stration	Clinical Services	Preventive Health	Urban Health	Management Training	Contract Support	ISDEA 105(*l*) Leases	Facilities	TOTAL Tribal Health Admini-stration	
SERVICES																	
Hospitals & Health Clinics	1,050,873	0	0	0	0	0	0	1,050,873	1,381,703	0	0	0	0	0	0	1,381,703	2,432,576
Electronic Health Record	125,000	0	0	0	0	0	0	125,000	0	0	0	0	0	0	0	0	125,000
Dental Health	89,507	0	0	0	0	0	0	89,507	129,873	0	0	0	0	0	0	129,873	219,380
Mental Health	52,061	0	0	0	0	0	0	52,061	76,167	0	0	0	0	0	0	76,167	128,228
Alcohol & Substance Abuse	71,902	0	0	0	0	0	0	71,902	163,843	0	0	0	0	0	0	163,843	235,745
Purchased/Referred Care	401,350	0	0	0	0	0	0	401,350	563,433	0	0	0	0	0	0	563,433	964,783
IHCIF	15,427	0	0	0	0	0	0	15,427	56,661	0	0	0	0	0	0	56,661	72,088
Subtotal (CS)	1,806,119	0	0	0	0	0	0	1,806,120	2,371,681	0	0	0	0	0	0	2,371,680	4,177,800
Public Health Nursing	0	32,897	0	0	0	0	0	32,897	0	62,456	0	0	0	0	0	62,456	95,353
Community Health	0	1,147	0	0	0	0	0	1,147	0	42,962	0	0	0	0	0	42,962	44,109
Health Education	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Community Health Repr.	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Immunization AK	0	0	0	0	0	0	0	0	0	2,165	0	0	0	0	0	2,165	2,165
Subtotal (PH)	0	34,044	0	0	0	0	0	34,044	0	107,583	0	0	0	0	0	107,583	141,627
Urban Health Project	0	0	0	0	0	0	0	0	0	0	49,636	0	0	0	0	49,636	49,636
Indian Health Professions	0	0	51,683	0	0	0	0	51,683	0	0	0	0	0	0	0	0	51,683
Tribal Management	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Direct Operations	0	0	0	59,888	0	0	0	59,888	0	0	0	21,592	0	0	0	21,592	81,480
Self-Governance	0	0	0	0	4,887	0	0	4,887	0	0	0	0	0	0	0	0	4,887
Subtotal (OS)	0	0	51,683	59,888	4,887	0	0	116,458	0	0	49,636	21,592	0	0	0	71,228	187,686
Total, Services	1,806,119	34,044	51,683	59,888	4,887	0	0	1,956,622	2,371,681	107,583	49,636	21,592	0	0	0	2,550,491	4,507,113
CONTRACT SUPPORT COSTS	0	0	0	0	0	0	0	0	0	0	0	0	855,000	0	0	855,000	855,000
ISDEAA 105(*l*) Leases	0	0	0	0	0	0	0	0	0	0	0	0	0	101,000	0	101,000	101,000
FACILITIES																	
Maintenance & Improvement	0	0	0	0	0	0	87,669	87,669	0	0	0	0	0	0	80,279	80,279	167,948
Sanitation Facilities Constr.	0	0	0	0	0	0	67,526	67,526	0	0	0	0	0	0	125,405	125,405	192,931
Health Care Facs. Constr.	0	0	0	0	0	0	62,834	62,834	0	0	0	0	0	0	62,084	62,084	124,918
Facs. & Env. Health Sup	0	0	0	0	0	0	162,092	162,092	0	0	0	0	0	0	97,671	97,671	259,763
Equipment	0	0	0	0	0	0	7,336	7,336	0	0	0	0	0	0	16,559	16,559	23,895
Total, Facilities	0	0	0	0	0	0	387,457	387,457	0	0	0	0	0	0	381,998	381,998	769,455
TOTAL, IHS	1,806,119	34,044	51,683	59,888	4,887	0	387,457	2,344,079	2,371,681	107,583	49,636	21,592	855,000	0	381,998	3,787,489	6,232,568

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2021 Performance Budget Submission to Congress

TABLE OF CONTENTS

Appropriation Accounts

THIS PAGE INTENTIONALLY LEFT BLANK

INDIAN HEALTH SERVICE

INDIAN HEALTH SERVICES

For expenses necessary to carry out the Act of August 5, 1954 (68 Stat. 674), the Indian Self-Determination and Education Assistance Act, the Indian Health Care Improvement Act, and titles II and III of the Public Health Service Act with respect to the Indian Health Service, **[**$4,315,205,000**]** *$4,507,113,000* to remain available until September 30, **[**2021**]** *2022*, except as otherwise provided herein, together with payments received during the fiscal year pursuant to sections 231(b) and 233 of the Public Health Service Act (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 $2,000,000 shall be available for grants or contracts with public or private institutions to provide alcohol or drug treatment services to Indians, including alcohol detoxification services:**]** *Provided further*, That **[**$964**,**819,000**]** *$964,783,000* for Purchased/Referred Care, including $53,000,000 for the Indian Catastrophic Health Emergency Fund, shall remain available until expended: *Provided further*, That of the funds provided, up to **[**$40,000,000**]** *$44,000,000* shall remain available until expended for implementation of the loan repayment program under section 108 of the Indian Health Care Improvement Act: *Provided further*, That of the funds provided, **[**$125,000,000 shall remain available until expended to supplement funds available for operational costs at tribal clinics operated under an Indian Self-Determination and Education Assistance Act compact or contract where health care is delivered in space acquired through a full service lease, which is not eligible for maintenance and improvement and equipment funds from the Indian Health Service, and**]** $58,000,000 shall be for costs related to or resulting from accreditation emergencies, including supplementing activities funded under the heading "Indian Health Facilities," of which up to $4,000,000 may be used to supplement amounts otherwise available for Purchased/Referred Care: *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 in the Fund authorized by section 108A of that Act (25 U.S.C. 1616a–1) and shall remain available until expended and, notwithstanding section 108A(c) of that 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 that Act (25 U.S.C. 1613a and 1616a): *Provided further*, That the amounts made available within this account for the Substance Abuse and Suicide

Prevention Program, for Opioid Prevention, Treatment and Recovery Services, for the Domestic Violence Prevention Program, for the Zero Suicide Initiative, for **[**the**]** *recruitment and retention, including a* housing subsidy authority for civilian employees, for Aftercare Pilot Programs at Youth Regional Treatment Centers, for transformation and modernization costs of the Indian Health Service Electronic Health Record system, for national quality and oversight **[**activities, to**]** *activities, to* improve collections from public and private insurance at Indian Health Service and tribally operated facilities, *for an initiative to treat or reduce the transmission of HIV and HCV, for the Telebehaviorial Health Center of Excellence, for a maternal health initiative, for Community Health*, and for accreditation emergencies shall be allocated at the discretion of the Director of the Indian Health Service and shall remain available until expended[1]: *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 (25 U.S.C. 1613) shall remain available until expended for the purpose of achieving compliance with the applicable conditions and requirements of titles XVIII and XIX of the Social Security Act, except for those related to the planning, design, or construction of new facilities: *Provided further*, That funding contained herein for scholarship programs under the Indian Health Care Improvement Act (25 U.S.C. 1613) shall remain available until expended: *Provided further*, That amounts received by tribes and tribal organizations under title IV of the Indian Health Care Improvement Act shall be reported and accounted for and available to the receiving tribes and tribal organizations until expended: *Provided further*, That the Bureau of Indian Affairs may collect from the Indian Health Service, and from 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 of the funds provided, $72,280,000 is for the Indian Health Care Improvement Fund and may be used, as needed, to carry out activities typically funded under the Indian Health Facilities account. **[***Provided further, That none of the funds appropriated by this Act to the Indian Health Service for the Electronic Health Record system shall be available for obligation or expenditure for the selection or implementation of a new Information Technology infrastructure system, unless the Committees on Appropriations of the House of Representatives and the Senate are consulted 90 days in advance of such obligation.***]**

CONTRACT SUPPORT COSTS

For payments to tribes and tribal organizations for contract support costs associated with Indian Self-Determination and Education Assistance Act agreements with the Indian Health Service for fiscal year **[**2020**]** *2021*, such sums as may be necessary: *Provided*, That notwithstanding any other provision of law, no amounts made available under this heading shall be available for transfer to another budget account*: Provided further, That amounts obligated but not expended by a tribe or tribal organization for contract support costs for such agreements for the current fiscal year shall be applied to contract support costs due for such agreements for subsequent fiscal years*[2].

PAYMENTS FOR TRIBAL LEASES

For payments to tribes and tribal organizations for leases pursuant to section 105(l) of the Indian Self Determination and Education Assistance Act (25 U.S.C. 5324(l)) for fiscal year 2021, such sums as may be necessary: Provided, That notwithstanding any other provision of law, no amounts made available under this heading shall be available for transfer to another budget account.

INDIAN HEALTH FACILITIES

For construction, repair, maintenance, *demolition,* 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, **[**$911,889,000**]** *$769,455,000* to remain available until expended: *Provided*, That notwithstanding any other provision of law, funds appropriated for the planning, design, construction, renovation or expansion of health facilities for the benefit of an Indian tribe or tribes may be used to purchase land on which such facilities will be located: *Provided further*, That not to exceed $500,000 may be used by the Indian Health Service to purchase TRANSAM equipment from the Department of Defense for distribution to the Indian Health Service and tribal facilities: *Provided further*, That none of the funds appropriated to the Indian Health Service may be used for sanitation facilities construction for new homes funded with grants by the housing programs of the United States Department of Housing and Urban Development. **[**: *Provided further*, That not to exceed $2,700,000 from this account and the "Indian

Health Services" account may be used by the Indian Health Service to obtain ambulances for the Indian Health Service and tribal facilities in conjunction with an existing interagency agreement between the Indian Health Service and the General Services Administration: *Provided further*, That not to exceed $500,000 may be placed in a Demolition Fund, to remain available until expended, and be used by the Indian Health Service for the demolition of Federal buildings**]**.

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 of Health and Human Services; uniforms or allowances therefor as authorized by 5 U.S.C. 5901–5902; and for expenses of attendance at meetings that relate to the functions or activities of the Indian Health Service: *Provided*, That in accordance with the provisions of the Indian Health Care Improvement Act, non-Indian patients may be extended health care at all tribally administered or Indian Health Service facilities, subject to charges, and the proceeds along with funds recovered under the Federal Medical Care Recovery Act (42 U.S.C. 2651–2653) shall be credited to the account of the facility providing the service and shall be available without fiscal year limitation: *Provided further*, That notwithstanding any other law or regulation, funds transferred from the Department of Housing and Urban Development to the Indian Health Service shall be administered under Public Law 86–121, the Indian Sanitation Facilities Act and Public Law 93–638: *Provided further*, That funds appropriated to the Indian Health Service in this Act, except those used for administrative and program direction purposes, shall not be subject to limitations directed at curtailing Federal travel and transportation: *Provided further*, That none of the funds made available to the Indian Health Service in this Act shall be used for any assessments or charges by the Department of Health and Human Services unless identified in the budget justification and provided in this Act, or approved by 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 et seq.), 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 costs associated with the provision of goods, services, or technical assistance: *Provided further*, That the Indian Health Service may provide to civilian medical personnel serving in hospitals operated by the Indian Health Service housing allowances equivalent to those that would be provided to members of the Commissioned Corps of the United States Public Health Service serving in similar positions at such hospitals: *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**]** *none of the funds made available in this Act may be used to compensate an Indian tribe or tribal organization for any lease under section 105(l) of the Indian Self-Determination and Education Assistance Act relating to a facility exceeding 40,000 square feet unless funds for the lease are specifically appropriated in advance for such purpose*[3].

General Provisions

Contract Support Costs, Prior Year Limitation

Sec. 405. Sections 405 and 406 of division F of the Consolidated and Further Continuing Appropriations Act, 2015 (Public Law 113–235) shall continue in effect in fiscal year [2020] *2021*.

Contract Support Costs, Fiscal Year 2021 Limitation

Sec. 406. Amounts provided by this Act for fiscal year [2020] *2021* under the headings "Department of Health and Human Services, Indian Health Service, Contract Support Costs" and "Department of the Interior, Bureau of Indian Affairs and Bureau of Indian Education, Contract Support Costs" are the only amounts available for contract support costs arising out of self-determination or self-governance

contracts, grants, compacts, or annual funding agreements for fiscal year [2020] *2021* with the Bureau of Indian Affairs or the Indian Health Service: *Provided*, That such amounts provided by this Act are not available for payment of claims for contract support costs for prior years, or for repayments of payments for settlements or judgments awarding contract support costs for prior years.

Status of Balances of Appropriations

Sec. 414. The Department of the Interior, Environmental Protection Agency, the Forest Service and the Indian Health Service shall provide the Committees on Appropriations of the House of Representatives and Senate quarterly reports on the status of balances of appropriations including all uncommitted, committed, and unobligated funds in each program and activity within 60 days of enactment of this act.

EXTEND FTCA COVERAGE TO URBAN INDIAN ORGANIZATIONS

SEC. 428. Title V of the Indian Health Care Improvement Act (25 U.S.C. 1651 et seq.) is amended by adding at the end the following:

"SEC. 519. Urban Indian organizations deemed part of Public Health Service.

"(a) Definitions. In this section:

"(1) Contract or agreement. The term "contract or agreement" means a contract, grant agreement, or cooperative agreement entered into under this title.

"(2) Covered claim. The term "covered claim" means a claim by any person initially filed on or after the date of enactment of this section for personal injury, including death.

"(b) Liability protection. For purposes of section 224 of the Public Health Service Act (42 U.S.C. 233), with respect to a covered claim resulting from the performance prior to, including, or after the date of enactment of this section, of medical, surgical, dental, or related functions, including the conduct of a clinical study or investigation, performed while carrying out a contract or agreement, or for purposes of section 2679, title 28, United States Code, with respect to a covered claim resulting from the operation of an emergency motor vehicle pursuant to a contract or agreement—

"(1) an urban Indian organization is deemed to be part of the Public Health Service in the Department while carrying out the contract or agreement; and

"(2) any officer, governing board member, or employee of the urban Indian organization (including any contractor or individual that provides health care services pursuant to a personal services contract) is deemed to be an employee of the Public Health Service while acting within the scope of their employment in carrying out

the contract or agreement.".

CONCURRENT FEDERAL AND STATE JURISDICTION AT IHS FEDERAL ENCLAVE PROPERTIES

SEC. 429.

(a) IN GENERAL.—The Secretary of Health and Human Services, on behalf of the United States, may, whenever the Secretary deems desirable, relinquish to a State all or part of the jurisdiction of the United States over lands and properties encompassing Indian Health Service facilities that are under the supervision or control of the Secretary.

(1) TERMS.—Relinquishment of jurisdiction under this section may be accomplished, under terms and conditions that the Secretary deems advisable:

(A) by filing with the Governor of such State a notice of relinquishment to take effect upon acceptance thereof; or

(B) as the laws of such State may otherwise provide.

INCOME TAX EXCLUSION FOR INDIAN HEALTH SERVICE SCHOLARSHIP AND LOAN REPAYMENT PROGRAMS

SEC. 430.

(a) IHS SCHOLARSHIP PROGRAM. Section 117(c)(2) of the Internal Revenue Code of 1986 is amended—

(1) in subparagraph (B), by striking "or";

(2) in subparagraph (C), by striking the period and inserting ", or"; and

(3) by adding the following new subparagraph: "(D) the Indian Health Service Health Professions Scholarship program under section 104 of the Indian Health Care Improvement Act.".

(b) IHS LOAN REPAYMENT PROGRAM.—

(1) EXCLUSION. Section 108(f) of the Internal Revenue Code of 1986 is amended by adding a new subsection to read as follows:

"(5) PAYMENTS UNDER INDIAN HEALTH SERVICE LOAN REPAYMENT PROGRAM. In the case of an individual, gross income shall not include any amount received under section 108 of the Indian Health Care Improvement Act.".

(2) CONFORMING AMENDMENT FOR TAX WITHHOLDING. Section 3401(a)(19) of the Internal Revenue Code of 1986 is amended by inserting"108(f)(5)," after "108(f)(4),".

HALF-TIME BASIS SERVICE OBLIGATION OPTION

SEC. 431.

(a) SCHOLARSHIP PROGRAM.—Section 104(b) of the Indian Health Care Improvement Act (25 U.S.C. 1613a(b)) is amended—

(1) in paragraph (3)(A), by inserting after "full-time" the following: ", or, pursuant to paragraph (6), half-time"; and

(2) by adding at the end the following paragraph:

"(6) HALF-TIME SERVICE OPTION. In carrying out paragraph (3), the Secretary may, in accordance with this paragraph, allow an individual to meet the individual's service obligation through half-time practice if—

"(A) the Secretary has determined that assignment of a health professional who would serve half-time would be appropriate for the location where, or the program in which, the individual will be performing his or her service;

"(B) the individual agrees in writing to fulfill all of the service obligations under this section through half-time clinical practice and double the period of obligated service that would otherwise be required; and

"(C) the individual agrees in writing that if the individual begins providing half-time service but fails to begin or complete the period of obligated service, the method stated in section 108(l) for determining the damages for breach of the individual's written contract will be used after converting periods of obligated service or of service performed into their full-time equivalents.".

(b) LOAN REPAYMENT PROGRAM. Section 108 of such Act (25 U.S.C. 1616a) is amended—

(1) in subsection (f)(1)(B)(iii), by inserting after "may agree to serve" the following: ", or, pursuant to subsection (o), 4 years or such longer period as the individual may agree to serve,"; and

(2) by adding at the end the following subsection:

"(o) HALF-TIME SERVICE OPTION. - In carrying out this section, the Secretary may, in accordance with this subsection, allow an individual to meet the individual's service obligation through half-time practice if—

"(1) the individual agrees in the written contract that the period of obligated service under subsection (f) shall be 4 years or such longer period as the individual may agree to serve, in place of the period otherwise prescribed in paragraph (1)(B)(iii) of such subsection;

"(2) the maximum loan repayment for each year of obligated service shall be 50 percent of the amount that would otherwise be payable, under subsection (g)(2)(A), for full-time service; and
"(3) the individual agrees in writing that if the individual begins providing half-time service but fails to begin or complete the period of obligated service, the method stated in subsection (l) for determining the damages for breach of the individual's written contract will be used after converting periods of obligated
service or of service performed into their full-time equivalents.".

FTCA AND FECA COVERAGE FOR IHS VOLUNTEERS

SEC. 432. Section 224 of the Public Health Service Act (42 U.S.C. 233) is amended by adding a new subsection as follows:
"(r) TORT CLAIMS AND WORK INJURY COMPENSATION COVERAGE FOR VOLUNTEERS IN INDIAN HEALTH SERVICE FACILITIES.
"(1) IN GENERAL. If under section 223 and regulations pursuant to such section, and through an agreement entered into in accordance with such regulations, the Secretary accepts volunteer and uncompensated services from an individual to provide health care services at a facility of the Indian Health Service during a specified period, such individual shall, during such period, have the coverages described in paragraphs (2) and (3).
"(2) FEDERAL TORT CLAIMS ACT COVERAGE. Such individual shall, during such period,
"(i) be deemed to be an employee of the Department of Health and Human Services, for purposes of claims under sections 1346(b) and 2672 of title 28, United States Code, for money damages for personal injury, including death, resulting from performance of functions under such agreement; and
"(ii) be deemed to be an employee of the Public Health Service performing medical, surgical, dental, or related functions, for purposes of having the remedy provided by such sections of title 28 be exclusive of any other civil action or proceeding by reason of the same subject matter against such individual or against the estate of such individual.
"(3) COMPENSATION FOR WORK INJURIES. Such individual shall, during such period, be deemed to be an employee of the Department of Health and Human Services, and an injury sustained by such an individual shall be deemed in the performance of duty, for purposes of chapter 81 of title 5, United States Code, pertaining to compensation for work injuries."

TRIBAL LEASES

SEC. 434.

(a) Notwithstanding any other provision of law, in the case of any lease under section 105(l) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 5324(l)), the initial lease term shall—

(1) be consistent with the calendar year or fiscal year basis of the funding agreement or annual funding agreement between the Secretary and Indian tribe or tribal organization under that Act; and

(2) commence no earlier than the date of receipt of the lease proposal.

(b) None of the funds made available under this Act may be used to compensate an Indian tribe or tribal organization for any lease under section 105(l) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 5324(l)) that is on a calendar year or fiscal year basis and that is received during the 120 day period ending on the last day of the calendar year or fiscal year.

(c) None of the funds made available under this Act may be used to compensate an Indian tribe or tribal organization for any portion of a lease under section 105(l) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 5324(l)) that exceeds the square footage necessary for the operation of the Federalprograms under the lease, as determined by the Secretary.

TRIBAL AGREEMENTS

SEC. 435. Notwithstanding sections 106(b)(2) and 516(a) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 5325(b)(2), 5396(a)), the Secretary of Health and Human Services and the Secretary of the Interior may reduce the amount of funds provided under the terms of a self-determination contract or compact entered into under that Act if—

(1) the approval of an increase to the amount of funds that would otherwise be required under the terms of such contract or compact was made pursuant to section 507(b) of that Act (25 U.S.C. 5387(b)) or section 900.18 or 1000.179 of title 25, Code of Federal Regulations; and

(2) the amount of the reduction does not exceed the amount of the increase.

Language Provision	Explanation
INDIAN HEALTH SERVICE PROVISIONS	
[1]*Provided further*, That the amounts made available within this account for the Substance Abuse and Suicide Prevention Program, for	Proposed initiative funding increases are added to this provision to allow funding to remain available until expended, and to ensure funds

Opioid Prevention, Treatment and Recovery Services, for the Domestic Violence Prevention Program, for the Zero Suicide Initiative, for [the] *recruitment and retention, including a* housing subsidy authority for civilian employees, for Aftercare Pilot Programs at Youth Regional Treatment Centers, for transformation and modernization costs of the Indian Health Service Electronic Health Record system, for national quality and oversight activities [activities to]*, activities, to* improve collections from public and private insurance at Indian Health Service and tribally operated facilities, *for an initiative to treat or reduce the transmission of HIV and HCV, for the Telebehaviorial Health Center of Excellence, for a maternal health initiative, for Community Health* and for accreditation emergencies shall be allocated at the discretion of the Director of the Indian Health Service and shall remain available until expended:	may be distributed at the discretion of the IHS Director.
CONTRACT SUPPORT COSTS	
[2]*Provided, That amounts obligated but not expended by a tribe or tribal organization for contract support costs for such agreements for the current fiscal year shall be applied to contract support costs otherwise due for such agreements for subsequent fiscal years:*	This provision was enacted by Congress in the Consolidated Appropriations Act, 2016 (P.L. 114-113), but not repeated in subsequent years. The proposed re-authorization of this provision seeks to reduce the burden on Tribes and IHS when it is determined that CSC has been overpaid in the final reconciliation for a year. In these instances, this authority would allow for the amount to be offset in the negotiation of CSC amounts for the next fiscal year. CSC amounts owed to a Tribe or Tribal Organization would continue to be paid in full, in accordance with the ISDEAA.
ADMINISTRATIVE PROVISIONS	
[3]*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**]**That *none of the funds made available in this Act may be used to compensate an Indian tribe or tribal organization for any lease under section 105(l) of the Indian Self-Determination and Education Assistance Act relating to a facility exceeding 40,000 square feet unless funds for the lease are specifically appropriated in advance for such purpose*.	New language is included to add clarity and specification regarding the usage of funds for ISDEAA section 105(*l*) leases.

INDIAN HEALTH SERVICE
Amounts Available for Obligations

SERVICES

	FY 2019	FY 2020	FY 2021
General Fund Discretionary Appropriation:			
Appropriation (Interior)	$4,103,190,000	$4,315,205,000	$4,507,113,000
Across-the-board reductions (Interior)	$0	$0	$0
Subtotal, Appropriation (Interior)	$4,103,190,000	$4,315,205,000	$4,507,113,000
Mandatory Appropriation:			
Appropriation 1/	$150,000,000	$150,000,000	$150,000,000
Offsetting Collections:			
Federal sources	($437,000)	($436,000)	($436,000)
Non-federal sources	($1,302,000,000)	($1,365,000,000)	($1,432,000,000)
Subtotal, Offsetting Collections	($1,302,437,000)	($1,365,436,000)	($1,432,436,000)
Unobligated Balances:			
Discretionary, Start of Year	$1,219,000,000	$1,510,000,000	$1,607,000,000
Mandatory, Start of Year	$291,000,000	$97,000,000	$97,000,000
End of Year	$1,510,000,000	$1,607,000,000	$1,704,000,000
Total Obligations, Services	$2,950,753,000	$3,099,769,000	$3,127,677,000

1/ The Budget requests an extension of the Special Diabetes Program for Indians through FY 2021. The FY2020 Further Consolidated Appropriations Act provides only $96.6 million for SDPI, for activity through May 22nd, 2020. The table includes actual and requested funding for SDPI in FY 2020.

INDIAN HEALTH SERVICE
Amounts Available for Obligations

FACILITIES

	FY 2019	FY 2020	FY 2021
General Fund Discretionary Appropriation:			
Appropriation (Interior)	$878,806,000	$911,889,000	$769,455,000
Across-the-board reductions (Interior)	$0	$0	$0
Subtotal, Appropriation (Interior)	$878,806,000	$911,889,000	$769,455,000
Offsetting Collections:			
Federal sources	(31,000,000)	($59,000,000)	(59,000,000)
Subtotal, Offsetting Collections	(31,000,000)	($59,000,000)	(59,000,000)
Unobligated Balances:			
Discretionary, Start of Year	$621,000,000	$630,000,000	$569,000,000
End of Year	$630,000,000	$569,000,000	$628,000,000
Total Obligations, Facilities	$838,806,000	$913,889,000	$651,455,000

INDIAN HEALTH SERVICE
Amounts Available for Obligations

CONTRACT SUPPORT COSTS

	FY 2019	FY 2020	FY 2021
General Fund Discretionary Appropriation:			
Appropriation (Interior) 1/	$822,227,000	$855,000,000	$855,000,000
Across-the-board reductions (Interior)	$0	$0	$0
Subtotal, Appropriation (Interior)	$822,227,000	$855,000,000	$855,000,000
Total Obligations, CSC	$822,227,000	$855,000,000	$855,000,000

1/ The Congressional Budget Office score for FY 2020 for Contract Support costs is $820,000,000.

INDIAN HEALTH SERVICE
Amounts Available for Obligations

PAYMENTS FOR TRIBAL LEASES

	FY 2019	FY 2020	FY 2021
General Fund Discretionary Appropriation:			
Appropriation (Interior) 1/	$0	$0	$101,000,000
Across-the-board reductions (Interior)	$0	$0	$0
Subtotal, Appropriation (Interior)	$0	$0	$101,000,000
Total Obligations, Payments for Tribal Leases	$0	$0	$101,000,000

1/ The FY 2021 President's Budget proposes a new indefinite discretionary appropriation for payments of tribal leases, owing to Section 105(l), ISDEAA (P.L. 93-638). Amounts for FY 2019 and FY 2020 are located in the Hospitals and Health Clinics line of the Services Appropriation.

INDIAN HEALTH SERVICE

SERVICES

Summary of Changes

FY 2020 Enacted	4,315,205,000
Total estimated budget authority	4,315,205,000
Less Obligations	(4,315,205,000)
FY 2021 Estimate	4,507,113,000
Less Obligations	(4,507,113,000)
Net Change	191,908,000
Less Obligations	(191,908,000)

		FY 2020 Enacted Base		Change from Base	
		FTE	BA	FTE/Pos	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2020 CO Pay Raise (3 months)	--	n/a	--	0
2	FY 2021 Pay Raise CO (9 months)	--	n/a	--	0
3	Annualization of FY 2020 CS Pay Raise (3 months)	--	n/a	--	0
4	FY 2021 Pay Raise CS (9 months)	--	n/a	--	0
5	Tribal Pay Cost	--	n/a	--	0
6	Increased Cost of Travel	--	30,261,664	--	64,295
7	Increased Cost of Transportation & Things	--	8,824,731	--	0
8	Increased Cost of Printing	--	29,347,987	--	286,895
9	Increased Cost of Rents, Communications, & Utilities	--	432,596	--	0
10	Increased Cost of Other Services	--	31,182,245	--	329,472
11	Increased Cost of Health Care Provided under Contracts & Grants	--	2,602,779,935	--	27,213,953
12	Increased Cost of Supplies	--	74,599,699	--	655,008
13	Increased Cost of Medical or other Equipment	--	6,354,305	--	51,439
14	Increased Cost of Land & Structure	--	99,545	--	0
15	Increased Cost of Grants	--	592,666,319	--	5,293,937
16	Increased Cost of Insurance / Indemnities	--	22,681,513	--	0
17	Increased Cost of Interest / Dividends	--	131,352	--	0
18	Population Growth	--	n/a	--	0
	Subtotal, Built-In	--	3,399,361,892	--	33,895,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	--	32,910,000
C. New Tribes		--	0	--	2,560,000
D. Program Adjustments		--	0	--	186,277,000
E. Program Increases		--	0	42	200,417,000
	TOTAL INCREASES	--	3,399,361,892	42	456,059,000
DECREASES					
A. Built-In					
1	Decrease in the number of compensable days	--	0	--	0
2	Absorption of Built-In Increases	--	0	--	0
	Subtotal Build-In Decreases	--	0	--	0
B. Transfer					
	Transfer of NIAAA Programs from Alcohol to Urban	--	0	--	0
C. Program Adjustments		--	0	--	(264,151,000)
	TOTAL DECREASES	--	0	--	(264,151,000)
NET CHANGE		--	**3,399,361,892**	**42**	**191,908,000**

INDIAN HEALTH SERVICE
CLINICAL Services
Summary of Changes

FY 2020 Enacted	3,934,831,000
Total estimated budget authority	3,934,831,000
Less Obligations	(3,934,831,000)
FY 2021 Estimate	4,177,800,000
Less Obligations	(4,177,800,000)
Net Change	242,969,000
Less Obligations	(242,969,000)

		FY 2020 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2020 CO Pay Raise (3 months)	--	n/a	--	0
2	FY 2021 Pay Raise CO (9 months)	--	n/a	--	0
3	Annualization of FY 2020 CS Pay Raise (3 months)	--	n/a	--	0
4	FY 2021 Pay Raise CS (9 months)	--	n/a	--	0
5	Tribal Pay Cost	--	n/a	--	0
6	Increased Cost of Travel	--	29,927,853	--	64,295
7	Increased Cost of Transportation & Things	--	6,217,173	--	0
8	Increased Cost of Printing	--	29,000,549	--	286,895
9	Increased Cost of Rents, Communications, & Utilities	--	168,631	--	0
10	Increased Cost of Other Services	--	28,644,583	--	261,318
11	Increased Cost of Health Care Provided under Contracts & Grants	--	2,568,911,956	--	26,583,953
12	Increased Cost of Supplies	--	72,522,810	--	639,724
13	Increased Cost of Medical or other Equipment	--	5,799,771	--	50,454
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	416,288,715	--	4,598,361
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	0
	Subtotal, Built-In	--	3,157,482,042	--	32,485,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	0	30,754,000
C. Program Adjustments		--	0	--	185,653,000
C. Funding for Newly Recognized Tribes		--	0	--	2,560,000
D. Program Increases		--	0	25	138,410,000
	TOTAL INCREASES	--	3,157,482,042	25	389,862,000
DECREASES					
A. Built-In					
1	Decrease in the number of compensable days	--	0	--	0
2	Absorption of Built-In Increases	--	0	--	0
	Subtotal Build-In Decreases	--	0	--	0
B. Transfer					
	Transfer of NIAAA Programs from Alcohol to Urban	--	0	--	0
C. Program Adjustments		--	0	--	(146,893,000)
	TOTAL DECREASES	--	0	--	(146,893,000)
NET CHANGE		--	**3,157,482,042**	**25**	**242,969,000**

INDIAN HEALTH SERVICE
Hospitals & Health Clinics
Summary of Changes

FY 2020 Enacted	2,324,606,000
Total estimated budget authority	2,324,606,000
Less Obligations	(2,324,606,000)
FY 2021 Estimate	2,432,384,000
Less Obligations	(2,432,384,000)
Net Change	107,778,000
Less Obligations	(107,778,000)

		FY 2020 Enacted Base		Change from Base	
		FTE	BA	FTE/Pos	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2020 CO Pay Raise (3 months)	--	n/a	--	0
2	FY 2021 Pay Raise CO (9 months)	--	n/a	--	0
3	Annualization of FY 2020 CS Pay Raise (3 months)	--	n/a	--	0
4	FY 2021 Pay Raise CS (9 months)	--	n/a	--	0
5	Tribal Pay Cost	--	n/a	--	0
6	Increased Cost of Travel	--	5,557,441	--	56,769
7	Increased Cost of Transportation & Things	--	5,491,788	--	0
8	Increased Cost of Printing	--	28,085,919	--	286,895
9	Increased Cost of Rents, Communications, & Utilities	--	166,870	--	0
10	Increased Cost of Other Services	--	0	--	0
11	Increased Cost of Health Care Provided under Contracts & Grants	--	1,575,981,145	--	16,098,509
12	Increased Cost of Supplies	--	52,610,486	--	537,411
13	Increased Cost of Medical or other Equipment	--	3,173,374	--	32,416
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	0	--	0
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	0
	Subtotal, Built-In	--	1,671,067,024	--	17,012,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	--	24,430,000
C. Program Adjustments		--	0	--	151,836,000
D. Built-In					
1	Elimination HIV/HCV			6	27,000,000
2	Recruitment and Retention			5	3,500,000
3	Improving Maternal Health In America			1	5,000,000
	Subtotal Program Changes	--	0	12	35,500,000
	TOTAL INCREASES	--	1,671,067,024	12	228,778,000
DECREASES					
A. Built-In					
1	Decrease in the number of compensable days	0	0	--	0
2	Absorption of Built-In Increases	--	0	--	0
	Subtotal Build-In Decreases	--	0	--	0
B. Program Adjustments					
1	Tribal Clinic Operating Leases				(20,000,000)
2	Community Health Realignment				(101,000,000)
	Subtotal Program Changes	--	0	--	(121,000,000)
	TOTAL DECREASES	--	0	--	(121,000,000)
NET CHANGE		--	**1,671,067,024**	**12**	**107,778,000**

INDIAN HEALTH SERVICE
Electronic Health Record
Summary of Changes

FY 2020 Enacted	8,000,000
Total estimated budget authority	8,000,000
Less Obligations	(8,000,000)
FY 2021 Estimate	125,000,000
Less Obligations	(125,000,000)
Net Change	117,000,000
Less Obligations	(117,000,000)

		FY 2020 Enacted Base		Change from Base	
		FTE	BA	Pos	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2020 CO Pay Raise (3 months)	--	n/a	--	0
2	FY 2021 Pay Raise CO (9 months)	--	n/a	--	0
3	Annualization of FY 2020 CS Pay Raise (3 months)	--	n/a	--	0
4	FY 2021 Pay Raise CS (9 months)	--	n/a	--	0
5	Tribal Pay Cost	--	n/a	--	0
6	Increased Cost of Travel	--	0	--	0
7	Increased Cost of Transportation & Things	--	0	--	0
8	Increased Cost of Printing	--	0	--	0
9	Increased Cost of Rents, Communications, & Utilities	--	0	--	0
10	Increased Cost of Other Services	--	5,000,000	--	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	--	1,000,000	--	0
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	0	--	0
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	--	6,000,000	--	0
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	--	0
C. Program Adjustment		--	0	--	17,000,000
D. Program Increase		--	0	6	100,000,000
	TOTAL INCREASES	--	6,000,000	6	117,000,000
DECREASES					
A. Built-In					
1	Decrease in the number of compensable days	--	0	--	0
2	Absorption of Built-In Increases	--	0	--	0
	Subtotal Build-In Decreases	--	0	--	0
	TOTAL DECREASES	--	0	--	0
NET CHANGE		--	**6,000,000**	**6**	**117,000,000**

INDIAN HEALTH SERVICE
Dental Health
Summary of Changes

FY 2020 Enacted	210,590,000
Total estimated budget authority	210,590,000
Less Obligations	(210,590,000)
FY 2021 Estimate	219,380,000
Less Obligations	(219,380,000)
Net Change	8,790,000
Less Obligations	(8,790,000)

		FY 2020 Enacted Base		Change from Base	
		FTE	BA	Pos	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2020 CO Pay Raise (3 months)	--	n/a	--	0
2	FY 2021 Pay Raise CO (9 months)	--	n/a	--	0
3	Annualization of FY 2020 CS Pay Raise (3 months)	--	n/a	--	0
4	FY 2021 Pay Raise CS (9 months)	--	n/a	--	0
5	Tribal Pay Cost	--	n/a	--	0
6	Increased Cost of Travel	--	654,987	--	7,526
7	Increased Cost of Transportation & Things	--	268,285	--	0
8	Increased Cost of Printing	--	110,421	--	0
9	Increased Cost of Rents, Communications, & Utilities	--	0	--	0
10	Increased Cost of Other Services	--	6,454,992	--	74,172
11	Increased Cost of Health Care Provided under Contracts & Grants	--	0	--	0
12	Increased Cost of Supplies	--	4,806,379	--	55,228
13	Increased Cost of Medical or other Equipment	--	801,248	--	9,207
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	131,660,513	--	1,512,866
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	--	144,756,825	--	1,659,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	--	3,808,000
C. Program Adjustment		--	0	--	3,323,000
D. Program Increase		--	0	--	0
	TOTAL INCREASES	--	144,756,825	--	8,790,000
DECREASES					
A. Built-In					
1	Decrease in the number of compensable days	--	0	--	0
2	Absorption of Built-In Increases	--	0	--	0
	Subtotal Build-In Decreases	--	0	--	0
	TOTAL DECREASES	--	0	--	0
NET CHANGE		--	**144,756,825**	--	**8,790,000**

INDIAN HEALTH SERVICE
Mental Health
Summary of Changes

FY 2020 Enacted	108,933,000
Total estimated budget authority	108,933,000
Less Obligations	(108,933,000)
FY 2021 Estimate	128,228,000
Less Obligations	(128,228,000)
Net Change	19,295,000
Less Obligations	(19,295,000)

		FY 2020 Enacted Base		Change from Base	
		FTE	BA	Pos	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2020 CO Pay Raise (3 months)	--	n/a	--	0
2	FY 2021 Pay Raise CO (9 months)	--	n/a	--	0
3	Annualization of FY 2020 CS Pay Raise (3 months)	--	n/a	--	0
4	FY 2021 Pay Raise CS (9 months)	--	n/a	--	0
5	Tribal Pay Cost	--	n/a	--	0
6	Increased Cost of Travel	--	267,557	--	0
7	Increased Cost of Transportation & Things	--	237,883	--	0
8	Increased Cost of Printing	--	17,731	--	0
9	Increased Cost of Rents, Communications, & Utilities	--	625	--	0
10	Increased Cost of Other Services	--	5,630,646	--	64,371
11	Increased Cost of Health Care Provided under Contracts & Grants	--	0	--	0
12	Increased Cost of Supplies	--	1,558,711	--	17,819
13	Increased Cost of Medical or other Equipment	--	38,907	--	445
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	76,832,567	--	878,365
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	--	84,584,627	--	961,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	--	1,930,000
C. Program Adjustments		--	0	--	13,494,000
D. Tele-Behavioral Health Center Program Change		--	0	7	2,910,000
	TOTAL INCREASES	--	84,584,627	7	19,295,000
DECREASES					
A. Built-In					
1	Decrease in the number of compensable days	--	0	--	0
2	Absorption of Built-In Increases	--	0	--	0
	Subtotal Build-In Decreases	--	0	--	0
	TOTAL DECREASES	--	0	--	0
NET CHANGE		--	**84,584,627**	**7**	**19,295,000**

INDIAN HEALTH SERVICE
Alcohol and Substance Abuse
Summary of Changes

FY 2020 Enacted	245,603,000
Total estimated budget authority	245,603,000
Less Obligations	(245,603,000)
FY 2021 Estimate	235,745,000
Less Obligations	(235,745,000)
Net Change	(9,858,000)
Less Obligations	9,858,000

		FY 2020 Enacted Base		Change from Base	
		FTE	BA	FTE/Pos	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2020 CO Pay Raise (3 months)	--	n/a	--	0
2	FY 2021 Pay Raise CO (9 months)	--	n/a	--	0
3	Annualization of FY 2020 CS Pay Raise (3 months)	--	n/a	--	0
4	FY 2021 Pay Raise CS (9 months)	--	n/a	--	0
5	Tribal Pay Cost	--	n/a	--	0
6	Increased Cost of Travel	--	418,275	--	0
7	Increased Cost of Transportation & Things	--	199,024	--	0
8	Increased Cost of Printing	--	422,365	--	0
9	Increased Cost of Rents, Communications, & Utilities	--	0	--	0
10	Increased Cost of Other Services	--	11,558,945	--	122,775
11	Increased Cost of Health Care Provided under Contracts & Grants	--	0	--	0
12	Increased Cost of Supplies	--	714,493	--	7,589
13	Increased Cost of Medical or other Equipment	--	141,805	--	1,506
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	207,795,636	--	2,207,130
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	--	221,250,542	--	2,339,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	0	586,000
C. Program Adjustment		--	0	--	0
	TOTAL INCREASES	--	221,250,542	0	2,925,000
DECREASES					
A. Built-In					
1	Decrease in the number of compensable days	--	0	--	0
2	Absorption of Built-In Increases	--	0	--	0
	Subtotal Build-In Decreases	--	0	--	0
B. Transfer					
	Transfer of NIAAA Programs from Alcohol to Urban	--	0	--	0
C. Transfer					
	Program Adjustment	--	0	--	(12,783,000)
	TOTAL DECREASES	--	0	--	(12,783,000)
NET CHANGE		--	**221,250,542**	**0**	**(9,858,000)**

INDIAN HEALTH SERVICE
Purchased/Referred Care
Summary of Changes

FY 2020 Enacted	964,819,000
Total estimated budget authority	964,819,000
Less Obligations	(964,819,000)
FY 2021 Estimate	964,783,000
Less Obligations	(964,783,000)
Net Change	(36,000)
Less Obligations	36,000

		FY 2020 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2020 CO Pay Raise (3 months)	--	n/a	--	0
2	FY 2021 Pay Raise CO (9 months)	--	n/a	--	0
3	Annualization of FY 2020 CS Pay Raise (3 months)	--	n/a	--	0
4	FY 2021 Pay Raise CS (9 months)	--	n/a	--	0
5	Tribal Pay Cost	--	n/a	--	0
6	Increased Cost of Travel	--	22,966,046	--	0
7	Increased Cost of Transportation & Things	--	58	--	0
8	Increased Cost of Printing	--	2,913	--	0
9	Increased Cost of Rents, Communications, & Utilities	--	0	--	0
10	Increased Cost of Other Services	--	0	--	0
11	Increased Cost of Health Care Provided under Contracts & Grants	--	928,510,061	--	9,795,000
12	Increased Cost of Supplies	--	10,810,362	--	0
13	Increased Cost of Medical or other Equipment	--	2,500	--	0
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	0	--	0
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	--	962,291,940	--	9,795,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	--	0
C. Funding for Newly Recognized Tribes		--	0	--	2,560,000
D. Program Adjustment		--	0	--	0
	TOTAL INCREASES	--	962,291,940	--	12,355,000
DECREASES					
A. Built-In					
1	Decrease in the number of compensable days	--	0	--	0
2	Absorption of Built-In Increases	--	0	--	0
	Subtotal Build-In Decreases	--	0	--	0
B. Program Adjustment		--	0	--	(12,391,000)
	TOTAL DECREASES	--	0	--	(12,391,000)
NET CHANGE		--	**962,291,940**	--	**(36,000)**

INDIAN HEALTH SERVICE
Indian Health Care Improvement Fund
Summary of Changes

FY 2020 Enacted	72,280,000
Total estimated budget authority	72,280,000
Less Obligations	(72,280,000)
FY 2021 Estimate	72,280,000
Less Obligations	(72,280,000)
Net Change	0
Less Obligations	0

		FY 2020 Enacted Base		Change from Base	
		FTE	BA	Pos	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2020 CO Pay Raise (3 months)	--	n/a	--	0
2	FY 2021 Pay Raise CO (9 months)	--	n/a	--	0
3	Annualization of FY 2020 CS Pay Raise (3 months)	--	n/a	--	0
4	FY 2021 Pay Raise CS (9 months)	--	n/a	--	0
5	Tribal Pay Cost	--	n/a	--	0
6	Increased Cost of Travel	--	63,548	--	0
7	Increased Cost of Transportation & Things	--	20,135	--	0
8	Increased Cost of Printing	--	361,200	--	0
9	Increased Cost of Rents, Communications, & Utilities	--	1,136	--	0
10	Increased Cost of Other Services	--	0	--	0
11	Increased Cost of Health Care Provided under Contracts & Grants	--	64,420,749	--	690,445
12	Increased Cost of Supplies	--	2,022,379	--	21,675
13	Increased Cost of Medical or other Equipment	--	641,936	--	6,880
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	0	--	0
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	--	67,531,084	--	719,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	--	0
C. Program Adjustment		--	0	--	0
D. Program Increase		--	0	--	0
	TOTAL INCREASES	--	67,531,084	--	719,000
DECREASES					
A. Built-In					
1	Decrease in the number of compensable days	--	0	--	0
2	Absorption of Built-In Increases	--	0	--	0
	Subtotal Build-In Decreases	--	0	--	0
B. Program Adjustment		--	0	--	(719,000)
	TOTAL DECREASES	--	0	--	(719,000)
NET CHANGE		--	**67,531,084**	--	**0**

INDIAN HEALTH SERVICE
PREVENTIVE Health
Summary of Changes

FY 2020 Enacted	177,567,000
Total estimated budget authority	177,567,000
Less Obligations	(177,567,000)
FY 2021 Estimate	141,627,000
Less Obligations	(141,627,000)
Net Change	(35,940,000)
Less Obligations	35,940,000

		FY 2020 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2020 CO Pay Raise (3 months)	--	n/a	--	0
2	FY 2021 Pay Raise CO (9 months)	--	n/a	--	0
3	Annualization of FY 2020 CS Pay Raise (3 months)	--	n/a	--	0
4	FY 2021 Pay Raise CS (9 months)	--	n/a	--	0
5	Tribal Pay Cost	--	n/a	--	0
6	Increased Cost of Travel	--	333,811	--	0
7	Increased Cost of Transportation & Things	--	783,788	--	0
8	Increased Cost of Printing	--	60,761	--	0
9	Increased Cost of Rents, Communications, & Utilities	--	4,961	--	0
10	Increased Cost of Other Services	--	2,491,835	--	24,154
11	Increased Cost of Health Care Provided under Contracts & Grants	--	0	--	0
12	Increased Cost of Supplies	--	1,987,517	--	15,284
13	Increased Cost of Medical or other Equipment	--	109,002	--	985
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	84,695,058	--	695,576
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	--	90,466,732	--	736,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	--	2,156,000
C. Program Adjustment		--	0	--	624,000
C. Program Change		--	0	6	44,109,000
	TOTAL INCREASES	--	90,466,732	6	47,625,000
DECREASES					
A. Built-In					
1	Decrease in the number of compensable days	--	0	--	0
2	Absorption of Built-In Increases	--	0	--	0
	Subtotal Build-In Decreases	--	0	--	0
B. Program Adjustments		--	0	--	(83,565,000)
	TOTAL DECREASES	--	0	--	(83,565,000)
NET CHANGE		--	**90,466,732**	**6**	**(35,940,000)**

INDIAN HEALTH SERVICE
Public Health Nursing
Summary of Changes

FY 2020 Enacted	91,984,000
Total estimated budget authority	91,984,000
Less Obligations	(91,984,000)
FY 2021 Estimate	95,353,000
Less Obligations	(95,353,000)
Net Change	3,369,000
Less Obligations	(3,369,000)

		FY 2020 Enacted Base		Change from Base	
		FTE	BA	Pos	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2020 CO Pay Raise (3 months)	--	n/a	--	0
2	FY 2021 Pay Raise CO (9 months)	--	n/a	--	0
3	Annualization of FY 2020 CS Pay Raise (3 months)	--	n/a	--	0
4	FY 2021 Pay Raise CS (9 months)	--	n/a	--	0
5	Tribal Pay Cost	--	n/a	--	0
6	Increased Cost of Travel	--	240,115	--	0
7	Increased Cost of Transportation & Things	--	767,613	--	0
8	Increased Cost of Printing	--	37,801	--	0
9	Increased Cost of Rents, Communications, & Utilities	--	2,045	--	0
10	Increased Cost of Other Services	--	2,339,680	--	24,154
11	Increased Cost of Health Care Provided under Contracts & Grants	--	0	--	0
12	Increased Cost of Supplies	--	1,480,494	--	15,284
13	Increased Cost of Medical or other Equipment	--	95,423	--	985
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	65,148,300	--	672,576
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	--	70,111,472	--	713,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	0	2,047,000
C. Program Adjustment		--	0	0	609,000
	TOTAL INCREASES	--	70,111,472	0	3,369,000
DECREASES					
A. Built-In					
1	Decrease in the number of compensable days	--	0	--	0
2	Absorption of Built-In Increases	--	0	--	0
	Subtotal Build-In Decreases	--	0	--	0
B. Program Reductions		--	0	--	0
	TOTAL DECREASES	--	0	--	0
NET CHANGE		--	**70,111,472**	**0**	**3,369,000**

INDIAN HEALTH SERVICE
Health Education
Summary of Changes

FY 2020 Enacted	20,568,000
Total estimated budget authority	20,568,000
Less Obligations	(20,568,000)
FY 2021 Estimate	0
Less Obligations	0
Net Change	(20,568,000)
Less Obligations	20,568,000

		FY 2020 Enacted Base		Change from Base	
		FTE	BA	Pos	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2020 CO Pay Raise (3 months)	--	n/a	--	0
2	FY 2021 Pay Raise CO (9 months)	--	n/a	--	0
3	Annualization of FY 2020 CS Pay Raise (3 months)	--	n/a	--	0
4	FY 2021 Pay Raise CS (9 months)	--	n/a	--	0
5	Tribal Pay Cost	--	n/a	--	0
6	Increased Cost of Travel	--	93,696	--	0
7	Increased Cost of Transportation & Things	--	16,175	--	0
8	Increased Cost of Printing	--	22,959	--	0
9	Increased Cost of Rents, Communications, & Utilities	--	2,917	--	0
10	Increased Cost of Other Services	--	152,154	--	0
11	Increased Cost of Health Care Provided under Contracts & Grants	--	0	--	0
12	Increased Cost of Supplies	--	507,023	--	0
13	Increased Cost of Medical or other Equipment	--	13,578	--	0
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	17,419,758	--	0
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	--	18,228,261	--	0
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	--	109,000
	TOTAL INCREASES	--	18,228,261	--	109,000
DECREASES					
A. Built-In					
1	Decrease in the number of compensable days	--	0	--	0
2	Absorption of Built-In Increases	--	0	--	0
	Subtotal Build-In Decreases	--	0	--	0
B. Program Reductions		--	0	--	(20,677,000)
	TOTAL DECREASES	--	0	--	(20,677,000)
NET CHANGE		--	**18,228,261**	--	**(20,568,000)**

INDIAN HEALTH SERVICE
Community Health Representatives
Summary of Changes

FY 2020 Enacted	62,888,000
Total estimated budget authority	62,888,000
Less Obligations	(62,888,000)
FY 2021 Estimate	0
Less Obligations	0
Net Change	(62,888,000)
Less Obligations	62,888,000

		FY 2020 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2020 CO Pay Raise (3 months)	--	n/a	--	0
2	FY 2021 Pay Raise CO (9 months)	--	n/a	--	0
3	Annualization of FY 2020 CS Pay Raise (3 months)	--	n/a	--	0
4	FY 2021 Pay Raise CS (9 months)	--	n/a	--	0
5	Tribal Pay Cost	--	n/a	--	0
6	Increased Cost of Travel	--	0	--	0
7	Increased Cost of Transportation & Things	--	0	--	0
8	Increased Cost of Printing	--	0	--	0
9	Increased Cost of Rents, Communications, & Utilities	--	0	--	0
10	Increased Cost of Other Services	--	0	--	0
11	Increased Cost of Health Care Provided under Contracts & Grants	--	0	--	0
12	Increased Cost of Supplies	--	0	--	0
13	Increased Cost of Medical or other Equipment	--	0	--	0
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	0	--	0
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	--	0	--	0
	TOTAL INCREASES	--	0	--	0
DECREASES					
A. Built-In					
1	Decrease in the number of compensable days	--	0	--	0
2	Absorption of Built-In Increases	--	0	--	0
	Subtotal Build-In Decreases	--	0	--	0
B. Program Reductions		--	0	--	(62,888,000)
	TOTAL DECREASES	--	0	--	(62,888,000)
NET CHANGE		--	**0**	--	**(62,888,000)**

INDIAN HEALTH SERVICE
Community Health
Summary of Changes

FY 2020 Enacted	0
Total estimated budget authority	0
Less Obligations	0
FY 2021 Estimate	44,109,000
Less Obligations	(44,109,000)
Net Change	44,109,000
Less Obligations	(44,109,000)

		FY 2020 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2020 CO Pay Raise (3 months)	--	n/a	--	0
2	FY 2021 Pay Raise CO (9 months)	--	n/a	--	0
3	Annualization of FY 2020 CS Pay Raise (3 months)	--	n/a	--	0
4	FY 2021 Pay Raise CS (9 months)	--	n/a	--	0
5	Tribal Pay Cost	--	n/a	--	0
6	Increased Cost of Travel	--	0	--	0
7	Increased Cost of Transportation & Things	--	0	--	0
8	Increased Cost of Printing	--	0	--	0
9	Increased Cost of Rents, Communications, & Utilities	--	0	--	0
10	Increased Cost of Other Services	--	0	--	0
11	Increased Cost of Health Care Provided under Contracts & Grants	--	0	--	0
12	Increased Cost of Supplies	--	0	--	0
13	Increased Cost of Medical or other Equipment	--	0	--	0
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	0	--	0
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	--	0	--	0
B. Program Change					
1	Consolidation of Health Ed, CHR, and National CHAP Exp.	--	0	6	44,109,000
	TOTAL INCREASES	--	0	6	44,109,000
DECREASES					
A. Built-In					
1	Decrease in the number of compensable days	--	0	--	0
2	Absorption of Built-In Increases	--	0	--	0
	Subtotal Build-In Decreases	--	0	--	0
B. Program Reductions		--	0	--	0
	TOTAL DECREASES	--	0	--	0
NET CHANGE		--	**0**	**6**	**44,109,000**

INDIAN HEALTH SERVICE
Immunization AK
Summary of Changes

FY 2020 Enacted	2,127,000
Total estimated budget authority	2,127,000
Less Obligations	(2,127,000)
FY 2021 Estimate	2,165,000
Less Obligations	(2,165,000)
Net Change	38,000
Less Obligations	(38,000)

		FY 2020 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2020 CO Pay Raise (3 months)	--	n/a	--	0
2	FY 2021 Pay Raise CO (9 months)	--	n/a	--	0
3	Annualization of FY 2020 CS Pay Raise (3 months)	--	n/a	--	0
4	FY 2021 Pay Raise CS (9 months)	--	n/a	--	0
5	Tribal Pay Cost	--	n/a	--	0
6	Increased Cost of Travel	--	0	--	0
7	Increased Cost of Transportation & Things	--	0	--	0
8	Increased Cost of Printing	--	0	--	0
9	Increased Cost of Rents, Communications, & Utilities	--	0	--	0
10	Increased Cost of Other Services	--	0	--	0
11	Increased Cost of Health Care Provided under Contracts & Grants	--	0	--	0
12	Increased Cost of Supplies	--	0	--	0
13	Increased Cost of Medical or other Equipment	--	0	--	0
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	2,127,000	--	23,000
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	--	2,127,000	--	23,000
B. Program Adjustment		--	0	--	15,000
	TOTAL INCREASES	--	2,127,000	--	38,000
DECREASES					
A. Built-In					
1	Decrease in the number of compensable days	--	0	--	0
2	Absorption of Built-In Increases	--	0	--	0
	Subtotal Build-In Decreases	--	0	--	0
B. Program Reductions		--	0	--	0
	TOTAL DECREASES	--	0	--	0
NET CHANGE		--	**2,127,000**	--	**38,000**

INDIAN HEALTH SERVICE
OTHER Services
Summary of Changes

FY 2020 Enacted	202,807,000
Total estimated budget authority	202,807,000
Less Obligations	(202,807,000)
FY 2021 Estimate	187,686,000
Less Obligations	(187,686,000)
Net Change	(15,120,000)
Less Obligations	15,120,000

		FY 2020 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2020 CO Pay Raise (3 months)	--	n/a	--	0
2	FY 2021 Pay Raise CO (9 months)	--	n/a	--	0
3	Annualization of FY 2020 CS Pay Raise (3 months)	--	n/a	--	0
4	FY 2021 Pay Raise CS (9 months)	--	n/a	--	0
5	Tribal Pay Cost	--	n/a	--	0
6	Increased Cost of Travel	--	0	--	0
7	Increased Cost of Transportation & Things	--	1,823,770	--	0
8	Increased Cost of Printing	--	286,678	--	0
9	Increased Cost of Rents, Communications, & Utilities	--	259,003	--	0
10	Increased Cost of Other Services	--	45,828	--	44,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	33,867,979	--	630,000
12	Increased Cost of Supplies	--	89,372	--	0
13	Increased Cost of Medical or other Equipment	--	445,533	--	0
14	Increased Cost of Land & Structure	--	99,545	--	0
15	Increased Cost of Grants	--	91,682,546	--	0
16	Increased Cost of Insurance / Indemnities	--	22,681,513	--	0
17	Increased Cost of Interest / Dividends	--	131,352	--	0
18	Population Growth	--	n/a	--	0
	Subtotal, Built-In	--	151,413,118	--	674,000
B. Program Increase		--	0	12	17,898,000
C. Transfer					
	Transfer of NIAAA Programs from Alcohol to Urban	--	0	--	0
	TOTAL INCREASES	--	151,413,118	12	18,572,000
DECREASES					
A. Built-In					
1	Decrease in the number of compensable days	--	0	--	0
2	Absorption of Built-In Increases	--	0	--	0
	Subtotal Build-In Decreases	--	0	--	0
B. Program Adjustments		--	0	--	(33,693,000)
	TOTAL DECREASES	--	0	--	(33,693,000)
NET CHANGE		--	**151,413,118**	**12**	**(15,121,000)**

INDIAN HEALTH SERVICE
Urban Indian Health
Summary of Changes

FY 2020 Enacted	57,684,000
Total estimated budget authority	57,684,000
Less Obligations	(57,684,000)
FY 2021 Estimate	49,636,000
Less Obligations	(49,636,000)
Net Change	(8,048,000)
Less Obligations	8,048,000

		FY 2020 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2020 CO Pay Raise (3 months)	--	n/a	--	0
2	FY 2021 Pay Raise CO (9 months)	--	n/a	--	0
3	Annualization of FY 2020 CS Pay Raise (3 months)	--	n/a	--	0
4	FY 2021 Pay Raise CS (9 months)	--	n/a	--	0
5	Tribal Pay Cost	--	n/a	--	0
6	Increased Cost of Travel	--	133,557	--	0
7	Increased Cost of Transportation & Things	--	10,276	--	0
8	Increased Cost of Printing	--	120,728	--	0
9	Increased Cost of Rents, Communications, & Utilities	--	0	--	0
10	Increased Cost of Other Services	--	0	--	0
11	Increased Cost of Health Care Provided under Contracts & Grants	--	28,703,761	--	630,000
12	Increased Cost of Supplies	--	87,031	--	0
13	Increased Cost of Medical or other Equipment	--	42,935	--	0
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	26,234,016	--	0
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	--	55,332,304	--	630,000
B. Program Adjustment		--	0	--	0
C. Transfer					
	Transfer of NIAAA Programs from Alcohol to Urban	--	0	--	0
	TOTAL INCREASES	--	55,332,304	--	630,000
DECREASES					
A. Built-In					
1	Decrease in the number of compensable days	--	0	--	0
2	Absorption of Built-In Increases	--	0	--	0
	Subtotal Build-In Decreases	--	0	--	0
B. Program Reductions		--	0	--	(8,678,000)
	TOTAL DECREASES	--	0	--	(8,678,000)
NET CHANGE		--	**55,332,304**	--	**(8,048,000)**

INDIAN HEALTH SERVICE
Indian Health Professions
Summary of Changes

FY 2020 Enacted	65,314,000
Total estimated budget authority	65,314,000
Less Obligations	(65,314,000)
FY 2021 Estimate	51,683,000
Less Obligations	(51,683,000)
Net Change	(13,631,000)
Less Obligations	13,631,000

		FY 2020 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2020 CO Pay Raise (3 months)	--	n/a	--	0
2	FY 2021 Pay Raise CO (9 months)	--	n/a	--	0
3	Annualization of FY 2020 CS Pay Raise (3 months)	--	n/a	--	0
4	FY 2021 Pay Raise CS (9 months)	--	n/a	--	0
5	Tribal Pay Cost	--	n/a	--	0
6	Increased Cost of Travel	--	10,118	--	0
7	Increased Cost of Transportation & Things	--	825	--	0
8	Increased Cost of Printing	--	615	--	0
9	Increased Cost of Rents, Communications, & Utilities	--	0	--	0
10	Increased Cost of Other Services	--	18,177	--	0
11	Increased Cost of Health Care Provided under Contracts & Grants	--	0	--	0
12	Increased Cost of Supplies	--	2,341	--	0
13	Increased Cost of Medical or other Equipment	--	1,523	--	0
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	63,002,199	--	0
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	--	63,035,798	--	0
B. Recruitment and Retention Program Change		--	0	--	8,000,000
	TOTAL INCREASES	--	63,035,798	--	8,000,000
DECREASES					
A. Built-In					
1	Decrease in the number of compensable days	--	0	--	0
2	Absorption of Built-In Increases	--	0	--	0
	Subtotal Build-In Decreases	--	0	--	0
B. Program Adjustments		--	0	--	(21,631,000)
	TOTAL DECREASES	--	0	--	(21,631,000)
NET CHANGE		--	**63,035,798**	--	**(13,631,000)**

INDIAN HEALTH SERVICE
Tribal Management
Summary of Changes

FY 2020 Enacted	2,465,000
Total estimated budget authority	2,465,000
Less Obligations	(2,465,000)
FY 2021 Estimate	0
Less Obligations	0
Net Change	(2,465,000)
Less Obligations	2,465,000

		FY 2020 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2020 CO Pay Raise (3 months)	--	n/a	--	0
2	FY 2021 Pay Raise CO (9 months)	--	n/a	--	0
3	Annualization of FY 2020 CS Pay Raise (3 months)	--	n/a	--	0
4	FY 2021 Pay Raise CS (9 months)	--	n/a	--	0
5	Tribal Pay Cost	--	n/a	--	0
6	Increased Cost of Travel	--	n/a	--	0
7	Increased Cost of Transportation & Things	--	0	--	0
8	Increased Cost of Printing	--	0	--	0
9	Increased Cost of Rents, Communications, & Utilities	--	0	--	0
10	Increased Cost of Other Services	--	18,669	--	0
11	Increased Cost of Health Care Provided under Contracts & Grants	--	0	--	0
12	Increased Cost of Supplies	--	0	--	0
13	Increased Cost of Medical or other Equipment	--	0	--	0
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	2,446,331	--	0
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	--	2,465,000	--	0
B. Program Change		--	0	--	0
	TOTAL INCREASES	--	2,465,000	--	0
DECREASES					
A. Built-In					
1	Decrease in the number of compensable days	--	0	--	0
2	Absorption of Built-In Increases	--	0	--	0
	Subtotal Build-In Decreases	--	0	--	0
B. Program Reductions		--	0	--	(2,465,000)
	TOTAL DECREASES	--	0	--	(2,465,000)
NET CHANGE		--	**2,465,000**	--	**(2,465,000)**

INDIAN HEALTH SERVICE
Direct Operations
Summary of Changes

FY 2020 Enacted	71,538,000
Total estimated budget authority	71,538,000
Less Obligations	(71,538,000)
FY 2021 Estimate	81,480,000
Less Obligations	(81,480,000)
Net Change	9,942,000
Less Obligations	(9,942,000)

		FY 2020 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2020 CO Pay Raise (3 months)	--	n/a	--	0
2	FY 2021 Pay Raise CO (9 months)	--	n/a	--	0
3	Annualization of FY 2020 CS Pay Raise (3 months)	--	n/a	--	0
4	FY 2021 Pay Raise CS (9 months)	--	n/a	--	0
5	Tribal Pay Cost	--	n/a	--	0
6	Increased Cost of Travel	--	1,666,524	--	0
7	Increased Cost of Transportation & Things	--	164,366	--	0
8	Increased Cost of Printing	--	239,845	--	0
9	Increased Cost of Rents, Communications, & Utilities	--	8,245	--	0
10	Increased Cost of Other Services	--	5,158,145	--	44,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	0	--	0
12	Increased Cost of Supplies	--	401,075	--	0
13	Increased Cost of Medical or other Equipment	--	99,545	--	0
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	19,739,033	--	0
16	Increased Cost of Insurance / Indemnities	--	131,352	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	0
	Subtotal, Built-In	--	27,608,130	--	44,000
B. Program Adjustments					
1	Quality and Oversight Program Change	--	0	12	4,920,000
2	Program Adjustment	--	0		4,978,000
Subtotal Program Adjustments		--	0	--	9,898,000
	TOTAL INCREASES	--	27,608,130	12	9,942,000
DECREASES					
A. Built-In					
1	Decrease in the number of compensable days	--	0	--	0
2	Absorption of Built-In Increases	--	0	--	0
	Subtotal Build-In Decreases	--	0	--	0
B. Program Reductions		--	0	--	0
	TOTAL DECREASES	--	0	--	0
NET CHANGE		--	**27,608,130**	**12**	**9,942,000**

INDIAN HEALTH SERVICE
Self-Governance
Summary of Changes

FY 2020 Enacted	5,806,000
Total estimated budget authority	5,806,000
Less Obligations	(5,806,000)
FY 2021 Estimate	4,887,000
Less Obligations	(4,887,000)
Net Change	(919,000)
Less Obligations	919,000

		FY 2020 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2020 CO Pay Raise (3 months)	--	n/a	--	0
2	FY 2021 Pay Raise CO (9 months)	--	n/a	--	0
3	Annualization of FY 2020 CS Pay Raise (3 months)	--	n/a	--	0
4	FY 2021 Pay Raise CS (9 months)	--	n/a	--	0
5	Tribal Pay Cost	--	n/a	--	0
6	Increased Cost of Travel	--	146,145	--	0
7	Increased Cost of Transportation & Things	--	969	--	0
8	Increased Cost of Printing	--	19,158	--	0
9	Increased Cost of Rents, Communications, & Utilities	--	736	--	0
10	Increased Cost of Other Services	--	6,074	--	0
11	Increased Cost of Health Care Provided under Contracts & Grants	--	0	--	0
12	Increased Cost of Supplies	--	0	--	0
13	Increased Cost of Medical or other Equipment	--	0	--	0
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	2,942,480	--	0
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	0
	Subtotal, Built-In	--	3,115,562	--	0
B. Self-Governance Restoration		--	0	--	0
	TOTAL INCREASES	--	3,115,562	--	0
DECREASES					
A. Built-In					
1	Decrease in the number of compensable days	--	0	--	0
2	Absorption of Built-In Increases	--	0	--	0
	Subtotal Build-In Decreases	--	0	--	0
B. Program Reductions		--	0	--	(919,000)
	TOTAL DECREASES	--	0	--	(919,000)
NET CHANGE		--	**3,115,562**	--	**(919,000)**

INDIAN HEALTH SERVICE
Contract Support Costs
Summary of Changes

FY 2020 Enacted	855,000,000
Total estimated budget authority	822,227,000
Less Obligations	(822,227,000)
FY 2021 Estimate	855,000,000
Less Obligations	(855,000,000)
Net Change	0
Less Obligations	0

		FY 2020 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2020 CO Pay Raise (3 months)	--	n/a	--	0
2	FY 2021 Pay Raise CO (9 months)	--	n/a	--	0
3	Annualization of FY 2020 CS Pay Raise (3 months)	--	n/a	--	0
4	FY 2021 Pay Raise CS (9 months)	--	n/a	--	0
5	Tribal Pay Cost	--	n/a	--	0
6	Increased Cost of Travel	--	0	--	0
7	Increased Cost of Transportation & Things	--	0	--	0
8	Increased Cost of Printing	--	0	--	0
9	Increased Cost of Rents, Communications, & Utilities	--	0	--	0
10	Increased Cost of Health Care Provided under Contracts & Grants	--	0	--	0
11	Increased Cost of Supplies	--	0	--	0
12	Increased Cost of Medical or other Equipment	--	0	--	0
13	Increased Cost of Land & Structure	--	0	--	0
14	Increased Cost of Grants	--	855,000,000	--	0
15	Increased Cost of Insurance / Indemnities	--	0	--	0
16	Increased Cost of Interest / Dividends	--	0	--	0
17	Population Growth	--	n/a	--	0
	Subtotal, Built-In	--	855,000,000	--	0
B. CSC Increase		--	0	--	0
	TOTAL INCREASES	--	855,000,000	--	0
DECREASES					
A. Built-In					
1	Decrease in the number of compensable days	--	0	--	0
2	Absorption of Built-In Increases	--	0	--	0
	Subtotal Build-In Decreases	--	0	--	0
	TOTAL DECREASES	--	0	--	0
NET CHANGE		--	**855,000,000**	--	**0**

INDIAN HEALTH SERVICE
Payments for Tribal Leases
Summary of Changes

FY 2020 Enacted	0
Total estimated budget authority	0
Less Obligations	0
FY 2021 Estimate	101,000,000
Less Obligations	(101,000,000)
Net Change	101,000,000
Less Obligations	(101,000,000)

		FY 2020 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2020 CO Pay Raise (3 months)	--	n/a	--	0
2	FY 2021 Pay Raise CO (9 months)	--	n/a	--	0
3	Annualization of FY 2020 CS Pay Raise (3 months)	--	n/a	--	0
4	FY 2021 Pay Raise CS (9 months)	--	n/a	--	0
5	Tribal Pay Cost	--	n/a	--	0
6	Increased Cost of Travel	--	0	--	0
7	Increased Cost of Transportation & Things	--	0	--	0
8	Increased Cost of Printing	--	0	--	0
9	Increased Cost of Rents, Communications, & Utilities	--	0	--	0
10	Increased Cost of Health Care Provided under Contracts & Grants	--	0	--	0
11	Increased Cost of Supplies	--	0	--	0
12	Increased Cost of Medical or other Equipment	--	0	--	0
13	Increased Cost of Land & Structure	--	0	--	0
14	Increased Cost of Grants	--	0	--	0
15	Increased Cost of Insurance / Indemnities	--	0	--	0
16	Increased Cost of Interest / Dividends	--	0	--	0
17	Population Growth	--	n/a	--	0
	Subtotal, Built-In	--	0	--	0
B. CSC Increase		--	0	--	101,000,000
	TOTAL INCREASES	--	0	--	101,000,000
DECREASES					
A. Built-In					
1	Decrease in the number of compensable days	--	0	--	0
2	Absorption of Built-In Increases	--	0	--	0
	Subtotal Build-In Decreases	--	0	--	0
	TOTAL DECREASES	--	0	--	0
NET CHANGE		--	**0**	--	**101,000,000**

INDIAN HEALTH SERVICE

FACILITIES

Summary of Changes

FY 2020 Enacted	911,889,000
Total estimated budget authority	911,889,000
Less Obligations	(911,889,000)
FY 2021 Estimate	769,455,000
Less Obligations	(769,455,000)
Net Change	(142,434,000)
Less Obligations	142,434,000

	FY 2020 Enacted Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 Annualization of FY 2020 CO Pay Raise (3 months)				
2 FY 2021 Pay Raise CO (9 months)	--	n/a	--	0
3 Annualization of FY 2020 CS Pay Raise (3 months)	--	n/a	--	0
4 FY 2021 Pay Raise CS (9 months)	--	n/a	--	0
5 Tribal Pay Cost	--	n/a	--	0
6 Increased Cost of Travel	--	1,141,790	--	0
7 Increased Cost of Transportation & Things	--	1,386,931	--	0
8 Increased Cost of Printing	--	7,119,842	--	0
9 Increased Cost of Rents, Communications, & Utilities	--	3,145	--	0
10 Increased Cost of Other Services	--	230,314,677	--	2,759,699
11 Increased Cost of Health Care Provided under Contracts & Grants	--	0	--	0
12 Increased Cost of Supplies	--	1,590,796	--	17,324
13 Increased Cost of Medical or other Equipment	--	13,627,527	--	126,460
14 Increased Cost of Land & Structure	--	0	--	0
15 Increased Cost of Grants	--	286,493,817	--	3,852,518
16 Increased Cost of Insurance / Indemnities	--	0	--	0
17 Increased Cost of Interest / Dividends	--	0	--	0
18 Population Growth	--	n/a	--	1,789,000
Subtotal, Built-In	--	541,678,526	--	8,545,000
B. Phasing-In of Staff & Operating Cost of New Facilities:	--	0	5	3,679,000
C. Program Adjustment	--	0	--	0
C. Program Increase	--	0	--	126,000,000
TOTAL INCREASES	--	541,678,526		138,224,000
DECREASES				
A. Built-In				
1 Decrease in the number of compensable days	--	0	--	0
2 Absorption of Built-In Increases	--	0	--	0
Subtotal Build-In Decreases	--	0	--	0
B. Adjustments	--	0	--	(280,658,000)
TOTAL DECREASES	--	0	--	(280,658,000)
NET CHANGE	**--**	**541,678,526**	**5**	**(142,434,000)**

INDIAN HEALTH SERVICE
Maintenance & Improvement
Summary of Changes

FY 2020 Enacted	168,952,000
Total estimated budget authority	168,952,000
Less Obligations	(168,952,000)
FY 2021 Estimate	167,948,000
Less Obligations	(167,948,000)
Net Change	(1,004,000)
Less Obligations	1,004,000

		FY 2020 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2020 CO Pay Raise (3 months)	--	n/a	--	0
2	FY 2021 Pay Raise CO (9 months)	--	n/a	--	0
3	Annualization of FY 2020 CS Pay Raise (3 months)	--	n/a	--	0
4	FY 2021 Pay Raise CS (9 months)	--	n/a	--	0
5	Tribal Pay Cost	--	n/a	--	0
6	Increased Cost of Travel	--	0	--	0
7	Increased Cost of Transportation & Things	--	0	--	0
8	Increased Cost of Printing	--	0	--	0
9	Increased Cost of Rents, Communications, & Utilities	--	0	--	0
10	Increased Cost of Other Services	--	0	--	0
11	Increased Cost of Health Care Provided under Contracts & Grants	--	0	--	0
12	Increased Cost of Supplies	--	0	--	0
13	Increased Cost of Medical or other Equipment	--	0	--	0
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	0	--	0
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	0	--	1,789,000
	Subtotal, Built-In	--	0	--	1,789,000
B. Program Adjustment		--	0	--	0
	TOTAL INCREASES	--	0	--	1,789,000
DECREASES					
A. Built-In					
1	Decrease in the number of compensable days	--	0	--	0
2	Absorption of Built-In Increases	--	0	--	0
	Subtotal Build-In Decreases	--	0	--	0
B	Program Adjustment	--	0	--	(2,793,000)
	TOTAL DECREASES	--	0	--	(2,793,000)
NET CHANGE		--	**0**	--	**(1,004,000)**

INDIAN HEALTH SERVICE
Sanitation Facilities Construction
Summary of Changes

FY 2020 Enacted	193,577,000
Total estimated budget authority	193,577,000
Less Obligations	(193,577,000)
FY 2021 Estimate	192,931,000
Less Obligations	(192,931,000)
Net Change	(646,000)
Less Obligations	646,000

		FY 2020 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2020 CO Pay Raise (3 months)	--	n/a	--	0
2	FY 2021 Pay Raise CO (9 months)	--	n/a	--	0
3	Annualization of FY 2020 CS Pay Raise (3 months)	--	n/a	--	0
4	FY 2021 Pay Raise CS (9 months)	--	n/a		0
5	Tribal Pay Cost	--	n/a		0
6	Increased Cost of Travel	--	0	--	0
7	Increased Cost of Transportation & Things	--	5,112	--	0
8	Increased Cost of Printing	--	0	--	0
9	Increased Cost of Rents, Communications, & Utilities	--	0	--	0
10	Increased Cost of Other Services	--	170,928,244	--	1,321,540
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	--	967	--	0
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	72,489,946	--	560,460
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	0	--	0
	Subtotal, Built-In	--	243,424,269	--	1,882,000
B. Program Adjustment		--	0	--	0
	TOTAL INCREASES	--	243,424,269	--	1,882,000
DECREASES					
A. Built-In					
1	Decrease in the number of compensable days	--	0	--	0
2	Absorption of Built-In Increases	--	0	--	0
	Subtotal Build-In Decreases	--	0	--	0
B. Program Adjustment		--	0	--	(2,528,000)
	TOTAL DECREASES	--	0	--	(2,528,000)
NET CHANGE		**--**	**243,424,269**	**--**	**(646,000)**

INDIAN HEALTH SERVICE
Health Care Facilities Construction
Summary of Changes

FY 2020 Enacted	259,290,000
Total estimated budget authority	259,290,000
Less Obligations	(259,290,000)
FY 2021 Estimate	124,918,000
Less Obligations	(124,918,000)
Net Change	(134,372,000)
Less Obligations	134,372,000

		FY 2020 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2020 CO Pay Raise (3 months)	--	n/a	--	0
2	FY 2021 Pay Raise CO (9 months)	--	n/a	--	0
3	Annualization of FY 2020 CS Pay Raise (3 months)	--	n/a	--	0
4	FY 2021 Pay Raise CS (9 months)	--	n/a		0
5	Tribal Pay Cost	--	n/a		0
6	Increased Cost of Travel	--	0	--	0
7	Increased Cost of Transportation & Things	--	0	--	0
8	Increased Cost of Printing	--	0	--	0
9	Increased Cost of Rents, Communications, & Utilities	--	0	--	0
10	Increased Cost of Other Services	--	56,213,100	--	1,404,900
11	Increased Cost of Health Care Provided under Contracts & Grants	--	0	--	0
12	Increased Cost of Supplies	--	0	--	0
13	Increased Cost of Medical or other Equipment	--	0	--	0
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	68,704,900	--	1,717,100
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	0	--	0
	Subtotal, Built-In	--	124,918,000	--	3,122,000
B.	Program Adjustment	--	0	--	0
C.	Health Care Facility Construction Increases				
1	Health Care Facility Funding Increase	--	0	--	106,000,000
2	Staff Quarters	--	0	--	20,000,000
	Subtotal Increases	--	0	--	126,000,000
	TOTAL INCREASES	--	124,918,000	--	129,122,000
DECREASES					
A.	Built-In				
1	Decrease in the number of compensable days	--	0	--	0
2	Absorption of Built-In Increases	--	0	--	0
	Subtotal Build-In Decreases	--	0	--	0
B.	Program Adjustment	--	0	--	(263,494,000)
	TOTAL DECREASES	--	0	--	(263,494,000)
NET CHANGE		**--**	**124,918,000**	**--**	**(134,372,000)**

INDIAN HEALTH SERVICE
Facilities & Environmental Health Support
Summary of Changes

FY 2020 Enacted	261,983,000
Total estimated budget authority	261,983,000
Less Obligations	(261,983,000)
FY 2021 Estimate	259,763,000
Less Obligations	(259,763,000)
Net Change	(2,220,000)
Less Obligations	2,220,000

		FY 2020 Enacted Base		Change from Base	
		FTE	BA	FTE/Pos	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2020 CO Pay Raise (3 months)	--	n/a	--	0
2	FY 2021 Pay Raise CO (9 months)	--	n/a	--	0
3	Annualization of FY 2020 CS Pay Raise (3 months)	--	n/a	--	0
4	FY 2021 Pay Raise CS (9 months)	--	n/a	--	0
5	Tribal Pay Cost	--	n/a	--	0
6	Increased Cost of Travel	--	1,141,790	--	0
7	Increased Cost of Transportation & Things	--	1,362,015	--	0
8	Increased Cost of Printing	--	7,119,112	--	0
9	Increased Cost of Rents, Communications, & Utilities	--	3,145	--	0
10	Increased Cost of Other Services	--	3,017,114	--	33,258
11	Increased Cost of Health Care Provided under Contracts & Grants	--	0	--	0
12	Increased Cost of Supplies	--	1,571,611	--	17,324
13	Increased Cost of Medical or other Equipment	--	496,973	--	5,478
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	130,537,497	--	1,438,939
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	--	145,249,257	--	1,495,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	5	3,679,000
	TOTAL INCREASES	--	145,249,257	--	5,174,000
DECREASES					
A. Built-In					
1	Decrease in the number of compensable days	--	0	--	0
2	Absorption of Built-In Increases	--	0	--	0
	Subtotal Build-In Decreases	--	0	--	0
B. Program Reduction		--	0	--	(7,394,000)
	TOTAL DECREASES	--	0	--	(7,394,000)
NET CHANGE		**--**	**145,249,257**	**5**	**(2,220,000)**

INDIAN HEALTH SERVICE
Equipment
Summary of Changes

FY 2020 Enacted	28,087,000
Total estimated budget authority	28,087,000
Less Obligations	(28,087,000)
FY 2021 Estimate	23,895,000
Less Obligations	(23,895,000)
Net Change	(4,192,000)
Less Obligations	4,192,000

		FY 2020 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2020 CO Pay Raise (3 months)	--	n/a	--	0
2	FY 2021 Pay Raise CO (9 months)	--	n/a	--	0
3	Annualization of FY 2020 CS Pay Raise (3 months)	--	n/a	--	0
4	FY 2021 Pay Raise CS (9 months)	--	n/a	--	0
5	Tribal Pay Cost	--	n/a	--	0
6	Increased Cost of Travel	--	0	--	0
7	Increased Cost of Transportation & Things	--	19,804	--	0
8	Increased Cost of Printing	--	731	--	0
9	Increased Cost of Rents, Communications, & Utilities	--	0	--	0
10	Increased Cost of Other Services	--	156,219	--	0
11	Increased Cost of Health Care Provided under Contracts & Grants	--	0	--	0
12	Increased Cost of Supplies	--	19,185	--	0
13	Increased Cost of Medical or other Equipment	--	13,129,586	--	120,982
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	14,761,475	--	136,018
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	0	--	0
	Subtotal, Built-In	--	28,087,000	--	257,000
	TOTAL INCREASES	--	28,087,000	--	257,000
DECREASES					
A. Built-In					
1	Decrease in the number of compensable days	--	0	--	0
2	Absorption of Built-In Increases	--	0	--	0
	Subtotal Build-In Decreases	--	0	--	0
B. Adjustments		--	0	--	(4,449,000)
	TOTAL DECREASES	--	0	--	(4,449,000)
NET CHANGE		**--**	**28,087,000**	**--**	**(4,192,000)**

INDIAN HEALTH SERVICE
Budget Authority by Activity

(Dollars in Thousands)

	2019 Final /3		2020 Enacted		2021 President's Budget	
	FTE 1/	Amount	FTE 1/	Amount	FTE 1/	Amount
SERVICES						
Hospitals & Health Clinics	6,158	$2,178,088	6,158	$2,324,606	6,170	$2,432,384
Electronic Health Record System (NEW)	0	$0	0	$8,000	6	$125,000
Dental Health	579	197,949	579	210,590	579	219,380
Mental Health	191	101,255	191	108,933	198	128,228
Alcohol & Substance Abuse	242	234,421	242	245,603	242	235,745
Purchased/Referred Care	0	964,819	0	964,819	0	964,783
Indian Health Care Improvement Fund	0	72,280	0	72,280	0	72,280
Total, Clinical Services	7,170	3,748,812	7,170	3,934,831	7,195	4,177,800
Public Health Nursing	201	86,354	201	91,984	201	95,353
Health Education	18	19,698	18	20,568	0	0
Comm. Health Reps.	3	61,613	3	62,888	0	0
Community Health 5/	0	0	0	0	27	44,109
Immunization AK	0	2,058	0	2,127	0	2,165
Total, Preventive Health	222	169,723	222	177,567	228	141,627
Urban Health	7	50,533	7	57,684	7	49,636
Indian Health Professions	24	56,363	24	65,314	24	51,683
Tribal Management	0	2,165	0	2,465	0	0
Direct Operations	275	70,788	275	71,538	287	81,480
Self-Governance	12	4,806	12	5,806	12	4,887
Total, Other services	318	184,655	318	202,807	330	187,686
Total, Services	7,710	4,103,190	7,710	4,315,205	7,753	4,507,113
CONTRACT SUPPORT COSTS	0	822,227	0	855,000	0	855,000
PAYMENTS FOR TRIBAL LEASES 4/	0	0	0	0	0	101,000
FACILITIES						
Maintenance & Improvement	0	167,527	0	168,952	0	167,948
Sanitation Facilities Constr.	119	192,033	119	193,577	119	192,931
Health Care Facs. Constr.	0	243,480	0	259,290	0	124,918
Facil. & Envir. Health Supp.	1,073	252,060	1,073	261,983	1,073	259,763
Equipment	0	23,706	0	28,087	0	23,895
Total, Facilities	1,192	878,806	1,192	911,889	1,192	769,455
SPECIAL DIABETES PROGRAM FOR INDIANS						
SDPI 2/	129	150,000	129	150,000	129	150,000
Total, SDPI	129	150,000	129	150,000	129	150,000
Total IHS	9,031	$5,954,223	9,031	$6,232,094	9,074	$6,382,568

1/ FTE estimates exclude FTEs funded by reimbursements such as Medicaid and Medicare collections.
2/ The Budget requests an extension of the Special Diabetes Program for Indians through FY 2021. The FY2020 Further Consolidated Appropriations Act provides only $96.6 million for SDPI, for activity through May 22nd, 2020. The Budget table includes actual and requested funding forassumes SDPI will funded at $150 million in FY 2020.
3/ Reflects Services account adjustments related to formal reprogramming notifications submitted to Congress in FY 2019. Amounts by "Sub IHS Activity" will continue to be adjusted during the period of availability, which concludes on Sept. 30, 2020, for impacted funds.
4/ A new separate, indefinite discretionary appropriation is created for Section 105(l), ISDEAA (P.L. 93-638) leases.

INDIAN HEALTH SERVICE
Appropriation History Table
Services

	Budget Request to Congress	House Allowance	Senate Allowance	Appropriation
2005	$2,612,824,000	$2,627,918,000	$2,633,624,000	$2,632,667,000
Rescission (PL 108-447, Sec. 501)				($15,638,000)
Rescission (PL 108-447, Sec. 122)				($20,936,000)
2006	$2,732,298,000	$2,732,298,000	$2,732,323,000	$2,732,298,000
Rescission (PL 109-54)				($13,006,000)
Rescission (PL 109-148)				($27,192,000)
2007	$2,822,449,000	$2,830,085,000	$2,835,493,000	$2,818,871,000
2008	$2,931,530,000	$3,023,532,000	$2,991,924,000	$3,018,624,000
Rescission (PL 110-161)				($47,091,000)
2009 Omnibus	$2,971,533,000	-	-	$3,190,956,000
2009 ARRA (PL 111-5)	-	-	-	$85,000,000
2010	$3,639,868,000	$3,657,618,000	$3,639,868,000	$3,657,618,000
2011	$3,657,618,000	-	-	$3,672,618,000
Rescission (PL 112-10)				($7,345,000)
2012	$4,166,139,000	$4,034,322,000	-	$3,872,377,000
Rescission (PL 112-74)				($6,195,804)
2013	$3,978,974,000	-	$ 3,914,599,000	$3,914,599,000
Sequestration				($194,492,111)
Rescission				($7,829,198)
2014 Omnibus (PL 113-64)	$3,982,498,000	-	-	$3,982,842,000
2015 Omnibus (PL 113-235)	$4,172,182,000	$4,180,557,000	-	$4,182,147,000
2016 Omnibus (PL 114-39)	$3,745,290,000	$3,603,569,000	$3,539,523,000	$3,566,387,000
2017 Omnibus (PL 115-31)	$3,815,109,000	$3,720,690,000	$3,650,171,000	$3,694,462,000
2018 Congressional Justification	$3,574,365,000	$3,867,260,000	$3,759,258,000	$3,952,290,000
2019 Congressional Justification	$3,945,975,000	$4,202,639,000	$4,072,385,000	$3,965,711,000
2020 Congressional Justification	$4,286,542,000	$4,556,870,000	$4,318,884,000	$4,315,205,000
2021 Congressional Justification	$4,507,113,000	-	-	-

INDIAN HEALTH SERVICE
Appropriation History Table
Facilities

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
2009 Omnibus	$353,329,000	-	-	$390,168,000
2009 ARRA (PL 111-5)	-	-	-	$415,000,000
2010	$394,757,000	$394,757,000	$394,757,000	$394,757,000
2011	$394,757,000	-	-	$404,757,000
Rescission (PL 112-10)				($810,000)
2012	$457,669,000	$427,259,000	-	$441,052,000
Rescission (PL 112-74)				($705,683)
2013	$443,502,000	-	$ 441,605,000	$441,605,000
Sequestration				($22,152,062)
Rescission				($883,210)
2014 Omnibus (PL 113-64)	$448,139,000	-	-	$451,673,000
2015 Omnibus (PL 113-235)	$461,995,000	$461,995,000	-	$460,234,000
2016 Omnibus (PL 114-39)	$639,725,000	$466,329,000	$521,818,000	$523,232,000
2017 Omnibus (PL 115-31)	$569,906,000	$557,946,000	$543,607,000	$545,424,000
2018 Congressional Justification	$346,956,000	$551,643,000	$563,658,000	$867,504,000
2019 Congressional Justification	$505,821,000	$882,748,000	$877,504,000	$868,704,000
2020 Congressional Justification	$803,026,000	$964,121	$902,878,000	$911,889,000
2021 Congressional Justification	$769,455,000	-	-	-

INDIAN HEALTH SERVICE
Appropriation History Table
Contract Support Costs

	Budget Request to Congress	House Allowance	Senate Allowance	Appropriation
2016 Omnibus (PL 114-39)	$717,970,000	$717,970,000	$717,970,000	$717,970,000
2017 Omnibus (PL 115-31)	$800,000,000	$800,000,000	$800,000,000	$800,000,000
2018 Congressional Justification	$717,970,000	$717,970,000	$717,970,000	$717,970,000
2019 Congressional Justification	$822,227,000	$822,227,000	$822,227,000	$717,970,000
2020 Congressional Justification	$855,000,000	$820,000,000	$820,000,000	$855,000,000
2021 Congressional Justification	$855,000,000	-	-	-

INDIAN HEALTH SERVICE
Appropriation History Table
ISDEAA 105*(l)* Leases

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
2019 Congressional Justification	$0	$0	$0	$0
2020 Congressional Justification	$0	$0	$0	$0
2021 Congressional Justification	$101,000,000	-	-	-

Indian Health Service

Authorizing Legislation

(Dollars in Thousands)

	FY 2020		FY 2021	
	Amount Authorized	Amount Appropriated	Amount Authorized	President's Budget
1. Services Appropriation:	4,315,205	4,315,205	4,507,113	4,507,113
Snyder Act, 25 U.S.C. 13.				
Transfer Act (P.L. 83-568), 42 U.S.C. 2001.				
Indian Health Care Improvement Act (IHCIA) (P.L. 94-437), as amended (most recently amended by the Patient Protection and Affordable Care Act (ACA) (P.L. 111-148), § 10221, 124 Stat. 119, 935 (2010)), 25 U.S.C. 1601 *et seq.*				
Indian Self Determination and Education Assistance Act (P.L. 93-638), as amended, 25 U.S.C. 450 *et seq.*				
Public Health Service Act, titles II & III, as amended, 25 U.S.C. 201-280m.				
2. Contract Support Costs Appropriation:	855,000	855,000	855,000	855,000
Indian Self Determination and Education Assistance Act (P.L. 93-638), as amended, 25 U.S.C. 450 *et seq.*				
3. Facilities Appropriation:	911,889	911,889	769,455	769,455
Indian Sanitation Facilities Act (P.L. 86-121), as amended, 42 U.S.C. 2004a.				
IHCIA, title III, as amended, 25 U.S.C. 1631-1638g.				
ISDEAA, sec. 102 & 509, as amended, 25 U.S.C. 450f & 458aaa-8.				
5 U.S.C. 5911 note (Quarters Rent Funds).	8,500	8,500	9,600	9,600
4. Public and Private Collections:	1,193,577	1,193,577	1,269,106	1,269,106
IHCIA sec. 206, 25 U.S.C. 1621e.				
Social Security Act, sec. 1880 & 1911, 42 U.S.C. 1395qq & 1396j.				
5. Special Diabetes Program for Indians:	150,000	150,000	150,000	150,000
42 U.S.C. 245c-3.				
6. Section 105(*l*) Leases	0	0	101,000	101,000
Sec. 900.69				
Unfunded authorizations:	0	0	0	0
Total appropriations:	7,434,171	7,434,171	7,661,274	7,661,274
Total appropriations against Definite authorizations:	7,434,171	7,434,171	7,661,274	7,661,274

THIS PAGE INTENTIONALLY LEFT BLANK

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2021 Performance Budget Submission to Congress

TABLE OF CONTENTS

Services

THIS PAGE INTENTIONALLY LEFT BLANK

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

	FY 2019[1]	FY 2020	FY 2021	
	Final	Enacted	President's Budget	FY 2021 +/- FY 2020
BA	$3,748,812	$3,934,831	$4,177,800	+$242,969
FTE*	7,170	7,170	7,195	+254

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

SUMMARY OF THE BUDGET REQUEST

The FY 2021 Indian Health Service (IHS) Budget submission for Clinical Services of $4.2 billion is $243.0 million above the FY 2020 Enacted level. Included in this budget is funding of $30.8 million for Staffing of New and Replacement Healthcare Facilities, $2.6 million for New Tribes, $117.0 million for Electronic Health Record modernization, $27.0 million for the elimination of HIV/HCV in Indian country, $3.5 million for recruitment and retention efforts, $5.0 million for the Improving Maternal Health in America, $32.5 million for medical inflation, and $142.8 million in adjustments to maximize funding for direct patient care services.

The detailed explanation of the request is described in each of the budget narratives that follow this summary.

- **Hospitals and Health Clinics**, supports essential personal health services and community based disease prevention and health promotion services. Health services include: inpatient care, routine and emergency ambulatory care; and medical support services including laboratory, pharmacy, nutrition, diagnostic imaging, medical records, physical therapy, and other services. Specialized programs are conducted to address: diabetes; maternal and child health; youth services; communicable diseases including human immunodeficiency virus/acquired immune deficiency syndrome (HIV), tuberculosis, and hepatitis; women's and men's health; geriatric health; disease surveillance; and healthcare quality improvement.

- **Electronic Health Record (EHR)**, holds an extremely high degree of mission criticality given the ability to provide much-anticipated clinical and administrative capabilities used in modern systems for the delivery of timely and impactful healthcare. Expected benefits from adopting and implementing a modernized or new system include but are not limited to improved patient safety, improved patient outcomes, better disease management, enhanced population health, improved clinical quality measures, opioid tracking, patient data exchange, third party revenue generation, agency performance reporting, etc. By identifying and properly selecting the best match for proposed system capabilities, the system will support the IHS mission. Additionally, the IHS aims to obtain interoperability with the Department of Veteran's Affairs, Department of Defense, tribal and urban Indian

[1] Reflects Services account adjustments related to formal reprogramming notifications submitted to Congress in FY 2019. Amounts by "Sub IHS Activity" will continue to be adjusted during the period of availability, which conclude on September 30, 2020, for impacted funds.

health programs, academic affiliates, and community partners, many of whom are on different Health Information Technology platforms. The IHS must consider an integrated EHR system solution that will allow for a meaningful integration to create a system that serves IHS/Tribal/Urban beneficiaries in the best possible way.

- **Dental Health**, supports preventive care, basic care, and emergency care, with approximately 90 percent of services covering basic and emergency care. Basic services are prioritized over more complex rehabilitative care such as root canals, crowns and bridges, dentures, and surgical extractions. The demand for dental treatment remains high due to high dental caries rate in American Indian and Alaska Native (AI/AN) children; however, a continuing emphasis on community oral health promotion and disease prevention is essential to impact long-term improvement of the oral health of AI/AN people.

- **Mental Health**, supports 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.

- **Alcohol and Substance Abuse**, supports an integrated behavioral health approach to collaboratively reduce the incidence of alcoholism and other drug dependencies in AI/AN communities.

- **Purchased/Referred Care (PRC)**, supports the purchase of essential health care services not available in IHS and Tribal healthcare facilities including inpatient and outpatient care, routine emergency ambulatory care, transportation, specialty care services (mammograms, colonoscopies, etc.), and medical support services (e.g., laboratory, pharmacy, nutrition, diagnostic imaging, physical therapy, etc.). The demand for PRC remains high as the cost of medical care increases. The PRC program continues to emphasize adherence to medical priorities, enrolling patients in alternate resources available to them (such as Medicare, Medicaid and private insurance), negotiating discounted rates with medical providers, and implementing improvements recommended by Tribes and oversight authorities.

The majority of clinical services funds are provided to 12 Area (regional) Offices that distribute resources, monitor and evaluate activities, and provide administrative and technical support to approximately 2.6 million American Indians and Alaska Natives through a network of over 605 hospitals, clinics, and health stations on or near Indian reservations[2] in service areas that are rural, isolated, and underserved.

Performance Summary Table

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

[2] Previous number of 850 from the Fiscal Year 2019 Congressional Justification represents buildings owned by IHS and/or tribes through Village Built Clinics and tribally-owned facilities. The over 605 number represents actual health care facilities that can be found in the OPDIV-Specific section of this publication titled: "Number of Service Units and Facilities Operated by IHS and Tribes, October 1, 2017."

OUTPUTS/OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2020 Target	FY 2021 Target	FY 2021 Target +/-FY 2020 Target
28 Unintentional Injury Rates: Age-Adjusted Unintentional injuries mortality rate in AI/AN population (Outcome)	FY 2010: 93.7 Target: Not Defined (Target Not In Place)	TBD	Not Defined	N/A
71 Childhood Weight Control: Proportion of children, ages 2-5 years with a BMI at or above the 95th percentile. IHS-All (Outcome)	FY 2019: 22.7 % Target: N/A (Target Not Met)	Not Defined	Not Defined	Maintain

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

(Dollars in Thousands)

	FY 2019[1]	FY 2020	FY 2021	
	Final	Enacted	President's Budget	FY 2021 +/- FY 2020
BA	$2,178,088	$2,324,606	$2,432,384	+$107,778
FTE*	6,158	6,158	6,170	+12

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

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

FY 2021 Authorization.....Permanent

Allocation Method… .....Direct Federal, P.L. 93-638 contracts and compacts, Tribal shares, interagency agreements, commercial contracts, and grants

PROGRAM DESCRIPTION

Hospitals and Health Clinics (H&HC) funds essential, personal health services for approximately 2.6 million American Indians and Alaska Natives (AI/AN). The Indian Health Service (IHS) provides medical and surgical inpatient care, routine and emergency ambulatory care, and medical support services including laboratory, pharmacy, nutrition, diagnostic imaging, medical records, and physical therapy. The IHS direct health care services supports the IHS Strategic Plan FY 2019-2023 and integrates the Department's Strategic Goal to protect the health of Americans where they live, learn, work, and play *(HHS Strategic Plan FY 2018-2022, Goal 2, Objective 2.1 Empower people to make informed choices for healthier living, 2.2 Prevent, treat, and control communicable diseases and chronic conditions, 2.3 Reduce the impact of mental and substance use disorders through prevention, early intervention, treatment, and recovery, & 2.4 Prepare for and respond to public health emergencies)*. The IHS and tribes primarily serve small, rural populations with primary medical care and community health services, relying on the private sector for much of the secondary and most of the tertiary medical care needs. Some IHS and tribal hospitals provide secondary medical services such as ophthalmology, orthopedics, infectious disease, emergency medicine, radiology, general and gynecological surgery, and anesthesia.

The IHS system of care is unique in that personal health care services are integrated with community health services. The program includes public/community health programs targeting health conditions disproportionately affecting AI/AN populations such as diabetes, maternal and child health, and communicable diseases including influenza, human immunodeficiency

[1] Reflects Services account adjustments related to formal reprogramming notifications submitted to Congress in FY 2019. Amounts by "Sub IHS Activity" will continue to be adjusted during the period of availability, which conclude on September 30, 2020, for impacted funds.

virus/acquired immune deficiency syndrome (HIV/AIDS), and viral hepatitis. The health status of AI/AN people has improved significantly in the past 60 years since IHS's inception. However, AI/AN people born today have a life expectancy that is 5.5 years less than the U.S. all races population, 73.0 years to 78.5 years, respectively.[2]

More than 60 percent of the H&HC budget is transferred under P.L. 93-638 contracts or compacts to tribal governments or tribal organizations that design and manage the delivery of individual and community health services through 22 hospitals, 285 health centers, 54 health stations, 127 Alaska village clinics, and five school health centers. The remainder of the H&HC budget is managed by direct federal programs that provide health care at the service unit and community level. The federal system consists of 24 hospitals (23 hospitals have emergency departments), 50 health centers, 24 health stations, and 11 school health centers.

Collecting, analyzing, and interpreting health information is done through a network of tribally-operated epidemiology centers in collaboration with a national IHS coordinating center leading to the identification of health conditions as well as promoting interventions. Information technology supports personal health services (including the Electronic Health Record and telemedicine) and public health initiatives (such as *Baby Friendly Hospitals* and *Improving Patient Care*) that are primarily funded through the H&HC budget *(HHS Strategic Plan FY 2018-2022, Goal 4, Objective 4.1 Foster sound, sustained advances in the sciences)*.

The H&HC funds provide critical support for direct health care services, ensures comprehensive, culturally appropriate services, provides available and accessible personnel, promotes excellence and quality through implemented quality improvement strategies, and strengthens the IHS program management and operations to raise the health status of AI/AN populations to the highest level (*IHS Strategic Plan FY 2019–2023, Goal 1, Objective 1.1: Recruit, develop, and retain a dedicated, competent, and caring workforce , Objective 1.2: Build, strengthen, and sustain collaborative relationships , , and Objective 1.3: Increase access to quality health care services.; Goal 2, Objective 2.1: Create quality improvement capability at all levels of the organization and Objective 2.2: Provide care to better meet the health care needs of American Indian and Alaska Native communities ; and Goal 3, Objective 3.1: Improve communication within the organization with Tribes, Urban Indian Organizations, and other stakeholders, and with the general public , Objective 3.2: Secure and effectively manage the assets and resources , and Objective 3.3: Modernize information technology and information systems to support data driven decisions; HHS Strategic Plan FY 2018-2022 Goal 1, Objective 1.2 Expand safe, high-quality healthcare options, and encourage innovation and competition, 1.3 Improve Americans' access to healthcare and expand choices of care and service options, & 1.4 Strengthen and expand the healthcare workforce to meet America's diverse needs; Goal 2, Objective 2.1 Empower people to make informed choices for healthier living, 2.2 Prevent, treat, and control communicable diseases and chronic conditions, 2.3 Reduce the impact of mental and substance use disorders through prevention, early intervention, treatment, and recovery, & 2.4 Prepare for and respond to public health emergencies; Goal 3, Objective 3.2 Safeguard the public against preventable injuries and violence of their results, 3.3 Support strong families and healthy marriage, and prepare children and youth for healthy, productive lives, & 3.4 Maximize the independence, well-being, and health or older adults, people with disabilities, and their families and caregivers; Goal 4, Objective 4.1 Improve surveillance, epidemiology, and laboratory services; Goal 5, Objective 5.1 Ensure responsible financial management, 5.2 Manage human capital to achieve the HHS mission, 5.3 Optimize information technology investments to improve*

[2] Data comparing the AI/AN population to the U.S. general population are documented and updated annually by the IHS.

process efficiency and enable innovation to advance program mission goals, & 5.4 Protect the safety and integrity of our human, physical, and digital assets).

PROGRAM ACCOMPLISHMENTS

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

Quality - In FY 2019, IHS elevated and institutionalized the goals and objectives included in the new IHS Strategic Plan that will guide quality improvement and patient safety efforts over the next several years. The OQ was established in FY 2019 and is actively leading quality and patient safety work from IHS Headquarters, including oversight of policy and accreditation standards, implementation of quality improvement strategies, and monitoring accountability of federally-operated facilities.

The IHS is working to appropriately staff the Office, which is subject to funding and hiring processes. To provide oversight of quality and safety of care at federally operated facilities, the OQ has identified four divisions: 1) Quality Assurance; 2) Patient Safety and Clinical Risk Management; 3) Innovation and Improvement, and, 4) Enterprise Risk Management and Internal Controls. The establishment of the OQ meets the *IHS Strategic Plan Goal Two, To promote excellence and quality through innovation of the Indian health system into an optimally performing organization; IHS Strategic Plan Goal Three To Strengthen IHS program management and operations; and, the HHS Strategic Plan Goal One, Strategic Objective 1.2, Expand safe, high quality healthcare options, and encourage innovation and competition.*

The OQ FY 2019 activities and accomplishments include the following:

Quality Assurance - The OQ Division of Quality Assurance has focused intently on ensuring quality of care in IHS facilities through external accreditation and certification. The OQ supports all IHS facilities through collaboration, assistance and participation in the facility Mock Survey process. Mock surveys use the accreditation standards to evaluate facility preparedness to ensure a state of continual readiness to achieve accreditation standards to provide high quality safe patient care. This activity meets the *IHS Strategic Plan Goal Two, Objective 2.2 Provide care to better meet the needs of American Indian and Alaska Native communities and the HHS Strategic Plan Goal One, Strategic Objective 1.2, Expand safe, high quality healthcare options, and encourage innovation and competition.*

In FY 2019, the OQ supported and provided assistance to IHS facilities in all 12 IHS Areas to achieve and maintain accreditation standards, including Centers for Medicare and Medicaid Services (CMS), The Joint Commission (TJC) Hospital, Ambulatory, Behavioral Health and Critical Assess Hospital Standards as well as Accreditation Association for Ambulatory Health Care (AAAHC) and Patient Centered Medical Home (PCMH). As of FY 2019, 97 percent of all IHS hospitals have received CMS certification. The remaining non-certified hospital has submitted its certification application to CMS. The Joint Commission (TJC) has provided external accreditation for 75 percent of all IHS hospitals. This activity meets the *IHS Strategic Plan Goal Two, Objective 2.2 Provide care to better meet the needs of American Indian and Alaska Native communities; the HHS Strategic Plan Goal One, Strategic Objective 1.2, Expand safe, high quality healthcare options, and encourage innovation and competition; and, the HHS*

Strategic Plan Goal One, Strategic Objective 1.3, Improve Americans' access to healthcare and expand choices of care and service options.

Increased focus on quality measurement has improved the IHS ability to monitor and report on compliance with policy requirements, accreditation standards, and regulations. In FY 2018, IHS implemented a National Accountability Dashboard for Quality (NAD-Q), standardization of practitioner credentialing and privileging software, and accreditation and re-accreditation hospital and ambulatory health center support. The NAD-Q is monitored at the service unit, area, and headquarters level to continuously offer performance capability and assistance. The NAD-Q currently consists of nine measures linked to accountability for compliance with IHS, Centers for Medicare & Medicaid Services (CMS), or Accrediting Organization requirements related to quality and safety of healthcare delivery services. IHS federally operated hospitals and ambulatory health centers report results on a quarterly basis in the following areas: quality (efficient, effective and equitable); accreditation; workforce; patient-centered care; safety; and timely care. IHS senior leadership monitors results and reports are publicly available on the IHS web site: https://www.ihs.gov/quality/. In FY 2019, IHS has completed quarterly reporting starting with the 4th quarter of FY 2017. IHS uses existing facility governance structures and processes to address performance improvement. This activity meets the *IHS Strategic Plan Goal Two, Objective 2.2 Provide care to better meet the needs of American Indian and Alaska Native communities and the HHS Strategic Plan Goal One, Strategic Objective 1.2, Expand safe, high quality healthcare options, and encourage innovation and competition. This activity also meets the Presidents Management Agenda Cross Agency Priority Goal 2: Leveraging data as a strategic asset.*

Patient Safety - The OQ purchased Datix software, an adverse event reporting system, to replace WebCident. WebCident was initially developed by IHS in 2002 as a worker injury reporting system and was modified over time to assist in medication and patient safety event tracking. However, due to WebCident limitations, which include a restricted focus on patient safety reporting and limited data analytic capability, and with limited staff and budget resources to effectively support the system, the Agency made the decision to transition to a new adverse event reporting system. The Division of Patient Safety and Clinical Risk Management is managing the piloting of the new software, which occurred December 4-18, 2019 at Red Lake Hospital (Bemidji Area), Crow/Northern Cheyenne Hospital (Billings Area) and Pawnee Indian Health Center (Oklahoma City Area), with system-wide training and deployment is anticipated to follow in January 2020. This activity meets the *IHS Strategic Plan Goal Two, Objective 2.2, Provide care to better meet the needs of American Indian and Alaska Native communities and the HHS Strategic Plan Goal One, Strategic Objective 1.2, Expand safe, high quality healthcare options, and encourage innovation and competition.*

In FY 2019, the OQ also provided guidelines to all IHS Area facilities to improve patient safety and compliance with new and upcoming US Pharmacopeia (USP) requirements for compounding sterile preparations. In addition, the OQ has collaborated with Centers for Disease Control and Prevention to provide infection control training to IHS areas to help meet industry standards for infection control, including sterilization and decontamination of surgical instruments used in patient care within hospitals, ambulatory care and dental facilities. This activity meets the *IHS Strategic Plan Goal Two, Objective 2.2 Provide care to better meet the needs of American Indian and Alaska Native communities and the HHS Strategic Plan Goal One, Strategic Objective 1.2, Expand safe, high quality healthcare options, and encourage innovation and competition.*

The IHS has modernized its credentialing and privileging processes to facilitate the hiring of qualified practitioners. The credentialing process evaluates the qualifications and practice history

of a provider such as training, residency, and licensing. Privileging authorizes a healthcare practitioner to practice within a specified scope of patient care services. The OQ manages the rollout and training of the new software system, which provides a centralized electronic database and standardization of credentialing data. The OQ continues to monitor processes and system changes for improvements. This is a critical effort in facilitating the timely hiring of appropriately qualified providers and ensuring patient safety. The improved credentialing and privileging process meets the *IHS Strategic Plan Goal Three, Objective 3.3 Modernize information technology and information systems to support data driven decisions and the HHS Strategic Plan Goal Five, Strategic Objective 5.3, Optimize information technology investments to improve efficiency and enable innovation to advance program mission goals.*

IHS leadership has committed to provide additional oversight and structure to monitor of quality efforts. In FY 2019, the Agency formalized the Quality Assurance Risk Management Committee (QARMC). The QARMC will provide senior level oversight and management for the highest risk clinical and administrative issues being addressed in the IHS. Currently, the QARMC is reviewing events and meeting monthly. This activity meets the *IHS Strategic Plan Goal Two, Objective 2.2 Provide care to better meet the needs of American Indian and Alaska Native communities and the HHS Strategic Plan Goal One, Strategic Objective 1.2, Expand safe, high quality healthcare options, and encourage innovation and competition.*

Innovation and Improvement - *The Division of Innovation and Improvement* increased quality improvement capacity within the Agency. A Patient Experience of Care Survey Working Group was established by the Steering Committee to develop a standardized patient experience of care survey instrument for use at all IHS healthcare facilities. These anonymous surveys are administered and the results analyzed individually by each IHS healthcare facility. The analysis will determine what improvements, if any, are required to improve the patient experience. The instrument was finalized in March 2017, and a first phase of pilot testing provided key findings and recommendations that are being used for improvement of the instrument. The pilot test found high patient and staff acceptance and specific areas for process improvements. Continued piloting and expansion of the number of facilities implementing this tool will continue throughout FY 2020. By listening to our patients, the survey will improve the quality of care provided by the IHS. This activity meets the *IHS Strategic Plan Goal Two, Objective 2.2 Provide care to better meet the needs of American Indian and Alaska Native communities and the HHS Strategic Plan Goal One, Strategic Objective 1.2, Expand safe, high quality healthcare options, and encourage innovation and competition.*

A Patient Wait Times Working Group was established by the Steering Committee to develop standards for primary care patient wait times for appointments. The Working Group completed standard development in June 2017, establishing the following standards: 28 days or less for primary care non-follow-up appointments, and 48 hours or less for primary care urgent visit appointments. Subsequently, Emergency Department (ED) wait time standards were implemented in policy for ED throughput time (arrival to Discharge) with the standard of median time 120 minute or less and left without being seen rate of 2 percent or less. To date IHS Area Offices and HQ have developed dashboards for the wait times standards and to use data for each of these wait time measures for evaluation and improvement. The IHS Standard for Wait Times for Primary Care automation process went live on June 10, 2019, and a monthly report is generated to monitor progress. The ED wait time standards automation process went live on June 24, 2019 and an ED Communication Memorandum and process flow was sent to Area Directors and Chief Medical Officers. Monthly reports are being generated and disseminated. Since the ED wait time went there, there has been an improvement, both wait time standards will continue to be monitored. Improving patient wait times will ensure that timely primary care is

available and accessible to IHS patients; this is a direct response to the GAO recommendation to improve oversight of patient wait times. This activity meets the *IHS Strategic Plan Goal Two, Objective 2.2 Provide care to better meet the needs of American Indian and Alaska Native communities and the HHS Strategic Plan Goal One, Strategic Objective 1.2, Expand safe, high quality healthcare options, and encourage innovation and competition.*

IHS continued its productive partnerships with the Premier Inc. Hospital Improvement and Innovation Network (HIIN) and HealthInsight New Mexico Quality Improvement Organization (QIO) with its Partnership to Advance Tribal Health (PATH). The Premier HIIN provides technical assistance and learning platforms to reduce Hospital Acquired Conditions and Readmissions. They coach hospital care teams and staff on best practices, lessons learned, and quality improvement activities aligned with these goals. The HealthInsight NM QIO and PATH provide leadership development learning opportunities, care team effectiveness enhancement, patient safety resources, patient/family engagement technical assistance, and system level assessments. IHS and CMS developed a set of three Aims for PATH in FY 2019. These Aims are: 1) Reduction of Harm; 2) improved and sustained compliance with Federal regulations and accreditation standards; and 3) Improve transitions in care. In FY 2019, PATH working with IHS direct service and CMS certified hospitals, have developed and begun baseline assessments for each of the Aims and developed action plans for each IHS hospital to reach the 2019 Aims by the end of the calendar year 2019. This activity meets the *IHS Strategic Plan Goal Two, Objective 2.2 Provide care to better meet the needs of American Indian and Alaska Native communities and the HHS Strategic Plan Goal One, Strategic Objective 1.2, Expand safe, high quality healthcare options, and encourage innovation and competition.*

In FY 2019, the OQ implemented the accelerated model for improvement (Ami™) improvement science framework, and has supported the training Healthcare Improvement Professionals (HIP) to support quality improvement initiatives throughout the IHS areas. There are 45 HIPS implementing various improvement projects and Ami™ is implemented in the Great Plains, Phoenix, and Portland Areas. This activity meets the *IHS Strategic Plan Goal Two, Objective 2., Create quality improvement capability at all levels of the organization; IHS Strategic Plan Goal Two, Objective 2.2 Provide care to better meet the needs of American Indian and Alaska Native communities; and, the HHS Strategic Plan Goal One, Strategic Objective 1.2, Expand safe, high quality healthcare options, and encourage innovation and competition.*

Improving Patient Care (IPC) Program - The purpose of the IPC Program is to promote the development and application of the quality improvement processes and to promote the implementation of the Patient-Centered Medical Home (PCMH) model of care to improve the health and wellness of AI/ANs. The IPC program provides a model of collaborative learning to develop proficiency in quality improvement. Data management and analysis are used to drive improvements. Success will be measured in FY 2019, and beyond, by achievement of clinical and process industry-benchmarks, as well as ultimate recognition or certification of participating sites as PCMHs. Participating teams report on clinical outcome measures aligned with the Government Performance and Results Act (GPRA) measures and some additional clinical process measures. This activity meets the *IHS Strategic Plan Goal Two, Objective 2.2 Provide care to better meet the needs of American Indian and Alaska Native communities and the HHS Strategic Plan Goal One, Strategic Objective 1.3, Improve Americans' access to healthcare and expand choices of care and service options.*

In 2019, the IPC program has provided 1000 subscriptions to the Institute for Healthcare Improvement (IHI) Open School to support IHS/Tribal/Urban (I/T/U) facility staff in their quality improvement efforts with enrollment of over 900 staff. The IHS collaboration with PATH) has

provided 1300 subscriptions to the IHI Open School to support IHS federally operated Hospital staff in their quality improvement efforts with enrollment of over 570 staff. Combined the IPC Program and the PATH have awarded over 8,000 Continuing Education Units (CEU) for I/T/U staff to date. In 2019, IHS implemented a web based collaborative learning environment to support quality improvement and PCMH information dissemination and knowledge exchange. In FY 2019, the IPC Program added four new enhancements to improve the IHS Quality Portal member's experience while utilizing the portal. The enhancements include subscription and notification settings, integration of a calendar invitation, the ability for the IHS staff to create "affinity groups" to do quality improvement work and the ability to upload resources when replying to a request in the Community Exchange. In FY 2019, IHS Quality had an increase of 46 percent of its membership from FY 2018. During FY 2019, the portal members have viewed over 1500 times resources in the IHS Quality Portal, averaging over 70 views a month of those resources available in the portal. These resources are in different formats. These formats include video, documents, audio files and website URL (uniform resource locator). In FY 2019, the IHS Quality portal members have uploaded over 200 resources to the portal. IPC Program used the support of CSI Solutions (contractor) to perform of a gap analysis and identify multiple process improvement and functionality enhancements for development on FY 2020. IPC Program with the assistance of CSI Solutions develop a process to improve the costumer experience of the active members of the portal utilizing the Community Exchange. This activity meets the *IHS Strategic Plan Goal Two, Objective 2., Create quality improvement capability at all levels of the organization; IHS Strategic Plan Goal Two, Objective 2.2 Provide care to better meet the needs of American Indian and Alaska Native communities; and, the HHS Strategic Plan Goal One, Strategic Objective 1.2, Expand safe, high quality healthcare options, and encourage innovation and competition.*

In FY 2019, the IPC Program led and coordinated a working group to review a draft charter of a future National Quality Council. The workgroup was composed of staff from multiple area offices and facilities across the IHS. The IPC Program coordinated the vote and election of an Executive Committee who will coordinate the final development of the charter with support from the IPC Program and the Office of Quality. This activity meets the *IHS Strategic Plan Goal Two, Objective 2.2 Provide care to better meet the needs of American Indian and Alaska Native communities and the HHS Strategic Plan Goal One, Strategic Objective 1.2, Expand safe, high quality healthcare options, and encourage innovation and competition.*

The OQ continues to work toward the goal of 100 percent recognition of ambulatory care as PCMH care by 2021. 27 of 31 (87 percent) eligible ambulatory care facilities and 9 of 24 (36 percent) of hospital-based ambulatory care clinics hold PCMH recognition through the TJC or the Accreditation Associated for Ambulatory Health Care (AAAHC). Further, 7 of 9 PCMH-recognized IHS hospitals received their recognition in FY 2019. This activity meets the *IHS Strategic Plan Goal Two, Objective 2.2 Provide care to better meet the needs of American Indian and Alaska Native communities; the HHS Strategic Plan Goal One, Strategic Objective 1.2, Expand safe, high quality healthcare options, and encourage innovation and competition; and, the HHS Strategic Plan Goal One, Strategic Objective 1.3, Improve Americans' access to healthcare and expand choices of care and service options.*

IPC program supports I/T/U facilities in providing them with the tools and resources needed to determine when a change is an improvement and to monitor the spread and scale-up of change using PCMH measures. The IPC program also implemented a national reporting system for the 21 PCMH measures in collaboration with the IHS Office of Information Technology. There are currently 21 approved measures and in FY 2019, IHS completed the implementation of all measures installed in our population health management tool (iCare) for facilities to view,

monitor, and evaluate quality improvement measures. The IPC program in FY 2019 also implemented risk stratification and patient-reported outcomes tools within our population health management tool to strengthen IHS's ability to provide care that best meets the healthcare needs of AI/AN people. In FY 2019, 70 percent of the IHS health care facilities providing ambulatory care services obtained PCMH designation from either a national accreditation organization or a state Medicaid program. This activity meets the *IHS Strategic Plan Goal Two, Objective 2., Create quality improvement capability at all levels of the organization; IHS Strategic Plan Goal Two, Objective 2.2 Provide care to better meet the needs of American Indian and Alaska Native communities; and, the HHS Strategic Plan Goal One, Strategic Objective 1.2, Expand safe, high quality healthcare options, and encourage innovation and competition.*

Enterprise Risk Management - The Division of Enterprise Risk Management and Internal Controls is responsible for identifying key risk areas throughout the agency. In FY 2019, key process areas were identified by the IHS Senior Assessment Team and assessed through documentation of key controls and risk assessment workshops. The OQ provided leadership in developing cycle process documentation with key process owners and testing the operational effectiveness through detailed transactional testing. Workshops were conducted with functional staff throughout all levels of the Agency to identify key drivers of risk related to Facility Accreditation Compliance, Employee Retention, and Quality of Care and developed risk response plans to mitigate critical risk areas. This activity meets the *IHS Strategic Plan Goal Three, Objective 3.2, Secure and effectively manage the assets and resources and, the HHS Strategic Plan Goal Five, Strategic Objective 5.1, Ensure responsible financial management.*

Nursing – Nursing represents the largest category of health care providers in the Indian health system and has a major impact on patient safety and health care outcomes. Nurses are actively engaged in the transformation of the health care system by placing more emphasis on prevention, wellness, and coordination of care.

As part of the *Let's Move! In Indian Country* (LMIC), the Indian Health Service (IHS) launched the Baby Friendly Hospital Initiative (BFHI) in 2011. This IHS initiative promotes breastfeeding to reduce the risk that children will develop obesity, diabetes, and other obesity-related conditions in the future.[1] The BFHI is a quality improvement initiative to increase breastfeeding (BF) initiation and duration, thereby creating a healthy start in life and preventing childhood obesity. Exclusive BF protects against obesity and type II diabetes, conditions to which American Indian/Alaska Natives (AI/ANs) are particularly prone. The BFHI initiative requires the following: establish a written BF policy; train all staff in the skills necessary to implement the policy; inform pregnant women of the benefits and management of BF; assist mothers initiate BF within 1 hour of birth; show mothers how to breastfeed and how to maintain lactation; give infants no food or drink other than breast-milk, unless medically indicated; allow mothers and infants to remain together 24 hours a day (rooming in); encourage breastfeeding on demand; give no pacifiers or artificial nipples to breastfeeding infants; and, foster the establishment of BF support groups and refer mothers to them upon discharge.

Ten IHS federally operated obstetrical (OB) hospitals are designated as Baby-Friendly. Baby Friendly designated facilities are required to be surveyed and re-designated every five years. The following obstetric hospitals have successfully completed Baby Friendly Re-designation assessment: Claremore Indian Hospital, Phoenix Indian Medical Center, Quentin N. Burdick Memorial Health Care Facility, Zuni Comprehensive Health Center, and Pine Ridge Service Unit; and, five IHS obstetrical hospitals are engaging in the re-designation process in 2019. This activity meets *IHS Objective 1.3 Access: Ensure that comprehensive, culturally appropriate*

personal and public health services are available and accessible to American Indian and Alaska Native people and the HHS Goal 2.2 Prevent, treat and control chronic conditions

Collaborations have been established with Tribal health care systems with the goal of providing safe and quality care for Native communities. A collaborative agreement was formed between IHS and the Chickasaw Nation Medical Center, Ada, Oklahoma, to enhance clinical competencies for IHS Emergency Department, Perioperative Room, and Labor and Delivery Registered Nurses (RNs). The agreement is designed to enhance IHS specialty nurses' clinical competency through preceptored clinical rotations offered at the Tribally-managed Chickasaw Medical Center, which maintains higher patient volume. Factors that impact IHS's capacity to assist RNs to maintain their level of clinical competency, beyond initial licensure, credentialing, and continuing education, are attributable to geographically isolated IHS hospitals that are further challenged with fluctuating patient volume. This activity meets the *IHS Strategic Plan Goal 2, Objective 2.2 Provide care to better meet the needs of American Indian and Alaska Native communities and the HHS Strategic Plan Goals 1, Strategic Objective 1.2, Expand safe, high quality Healthcare options, and encourage innovation and competition.*

The Division of Nursing Services (DNS) implemented the Rural Obstetrical Nurse Residency Program (RONR). The purpose of RONR is to facilitate a structured professional nursing experience for new and inexperienced obstetrical nurses in an effort to alleviate critical shortages of practicing nurses within the Indian Health System. To sustain the RONR, DNS led a workgroup to develop and draft a RONR charter. The workgroup consisted of Area Nurse Consultants through the agency. This activity meets the *IHS Strategic Plan Goal 2, Objective 2.2 Provide care to better meet the needs of American Indian and Alaska Native communities and the HHS Strategic Plan Goals 1, Strategic Objective 1.2, Expand safe, high quality Healthcare options, and encourage innovation and competition.*

DNS made available 400 subscriptions to the Emergency Severity Index (ESI) web-based course. The web course was offered to Registered Nurses and Advanced Practice Nurses who care for patients in the emergency department, urgent care or other critical care settings, as well as nurses who provide additional coverage for these units. This activity meets the *IHS Strategic Plan Goal 2, Objective 2.2 Provide care to better meet the needs of American Indian and Alaska Native communities and the HHS Strategic Plan Goals 1, Strategic Objective 1.2, Expand safe, high quality Healthcare options, and encourage innovation and competition.*

HIV Program – AI/AN people face significant health disparities in rates of sexually transmitted infections including HIV. From 2010 to 2016, the annual number of HIV diagnoses increased 46 percent (from 157 to 230) among AI/AN overall and 81 percent (from 90 to 163) among AI/AN gay and bisexual men. Of AI/AN with HIV in 2015, 60 percent received HIV care, 43 percent were retained in care, and 48 percent had achieved viral suppression.[3] Current statistics indicate HIV has affected nearly all communities served by the IHS.

The HIV Program goal is to prevent new HIV infections and ensure access to quality health services for AI/ANs living with HIV (*IHS Strategic Plan Goal 1, Objective 1.1 Recruit, develop, and retain a dedicated, competent, and caring workforce, 1.2 Build, strengthen, and sustain collaborative relationships, & 1.3 Increase access to quality health care services; Goal 2, Objective 2.1 Create quality improvement capability at all levels of the organization & 2.2 Provide care to better meet the health care needs of American Indian and Alaska Native communities; HHS Strategic Plan FY 2018-2022 Goal 1, Objective 1.2 Expand safe, high-quality*

[3] https://www.cdc.gov/hiv/group/racialethnic/aian/index.html

healthcare options, and encourage innovation and competition, 1.3 Improve Americans' access to healthcare and expand choices of care and service options, & 1.4 Strengthen and expand the healthcare workforce to meet America's diverse needs; Goal 2 Objective 2.1 Empower people to make informed choices for healthier living, 2.2 Prevent, treat, and control communicable diseases and chronic conditions, 2.4 Prepare for and respond to public health emergencies. Integrating the Department's Strategic Goal to protect the health of Americans where they live, learn, work, and play) IHS increased overall prenatal HIV screening to 87 percent in FY 2016 – a 15 percent increase over FY 2006 data *(HHS Strategic Plan FY 2018-2022 Goal 2, Objective 2.1 Empower people to make informed choices for healthier living*). In FY 2016, IHS included HIV screening of 13-64 year-olds in its nationally reportable quality of care metrics. This effort resulted in 80,000 unique AI/AN patients receiving HIV screening for the first time. The overall HIV screening rate has increased by 22 percent. Some of the highest performing IHS facilities have achieved HIV screening levels of more than 70 percent for the eligible population. In FY 2018, efforts continued to expand screening to our most at-risk populations, including men who have sex with men. To improve AI/AN access to healthcare in remote areas, the IHS HIV Program provides technical support to IHS, tribal, and urban Indian health sites on screening and treatment, and the use of tele-health *(HHS Strategic Plan FY 2018-2022 Goal 1, Objective 1.2 Expand safe, high-quality healthcare options, and encourage innovation and competition, 1.3 Improve Americans' access to healthcare and expand choices of care and service options, & 1.4 Strengthen and expand the healthcare workforce to meet America's diverse needs)*

The IHS National HIV/HCV Program submitted three FY 2019 Minority HIV/AIDS Fund (MHAF) applications to the Office of the Assistant Secretary for HHS, Office of Infectious Disease and HIV/AIDS Policy (OIDP). IHS received notice of $7.9 million in MHAF awards. There are seven components to the funding, including a section on tribal consultation and urban confer *(IHS Strategic Plan FY 2019-2023 Goal 1, Objective 1.2 Expand safe, high-quality healthcare options, and encourage innovation and competition*). Through MHAF, IHS awarded the National Indian Health Board (NIHB) $200,000 to host at least four tribal consultation sessions by July 2020 with the various federally recognized tribes throughout the U.S. to gain input and provide advice to IHS on reaching the goals of the *Ending the HIV Epidemic: A Plan for America* (EHE or The Plan). With MHAF, IHS awarded the National Council of Urban Indian Health (NCUIH) $25,000 to host at least two urban confer sessions by April 2020 with their member organizations to gain input and provide advice to IHS on meeting the goals of the EHE. In addition, IHS awarded the Albuquerque Area Indian Health Board (AAIHB) $200,000 to institute and manage the National Native HIV Network (NNHN) that will bring together a wide array of key stakeholders from the 12 IHS Areas to support IHS' community level efforts to meet the goals of the Plan. This funding falls under the EHE Empowering Healthier Tribal Communities (Community Planning).

Through the IHS National HIV Program, MHAF also provided $1.5 million to the Cherokee Nation Health Services (CNHS) for an EHE pilot project to ensure the future success of The Plan in Indian Country. The program has four main objectives that will help to meet this outcome: (1) Implement a public education campaign in Cherokee Nation centering on HIV care and HIV prevention; (2) Educate CNHS providers on the need to have discussions about the sexual health of their patients; (3) Identify and link to care CNHS patients currently living with HIV; and (4) Establish a robust pre-exposure prophylaxis (PrEP) program within the CNHS *(IHS Strategic Plan FY 2019-2023 Goal 1, Objective 1.1 Recruit, develop, and retain a dedicated, competent, and caring workforce, 1.2 Build, strengthen, and sustain collaborative relationships, & 1.3 Increase access to quality health care services; HHS Strategic Plan FY 2018-2022 Goal 1,*

Objective 1.2 Expand safe, high-quality healthcare options, and encourage innovation and competition, 1.3 Improve Americans' access to healthcare and expand choices of care and service options, & 1.4 Strengthen and expand the healthcare workforce to meet America's diverse needs). By educating the public and providers, implementing tools for screening high-risk patients, and establishing a PrEP program, CNHS will not only be detecting those individuals who are at risk for HIV and preventing new infections but will also be detecting, linking to care, and providing treatment for those who have previously undiagnosed infections. The pilot project will provide an opportunity to begin implementing and evaluating some key foundational activities that will help accelerate progress toward ending the HIV epidemic in Indian Country.

Another section of the FY 2019 MHAF funds provides $2.4 million in competitive funds for the 12 Tribal Epidemiology Centers (TECs). In October 2019, the IHS awarded $2.4 million to nine TECs to support AI/AN communities in reducing new HIV infections and relevant co-morbidities, specifically hepatitis C and sexually transmitted infections *(IHS Strategic Plan FY 2019-2023 Goal 1, Objective 1.1 Recruit, develop, and retain a dedicated, competent, and caring workforce, 1.2 Build, strengthen, and sustain collaborative relationships, & 1.3 Increase access to quality health care services; HHS Strategic Plan FY 2018-2022 Goal 1, Objective 1.2 Expand safe, high-quality healthcare options, and encourage innovation and competition, 1.3 Improve Americans' access to healthcare and expand choices of care and service options, & 1.4 Strengthen and expand the healthcare workforce to meet America's diverse needs)*. The TECs will provide resources to help Native communities address the four main pillars of the Ending the HIV Epidemic plan: Diagnose, Treat, Protect, and Respond (HHS Strategic Plan FY 2018-2022 Goal 4, Objective 4.1 *Improve surveillance, epidemiology, and laboratory services*). Only current TEC grantees were eligible to apply for the competing supplemental funding under this announcement and had to demonstrate that they have complied with previous terms and conditions of the TEC program. There were two separate, but related notices in the Federal Register. The first was for those Tribal Epi Centers that do not provide services in the 48 counties or 7 southern states of the EHE Phase One Jurisdictions. These "Group A" applicants could apply for up to $100,000. The second announcement – for "Group B" applicants – was for those TECs whose constituency contains one or more of the 48 counties or 7 southern states in the Phase One jurisdictions of the EHE. These "Group B" applicants could apply for up to $275,000.

Hepatitis C Virus (HCV) infections can result in illness varying in severity from mild (lasting a few weeks), to serious (a lifelong illness ending in death by liver failure). The likelihood of liver damage is related to the duration and severity of untreated infection. The CDC estimates that 3.5 million persons in the U.S. have HCV; approximately 120,000 of whom identify as AI/AN.[4] The IHS National Patient Information Reporting System (NPIRS) data identifies 29,803 IHS patients from 2005-2015 with HCV, and estimates nearly 200 new cases each year; 53.4 percent were among persons born 1945–1965. The overall HCV burden was higher among males than females. This data does not include up to 50 percent of patients who remain undiagnosed. AI/AN people have the largest increase of liver and intrahepatic bile duct cancer compared to any other race/ethnic groups. IHS data also identifies fewer than 1,000 HCV patients currently undergoing treatment. HCV death rates among AI/ANs are more than twice the national average compared to other ethnic groups.[5]

[4] https://www.ncbi.nlm.nih.gov/pubmed/?term=Edlin+Toward+amore+accurate+estimate

[5] https://www.cdc.gov/hepatitis/statistics/2016surveillance/commentary.htm

The CDC and the U.S. Preventive Services Task Force (USPSTF) recommends that all persons born from 1945-1965 should be screened for HCV. IHS aligned program initiatives with the National Viral Hepatitis Action Plan (NVHAP) 2017-2020, to eliminate new viral hepatitis infections, increase knowledge of hepatitis diagnoses, improve access to high quality health care and curative treatments, and eliminate stigma and *discrimination (IHS Strategic Plan FY 2019-2023 Goal 1, Objective 1.1 Recruit, develop, and retain a dedicated, competent, and caring workforce, 1.2 Build, strengthen, and sustain collaborative relationships, & 1.3 Increase access to quality health care services; HHS Strategic Plan FY 2018-2022 Goal 1, Objective 1.2 Expand safe, high-quality healthcare options, and encourage innovation and competition, 1.3 Improve Americans' access to healthcare and expand choices of care and service options, & 1.4 Strengthen and expand the healthcare workforce to meet America's diverse needs).* IHS clinical data shows that screening for HCV among AI/ANs born from 1945-1965, increased from 8 percent in 2012, to 54 percent in 2017. This achievement is due in part to the *integration of the Department's Strategic Goal One to reform, strengthen, and modernize the Nation's Healthcare System* through the development of technical support tools like electronic health record (EHR) clinical reminders, publication of IHS policy guidelines for HIV and HCV, and creation of clinical linkages to care *(HHS Strategic Plan FY 2018-2022 Goal 1, Objective 1.2 Expand safe, high-quality healthcare options, and encourage innovation and competition, 1.3 Improve Americans' access to healthcare and expand choices of care and service options, & 1.4 Strengthen and expand the healthcare workforce to meet America's diverse needs*). IHS anticipates higher costs associated with HCV care in FY 2018 and FY 2019 associated with the increased rate of diagnosis (based on increased screening of Baby-Boomers and women of reproductive age) and the substantially high cost of curative medications. In FY 2019, IHS established universal screening for HCV for all patients over the age of 18 years at least once in their lifetime, followed by guideline-based treatment, as appropriate (IHS Strategic Plan FY 2019-2023 Goal 1, Objective 1.1 *Recruit, develop, and retain a dedicated, competent, and caring workforce*, 1.2 *Build, strengthen, and sustain collaborative relationships*, & 1.3 *Increase access to quality health care services*; HHS Strategic Plan FY 2018-2022 Goal 1, Objective 1.2 *Expand safe, high-quality healthcare options, and encourage innovation and competition*, 1.3 *Improve Americans' access to healthcare and expand choices of care and service options,* & 1.4 *Strengthen and expand the healthcare workforce to meet America's diverse needs*).

Sexually Transmitted Disease (STD) rates continue to rise in Indian Country, and recurrent STDs can increase the likelihood of HIV transmission. Gonorrhea and syphilis often present as co-morbid conditions with HIV diagnosis, particularly among men who have sex with men (MSM). Data show that the incidence rates of chlamydia and gonorrhea among AI/AN people are approximately four times that of whites, and AI/AN have the second highest overall rates for both conditions when compared to all other races and ethnicities.[6] Regional differences in STDs in Indian Country are also observed, and AI/AN youth and AI/AN women, particularly women of reproductive age, have a disparate and increased STD burden.[7] Recent and sustained outbreaks of syphilis have also been observed among AI/AN communities, some related to injection drug and methamphetamine use, and both are recognized risk factors for HIV transmission.

Domestic Violence Prevention Program (DVPP) – Domestic and intimate partner violence has a disproportionately large impact on AI/AN communities. According to a 2016 report by the National Institute of Justice,[8] more than four in five AI/AN women (84.3 percent) have

[6] https://www.cdc.gov/std/stats17/minorities.htm

[7] https://www.ihs.gov/sites/epi/themes/responsive2017/display_objects/documents/std/Indian_Health_Surveillance_Report_STD_2015.pdf

[8] https://www.ncjrs.gov/pdffiles1/nij/249736.pdf

experienced violence in their lifetime. This includes 56.1 percent who have experienced sexual violence, 55.5 percent who have experienced physical violence by an intimate partner, 48.8 percent who have experienced stalking, and 66.4 percent who have experienced psychological aggression by an intimate partner. Data from the National Institutes for Justice and the Center for Disease Control show that more than 1.5 million American Indian and Alaska Native women have experienced violence, including sexual violence in their lifetimes.[9] Many of the projects supported by the DVPP are focused on increasing community awareness and identifying resources to address high rates of missing and murdered indigenous women and girls (MMIW).

DVPP was established in 2015, as a nationally coordinated program that provides culturally appropriate domestic violence and sexual assault prevention and intervention resources to AI/AN communities with a focus on providing trauma informed services. The DVPP supports IHS *Goal 1 to ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to AI/AN people and Goal 1, Objective 1.2 to build, strengthen, and sustain collaborative relationships.* The DVPP focuses on domestic and sexual violence prevention, advocacy, and education about domestic violence and sexual violence, coordinated community responses, as well as providing forensic healthcare services to victims of domestic and sexual violence. In FY 2019, IHS supported a total of 83 awards to participate in the DVPP. In 2019, IHS participated in formal Tribal Consultation and an Urban Confer regarding behavioral health initiatives and the distribution of funding for the DVPP program. Recommendations and modifications impacting the DVPP as a result of the Tribal Consultation and an Urban Confer will be announced in FY 2020.

A total of 83 grantees and federal awardees work to meet the following goals:

1. Build Tribal, Urban Indian Health Programs, and Federal capacity to provide coordinated community responses to AI/AN victims of domestic and sexual violence,
2. Increase access to domestic and sexual violence prevention, advocacy, crisis intervention, and behavioral health services for AI/AN victims and their families,
3. Promote trauma-informed services for AI/AN victims of domestic and sexual violence and their families,
4. Offer health care provider and community education on domestic violence and sexual violence,
5. Respond to the health care needs of AI/AN victims of domestic and sexual violence, and
6. Incorporate culturally appropriate practices and/or faith-based services for AI/AN victims of domestic and sexual violence.

DVPP is on a five-year funding cycle from FY 2015 – FY 2020. The third year concluded on September 29, 2018, with 99 percent of projects submitting progress reports. Data collected throughout this period indicate an approximate 58,000 direct service encounters including services related to coordinated community responses, advocacy, forensic healthcare, integration of traditional healing, faith-based and culturally competent services. Evaluation of year three projects indicate an expansion of services delivered to victims of domestic violence and intimate partner violence. Sites also experienced an increase in partnerships among tribal programs to develop Coordinated Community Response and Sexual Assault Response Teams as well as establishing intervention programs that include evidence-based and traditional practices.

[9] https://www.whitehouse.gov/presidential-actions/missing-murdered-american-indians-alaska-natives-awareness-day-2019/

In addition, these funds support the Forensic Health Care activities within IHS HQ. The Forensic Health Care program was developed in 2009 and aims to increase recognition of and prevent sexual assault, child maltreatment (all forms including sexual abuse), intimate partner violence, human trafficking, and elder abuse in Native communities by providing: high-quality staff training, assistance to local facilities to create or sustain appropriate acute forensic care services, and strengthen on-going comprehensive services that enhance survivor healing. The program has established a strong partnership with the International Association of Forensic Nurses. The services provided through this agreement include didactic and clinical forensic examination courses, quarterly educational webinars, and technical assistance to sexual assault programs operating within the I/T/U system.

FUNDING HISTORY

Fiscal Year	Amount	DVPP
2017	$1,935,178,000	($12,967,278)
2018	$2,055,128,000	($12,967,278)
2019	$2,178,088,000	($12,967,278)
2020 Enacted	$2,324,606,000	($12,967,278)
2021 President's Budget	$2,432,384,000	($12,967,278)

TRIBAL SHARES

H&HC funds are subject to tribal shares and are transferred to Tribes when they assume responsibility for operating associated programs, functions, services, and activities. A portion of the overall H&HC budget line is reserved for inherently federal functions and is therefore retained by IHS to perform the basic operational services of the Agency.

BUDGET REQUEST

The FY 2021 budget submission for Hospitals and Health Clinics is $2.4 billion, which is $108.0 million above the FY 2020 Enacted level.

FY 2020 Base Funding of $2.3 billion - supports the largest portion of clinical care at IHS and Tribal health facilities, including salaries and benefits for hospital/clinic administration; salaries and benefits for physicians, nurses, and ancillary staff; pharmaceuticals; and medical supplies. These funds make up the lump sum recurring base distribution to the Areas each fiscal year. In addition, an amount of H&HC funding that initially is allocated to Headquarters each year is reallocated on a non-recurring basis to Areas during the fiscal year and supports national activities. Also included in the base is funding to provide technical assistance to IHS facilities to promote efficient, effective, high quality care to the AI/AN population. The IHS will strengthen its quality system to ensure alignment with and attainment of national standards for quality and patient safety for inpatient and outpatient facilities. This will include accreditation preparation, readiness, and survey activities; bringing health care quality expertise to IHS; and development and dissemination of education tools and experiential opportunities to ensure staff competencies in quality assurance and quality improvement.

FY 2021 Funding Increase of $108.0 million includes:

1. Current Services: +$17.0 million for current services including:

- Inflation +17.0 million – This request offsets the increasing costs of medical products and services, projected to be 3.9 percent. Without these funds, IHS would have to reduce services and slow the purchase of necessary medical supplies to operate its health program within available funds.

2. Staffing for New Facilities +$24.4 million - These funds will support staffing and operating costs for new and replacement projects listed below. Funding for new/renovated healthcare facilities allows IHS to expand provision of health care in those areas where capacity has been expanded to address health care needs. The following table displays this request.

New Facilities	Amount	FTE/Tribal Positions
Yukon-Kuskokwim Primary Care Center (JV), Bethel, AK	$13,022,000	72
Naytahwaush Health Center (JV), Naytahwaush, MN	$7,446,000	57
Yakutat Tlingit Health Center (JV), Yakutat, AK	$861,000	5
Ysleta Del Sur Health Center (JV), El Paso, TX	$3,101,000	27
Grand Total:	**$24,430,000**	**161**

3. Elimination of HIV, Hepatitis C, and Sexually Transmitted Diseases +$27.0 million to focus on the treatment as prevention model and supports efforts to diagnose all HIV-positive IHS patients as early as possible after infection; treat those living with HIV rapidly and effectively to achieve sustained viral suppression; protect individuals at risk of HIV using proven prevention approaches; effectively identify, treat, and prevent related conditions and risks for HIV infection, including hepatitis C virus (HCV) and sexually transmitted disease (STD) infections; and respond rapidly to growing HIV clusters to prevent propagated transmission resulting in new HIV infections.

Rates of STDs other than HIV also continue to rise in Indian country and can increase risk for HIV transmission. Additionally, IHS serves a population also disproportionately affected by HCV—the AI/AN population has more than twice the rate of HCV incidence and nearly three times the rate of HCV-related mortality as the general U.S. population (CDC 2018). Without concerted intervention that includes expanded HIV, STD, and HCV prevention, testing, and treatment, along with increased clinical and public health resourcing and infrastructure, including associated pharmaceuticals and data generation and analysis capacity, rates of AI/AN HIV, STDs, and HCV will likely continue to increase in FY 2021 and beyond. Additional health statistics about these priority diseases are provided in the program accomplishments section of this narrative.

This request supports the President's Ending the HIV Epidemic: A Plan for America (EHE) and the Eliminating Hepatitis C in Indian Country initiatives. Key components of this budget include:

- Increased access to treatment and medication.
- Expanded public health surveillance and data infrastructure to inform prevention and interventions.
- Increased resources and funding targeted at building tribal and local capacity for addressing the prevention and treatment of HIV, HCV, and STD infections.
- Expansion of the IHS workforce to coordinate and manage initiative efforts.

- Increased support for evaluation, outreach, education, and training.

This increase will expand patient screening and treatment for those living with HIV, STDs, and HCV; provide targeted PrEP and expedited partner therapy to those at greater risk for acquiring HIV and other STDs, effectively screen and treat those patients living with chronic HIV and HCV, sufficiently staff and resource internal programs to ensure success, and lays the overall groundwork for IHS' expanded efforts toward operationalizing the EHE with the ambitious goals of reducing new HIV infections by 75 percent in five years and by at least 90 percent in ten years. Expansion of IHS services is critical in reducing the high levels of HIV, STDs, and HCV infections experienced by AI/AN people. IHS headquarters, area offices, and service units will focus HIV/HCV diagnostic, treatment, prevention, and response services to those geographic areas with the greatest recognized need as follows:

- HIV Treatment with antiretroviral and prevention through PrEP, and HCV care and treatment with direct acting antiretroviral: $15.6 million: [treatment capacity goals: $13.2 million for HCV (approximately 1,100 patients), $1.4 million for PrEP (approximately 100 patients), and $1 million for HIV care (approximately 100 patients).]
- Partnerships with Tribal Epidemiology Centers: $2.5 million
- Staffing: $2.9 million for 12 FTEs ranging from GS-11 to GS-14
- Public health surveillance and data infrastructure (Data bridges and work): $1.5 million
- Evaluation: $500,000
- Outreach, education, and training: $4 million (IHS, tribal and urban clinical and public health staff training, Project ECHO, PrEP navigator training, stigma reduction, social media and outreach to AI/AN communities, etc.).

The National HIV/HCV Program focuses the $27.0 million on staff support for patient care that includes a training coordinator and almost double field located coordinators, and one public health training advisor, with a less robust treatment component. *(IHS Strategic Plan FY 2019-2023 Goal 1, Objective 1.1 Recruit, develop, and retain a dedicated, competent, and caring workforce, 1.2 Build, strengthen, and sustain collaborative relationships, & 1.3 Increase access to quality health care services; HHS Strategic Plan FY 2018-2022 Goal 1, Objective 1.2 Expand safe, high-quality healthcare options, and encourage innovation and competition, 1.3 Improve Americans' access to healthcare and expand choices of care and service options, & 1.4 Strengthen and expand the healthcare workforce to meet America's diverse needs*). IHS will concentrate efforts on building up its HIV and HCV infrastructure in the 12 Area Offices and Service Units.

In partnership, this funding request provides overall support for public health surveillance and data infrastructure support at the national level and provides supplementary resources for the Tribal Epidemiology Centers (TECs). TECs are uniquely positioned to complement the STD, HIV, and HCV prevention and control efforts of IHS clinical operations and staff through the expansion of TEC public health expertise that directly supports Tribal communities primarily via technical assistance, training, and coordination. *(IHS Strategic Plan FY 2019-2023 Goal 1, Objective 1.1 Recruit, develop, and retain a dedicated, competent, and caring workforce, 1.2 Build, strengthen, and sustain collaborative relationships, & 1.3 Increase access to quality*

health care services; HHS Strategic Plan FY 2018-2022 Goal 1, Objective 1.2 Expand safe, high-quality healthcare options, and encourage innovation and competition, 1.3 Improve Americans' access to healthcare and expand choices of care and service options, & 1.4 Strengthen and expand the healthcare workforce to meet America's diverse needs). As previously described, in 2019, the IHS through partnership with MHAF launched two funding opportunities (totaling $2.4 million) supporting foundational work among the national network of TECs that further the goals of the overall EHE initiative and specifically engage Tribal communities to leverage local and/or regional Tribally-managed public health resources (e.g., TECs). This work will first seek to develop local plans that address the transmission and treatment burdens of STDs, HIV, HCV, and related health conditions. *(IHS Strategic Plan FY 2019-2023 Goal 1, Objective 1.1 Recruit, develop, and retain a dedicated, competent, and caring workforce, 1.2 Build, strengthen, and sustain collaborative relationships, & 1.3 Increase access to quality health care services; HHS Strategic Plan FY 2018-2022 Goal 1, Objective 1.2 Expand safe, high-quality healthcare options, and encourage innovation and competition, 1.3 Improve Americans' access to healthcare and expand choices of care and service options, & 1.4 Strengthen and expand the healthcare workforce to meet America's diverse needs*). This proposed increase leverages and strengthens these foundational efforts, further enhances Tribal capacity, and provides additional regional and local resources for sustainment. For more information about the TECs, please refer to the Tribal Epidemiology Centers narrative.

The majority of funding will be distributed through new or existing programs, functions, services, and activity lines to support IHS facilities, tribes, and tribal organizations using direct transfers, contracts, cooperative agreements, and compacts, with a set aside for grants to urban Indian organizations.

4. National Community Health Aide Program (CHAP) -$20.0 million. This amount moved to the new Community Health line item. Funding for the Alaska CHAP will remain in H&HC.

5. Recruitment and Retention +$3.5 million - for the recruitment and retention of medical and other critical personnel for IHS facilities. The additional funds will be used to develop and expand a range of recruitment and retention strategies aimed to enhance and support the mission of the Indian Health Service. Initiatives include the IHS housing subsidy program, expanding the Title 38 compensation pay tables, and supporting the expansion of IHS recruitment and outreach activities, including the development of an applicant tracking system, expanding the medical resident rotation website project, updating and enhancing the IHS jobs board, and implementing the Federal Student Loan Repayment Program.

6. Improving Maternal Health in America +$5.0 million - The Centers for Disease Control and Prevention (CDC) reports that the number of reported pregnancy-related deaths in the United States increased from 7.2 deaths per 100,000 live births in 1987 to 16.9 deaths per 100,000 live births in 2016. Lack of access to appropriate and high-quality care, missed or delayed diagnoses, and lack of knowledge among patients and providers around warning signs contributed to pregnancy-related deaths. Trends also increased across the nation due to an increase in chronic conditions. The pregnancy-related death rate for AI/AN women was more than twice the rate of non-Hispanic white women, and AI/AN women had significantly higher proportion of pregnancy-related deaths for hemorrhage

and hypertensive disorders of pregnancy than non-Hispanic white women did.[10,11] AI/AN populations have higher rates of diabetes and obesity than the general population, which can increase their risk for pregnancy-related morbidity or death. Improving women's health overall in the preconception, pregnancy and postpartum period and increasing awareness of 'warning signs' can improve maternal outcomes. In addition, opioids, alcohol and other drugs continue to affect the nation, contributing to deaths of AI/AN pregnant woman, affecting their health and pregnancy outcomes and increasingly affecting their newborn infants.

Funding will be used to deliver on three goals: (1) support IHS preventive, perinatal, and postpartum care, (2) address the needs of pregnant women with substance use disorder including opioids, alcohol, and other drugs, and (3) improve quality of services and health outcomes in order to reduce maternal morbidity by 50 percent.
A breakdown of funding is as follows:

- $4 million ($3.5 million for standards of service, screening, training, outreach and education (includes education and tools for patients); $227,000 for staffing; and $250,000 for evaluation)
- $500,000 (I/T/U substance use disorder training, implementation of the American College of Obstetrics and Gynecology (ACOG) guidelines)
- $500,000 for the Alliance for Innovation on Maternal Health (AIM) Bundle implementation

Activities that support goal (1) include updating standards of the Service[12] and providing subsequent training on those standards for I/T/U that routinely provide care for pregnant women. Funding will also be used to implement and systematize screening and follow up for social determinants of health for pregnant women and to increase cultural awareness to improve health outcomes.[13] Using risk-based stratification, staff will then be able to link those at higher risk for poor pregnancy outcomes to enhanced care[14] that will also be expanded. *(HHS Goal 1.2 Expand safe, high quality healthcare options and encourage innovation and competition IHS Objective 1.2 Build, strengthen, and sustain collaborative relationships and 2.2 Provide care to better meet the health care needs of American Indian and Alaska Native communities)*

IHS plans also include development of a culturally appropriate publication/app to provide pregnancy and post-partum education for AI/AN women, including warning signs, to be available no matter where women live or obtain care. *(HHS Goal 2.1 Empower people to make informed choices for healthier living IHS Objective 2.2: Provide care to better meet the health care needs of American Indian and Alaska Native communities and HHS Goal 2.2 Prevent, treat and control chronic conditions IHS Objective 1.3 Access: Ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people).*

---

[10] https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm

[11] Petersen EE, Davis NL, Goodman D, et al. Racial/Ethnic Disparities in Pregnancy-Related Deaths — United States, 2007–2016. MMWR Morb Mortal Wkly Rep 2019;68:762–765. DOI http://dx.doi.org/10.15585/mmwr.mm6835a3external icon.

[12] This will include the Maternal and Child Health chapter in the Indian Health Manual

[13] ACOG has released a committee opinion urging health care providers to improve patient-centered care and decrease inequities in reproductive health care. Standardized screening tools, such as the Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tools, which was developed by Centers for Medicare & Medicaid Services (CMS) Center for Medicare and Medicaid Innovation (CMMI), will be utilized. The AHC HRSN Screening Tool is self-administered.

[14] Which may include the evidence-based, culturally tailored Family Spirit home-visiting program

In order to address goal (2), IHS will provide tools and training to I/T/U that routinely see pregnant women to increase targeted outreach to pregnant women and women of childbearing age at risk for substance use disorder, including those at risk from opioids, alcohol, and other drugs. IHS will leverage the newly released recommendations for healthcare providers treating AI/AN pregnant women and women of childbearing age with opioid use disorder developed for the IHS by ACOG. *(HHS Goal 2.2 Prevent, treat and control chronic conditions) IHS Objective 1.3 Access: Ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people).*

Finally, to address goal (3), the funding will support all IHS and Tribal hospitals with routine labor and delivery services on site to fully participate in the AIM as well as in Perinatal Quality Collaboratives (PQCs) in states where they exist.[15]

AIM is a national data-driven maternal safety and quality improvement initiative based on proven implementation approaches to improving maternal safety and outcomes in the U.S. The goal of the AIM Bundles is to move already established guidelines into practice with a standard approach.

PQCs are state or multi-state networks of teams working to improve the quality of care for mothers and babies. PQC members identify health care processes that need to be improved and use the best available methods to make changes as quickly as possible.

PQCs have contributed to important improvements in health care and outcomes for mothers and babies, including:

- Reductions in deliveries before 39 weeks of pregnancy without a medical reason.
- Reductions in health care–associated bloodstream infections in newborns.
- Reductions in severe pregnancy complications.[16]

7. ISDEAA section 105(*l*) Leases -$101.0 million – transfer from H&HC to the new indefinite discretionary account Payments for Tribal Leases.

8. Program Adjustment +$151.8 million - to maximize funding for direct patient care services.

[15] AIM is a national alliance to promote consistent and safe maternity care. Funding will support implementation of all care bundles at IHS and Tribal facilities that offer routine labor and delivery services, as well as facilitation of data-collection, data-mining, and data-sharing necessary to track maternal safety and quality improvement efforts. IHS will seek to connect all federal sites through the secure and centralized AIM Data Center. The AIM Data Center provides timely tracking of outcome, process, and structure data measures to ensure IHS can effectively reduce maternal morbidity and mortality outcomes at both the hospital and system level. Perinatal quality collaboratives (PQCs) are state or multi-state networks of teams working to improve the quality of care for mothers and babies. PQC members identify health care processes that need to be improved and use the best available methods to make changes as quickly as possible.

[16] Centers for Disease Control and Prevention PQC: https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pqc.htm

OUTPUTS/OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2020 Target	FY 2021 Target	FY 2021 Target +/-FY 2020 Target
20 100 percent of hospitals and outpatient clinics operated by the Indian Health Service are accredited or certified (excluding tribal and urban facilities). (Outcome)	FY 2019: 97 % Target: 100 % (Target Not Met)	100 %	100 %	Maintain
44 Years of Potential Life Lost (YPLL) in the American Indian/Alaska Native population (Outcome)	FY 2009: 86.3 years Target: Not Defined (Target Not In Place)	TBD	Not Defined	N/A
45 Hospital admissions per 100,000 service population for long-term complications of diabetes (Efficiency)	FY 2016: 58.1 Target: 56 (Target Not Met)	TBD	Not Defined	N/A
55 Nephropathy Assessed (Outcome)	FY 2019: 44.0 % Target: 34 % (Target Exceeded)	48.1 %	45.5%	-2.6%
56 Retinopathy Exam (Outcome)	FY 2019: 49.7 % Target: 49.7 % (Target Met)	53.5 %	51.4%	-2.1%
57 Pap Smear Rates (Outcome)	FY 2019: 37.1 % Target: 35.9 % (Target Exceeded)	39.2 %	38.4%	-0.8%
59 Colorectal Cancer Screening Rates (Outcome)	FY 2019: 31.5 % Target: 32.6 % (Target Not Met)	34.7 %	32.6%	-2.1%
66 American Indian and Alaska Native patients, aged 19-35 months, receive the following childhood immunizations: 4 DTaP (diphtheria, tetanus, and acellular pertussis); 3 IPV (polio); 1 MMR	FY 2019: 41.4 % Target: 45.6 % (Target Not Met)	45.9 %	42.8%	-3.1%

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2020 Target	FY 2021 Target	FY 2021 Target +/-FY 2020 Target
(measles, mumps, rubella); 3 or 4 Hib (Haemophilus influenzae type b); 3 HepB (hepatitis B); 1 Varicella (chicken pox); 4 Pneumococcal conjugate. (Outcome)				
67 Influenza Vaccination Rates among children 6 months to 17 years (Outcome)	FY 2019: 25.7 % Target: 20.6 % (Target Exceeded)	26.1 %	26.6%	+0.5%
68 Influenza vaccination rates among adults 18 years and older (Outcome)	FY 2019: 23.6 % Target: 18.8 % (Target Exceeded)	25.4 %	24.4%	-1.0%
69 Adult Composite Immunization (Output)	FY 2019: 53.3 % Target: 54.9 % (Target Not Met)	59.7 %	55.1%	-4.6%
70 Statin Therapy for the Prevention and Treatment of Cardiovascular Disease among American Indians and Alaska Natives (Outcome)	FY 2019: 32.2 % Target: 26.6 % (Target Exceeded)	35.7 %	33.3%	-2.4%
72 Tobacco Cessation Intervention (Outcome)	FY 2019: 32.9 % Target: 27.5 % (Target Exceeded)	31.4 %	34.0%	+2.6%
73 HIV Screening Ever (Outcome)	FY 2019: 30.9 % Target: 17.3 % (Target Exceeded)	28.4 %	32.0%	+3.6%
74 Breastfeeding Rates (Outcome)	FY 2019: 38.7 % Target: 39 % (Target Not Met)	43.6 %	40.0%	-3.6%
75 Controlling High Blood Pressure - MH (Outcome)	FY 2019: 41.5% Target: 42.3 % (Target Not Met)	52.6 %	42.9%	-9.7%
81 Increase Intimate Partner (Domestic) Violence screening	FY 2019: 36.3% Target:	41.5 %	37.5%	-4.0%

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2020 Target	FY 2021 Target	FY 2021 Target +/-FY 2020 Target
among American Indian and Alaska Native (AI/AN) Females (Outcome)	41.6 % (Target Not Met)			
87 Mammogram Rates: Proportion of eligible women who have had mammography screening within the previous two years. (Output)	FY 2019: 42.0% Target: Set Baseline	42.0%	43.4%	+1.4%

GRANTS AWARDS - H&HC funds support the Healthy Lifestyles in Youth Project,[17] a $1.3 million cooperative agreement with the National Congress of American Indians. This grant program promotes healthy lifestyles among AI/AN youth using the curriculum "Together Raising Awareness for Indian Life" at selected Boys and Girls Club sites across the country and represents responsiveness to Tribal input for more prevention activities. H&HC also funds 83 DVPP grants.

(whole dollars)	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Number of Awards	84	84	84
Average Award	$148,207	$148,207	$148,207
Range of Awards	$49,750-$1,250,000	$49,750-$1,250,000	$49,750-$1,250,000

AREA ALLOCATION

Hospital and Health Clinics

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2019 Final 1/			FY 2020 Estimated			FY 2021 Estimated			FY '21 +/- FY '20
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$7,702	$373,992	$381,694	$8,221	$399,150	$407,371	$8,602	417,656	$426,258	$18,887
Albuquerque	54,357	34,263	88,620	58,014	36,568	94,581	60,704	38,263	$98,967	$4,385
Bemidji	24,431	91,460	115,891	26,074	97,612	123,687	27,283	102,138	$129,421	$5,735
Billings	55,758	16,607	72,365	59,509	17,724	77,233	62,268	18,546	$80,814	$3,581
California	5,968	78,718	84,686	6,370	84,013	90,383	6,665	87,908	$94,573	$4,191
Great Plains	147,446	44,226	191,672	157,365	47,201	204,566	164,661	49,389	$214,050	$9,484
Nashville	14,287	71,263	85,550	15,248	76,056	91,305	15,955	79,583	$95,538	$4,233
Navajo	196,617	78,573	275,190	209,843	83,859	293,702	219,572	87,747	$307,319	$13,617
Oklahoma	121,066	283,985	405,051	129,210	303,088	432,298	135,200	317,141	$452,341	$20,043
Phoenix	120,305	83,043	203,348	128,398	88,629	217,027	134,351	92,738	$227,089	$10,062
Portland	27,397	59,831	87,228	29,240	63,855	93,095	30,596	66,816	$97,412	$4,316
Tucson	2,434	21,195	23,629	2,598	22,620	25,218	2,718	23,669	$26,388	$1,169
Headquarters	163,165	0	163,165	174,141	0	174,141	182,214	0	$182,214	$8,074
Total, H&HC	**$940,934**	**$1,237,154**	**$2,178,088**	**$1,004,229**	**$1,320,376**	**$2,324,606**	**$1,050,790**	**$1,381,594**	**$2,432,384**	**+$107,778**

1/ Reflects Services account adjustments related to formal reprogramming notifications submitted to Congress in FY 2019. Amounts by "Sub IHS Activity" will continue to be adjusted during the period of availability, which conclude on September 30, 2020, for impacted funds.

Note: FY 2020 through 2021 are estimates.

17 The current Healthy Lifestyles in Youth cooperative agreement expires August 31, 2022.

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

(Dollars in Thousands)

	FY 2019[1]	FY 2020	FY 2021	
	Final	Enacted	President's Budget	FY 2021 +/- FY 2020
BA	$2,178,088	$2,324,606	$2,432,384	+$107,778
Epi Ctr	*$4,433*	*$5,433*	*$5,433*	*+$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

FY 2021 Authorization.....Permanent

Allocation Method .....Cooperative Agreements

PROGRAM DESCRIPTION

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

The TECs play a critical role in IHS' overall public health infrastructure. Operating within Tribal organizations, TECs are uniquely positioned to provide support to local Tribal disease surveillance and control programs, and assess the effectiveness of public health programs. All TECs monitor the health status of their constituent Tribes, produce a variety of reports annually or bi-annually that describe activities and progress towards public health goals, and provide support to Tribes who self-govern their health programs.

The TEC program funds eleven TECs that provide comprehensive geographic coverage for all IHS administrative areas and one additional TEC serving American Indian and Alaska Native (AI/AN) populations residing in major urban centers nationally. The IHS Division of Epidemiology and Disease Prevention (DEDP) functions as the national coordinating center and provides technical support and guidance to TECs. The DEDP and TECs collect, analyze, interpret, and disseminate health information in addition to identifying diseases to target for intervention, suggesting strategies, and testing the effectiveness of implemented health interventions. The TEC Program supports Tribal communities by providing technical training in public health practice and prevention-oriented research, and promoting public health career pathways for Tribal members.

Over 90 percent of the TEC Program budget is distributed through cooperative agreements based on a 5-year competitive award cycle. In the current 5-year award cycle beginning FY 2016, the

[1] Reflects Services account adjustments related to formal reprogramming notifications submitted to Congress in FY 2019. Amounts by "Sub IHS Activity" will continue to be adjusted during the period of availability, which conclude on September 30, 2020, for impacted funds.

average annual award across all 12 TECs was $338,675. The next 5-year competitive award cycle will encompass FYs 2021-2026 and is projected to increase to $422,000 per TEC based on the FY 2020 enacted.

The TECs are fundamental to the IHS' partnership with Tribes by supporting epidemiology and public health functions essential to the delivery of healthcare services. Independent TEC goals are set as directed by their constituent Tribes and health boards. The DEDP tracks these goals and objectives as written in their cooperative agreements (e.g., surveillance of disease and control programs; collecting epidemiological data for use in determining health status of Tribal communities).

The TEC funds provide critical support in strengthening the collaborative partnerships among the 12 TECs' constituent AI/AN communities as a part of the agency's work to address the IHS Strategic Plan FY 2019-2023, Goal 1, Objective 1.2 (*Build, strengthen, and sustain collaborative relationships***)** and the HHS Strategic Plan 2018-2022 Goal 4.1 (*Improve surveillance, epidemiology, and laboratory services*).

The work of the TECs to collect data relating to, and monitor progress made toward meeting, each of the health status objectives of the Service, the Indian Tribes, Tribal organizations, and urban Indian organizations in the service area is an essential part of meeting the IHS Goal 1, Objective 1.3, Strategy 7 (*Reduce health disparities in the AI/AN population*) by highlighting disparities in the AI/AN population so they can be reduced through Public Health efforts. This includes the significant health impact of the Opioid crisis in Indian Country and the disproportionate burden of HIV/AIDS, HCV, and sexually transmitted diseases in AI/AN communities. Significant improvements in reducing the burden of disparities in this population would strongly address the HHS Goal 2: *Protect the Health of Americans Where They Live, Learn, Work, and Play*.

PROGRAM ACCOMPLISHMENTS

The TEC funds provide critical support in strengthening the collaborative partnerships among the 12 TECs and AI/AN communities *(IHS Strategic Plan FY 2019-2023, Goal 1, Objective 1.2)*. Below are key TEC activities.

Data Projects that Engage Local Resources

Data generated locally and analyzed by TECs enable Tribes to evaluate Tribal and community-specific health status for planning the needs of their Tribal membership. Immediate feedback is provided to the local data systems and leads to improvements in Indian health data overall. The Indian Health Care Improvement Act (Section 130) includes language that designates the TECs as public health authorities in regards to the Health Insurance Portability and Accountability Act (HIPAA) of 1996. This designation permits TECs to access IHS-generated data sets used to support various public health activities.

TECs assist Tribes with projects such as conducting behavioral risk factor surveys to establish a base of measurement for successfully evaluating intervention and prevention activities related to behavioral health needs. Because national surveys (e.g., Behavioral Risk Factor Surveillance System Survey, Youth Risk Behavior Survey) do not consistently capture representative data for AI/AN populations, TECs have had an essential role in piloting adapted versions of these national surveys to include AI/AN populations. These surveys provide baseline and trend data used by Tribes and Urban Indian organizations (UIOs) to identify health-related needs and to prioritize

interventions and prevention services. For example, one TEC combines these surveys and other data to generate reports on the health disparities of urban Indians and distributes nationally to all UIOs to identify health priorities, seek opportunities for new data collection, and support competitive, evidence-driven applications for funding opportunities to address these priorities.

Improving Public Health Reporting for AI/AN Communities

In public health administrative records, AI/AN people are often misidentified as another race, called racial misclassification. Racial misclassification occurs more often in AI/AN records than in records from other racial groups, which makes it hard to accurately measure and describe the health status of AI/AN people. A specific effort by the Urban Indian Health Institute TEC recently drew attention to serious underreporting of AI/AN race in existing statistics in the report entitled, *Missing and Murdered Indigenous Women and Girls*. To further TEC efforts to correct for racial misclassification to improve public health data quality, in 2019, IHS launched a pilot project with one TEC permitting the use of IHS patient data to correct records within numerous existing public health data sets for AI/AN race. This work is currently underway and directly supports the IHS Strategic Plan Goal 3, Objective 3.3, Strategy 8 (*Assure system of data sharing to solidify partnerships with Tribal and urban Epidemiology Centers and other Tribal programs and Urban Indian Organizations*). This increase in information sharing with our TEC partners acknowledges and strengthens the statutory Public Health functions of the TEC program and builds on the expertise developed over the life of the program.

Disease Surveillance and Evaluation

In the expanding environment of Tribally-operated health programs, TECs provide additional public health services, such as disease control and prevention programs, in areas such as sexually transmitted disease control, HIV, and cancer prevention. The expertise of the TEC program in sexually transmitted disease and HIV control will be leveraged in the Elimination of HIV, Hepatitis C, and Sexually Transmitted Diseases Initiative, if funded.

TEC efforts build capacity in the Indian health system by evaluating and monitoring the effectiveness of health and public health programs. This allows TECs to assess access, use, and/or assess quality of care, and to develop recommendations for the targeting of services needed by the populations served. They manage public health information systems, investigate diseases of concern, manage disease prevention and control programs, communicate vital health information and resources, respond to public health emergencies, and coordinate these activities with other public health authorities.

Collaboration

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

TECs support national public health goals by working to improve data for the Government Performance and Results Act, agency performance reports, and monitoring of the Healthy People 2020 objectives at the Tribal level. Health status reports across all TECs will lead to a more comprehensive picture of Indian health. In the long term, these activities create opportunities for IHS to improve the delivery of services by calling attention to health disparities or concerns experienced by the population the Agency serves.

FUNDING HISTORY

Fiscal Year	Amount*
2017	*$4,433,361*
2018	*$4,433,361*
2019	*$4,433,361*
2020 Enacted	*$5,433,361*
2021 President's Budget	*$5,433,361*

*Funded under the H&HC budget.

BUDGET REQUEST

The FY 2021 budget submission for the TECs under Hospitals and Health Clinics is $5.4 million and is the same as the FY 2020 Enacted level.

Current funding, an average of $338,675 per TEC, covers the salaries of a Director, one full-time Epidemiologist, administrative assistance/support, and the execution of one or two pressing disparity projects or tribal priorities.

Tribal Epidemiology Centers and Locations		
1	Alaska Native Tribal Health Consortium	Anchorage, AK
2	Albuquerque Area Indian Health Board	Albuquerque, NM
3	Great Lakes Inter-Tribal Council	Lac du Flambeau, WI
4	Inter-Tribal Council of Arizona	Phoenix, AZ
5	Rocky Mountain Tribal Leaders Council	Billings, MT
6	Navajo Nation Division of Health	Window Rock, AZ
7	Great Plains Tribal Chairmen's Health Board Northern Plains – Great Plains Area	Rapid City, SD
8	Northwest Portland Area Indian Health Board	Portland, OR
9	Southern Plains Tribal Health Board Foundation	Oklahoma City, OK
10	Seattle Indian Health Board	Seattle, WA
11	United South and Eastern Tribes, Inc.	Nashville, TN
12	California Rural Indian Health Board	Sacramento, CA

OUTPUTS / OUTCOMES

Measure	**Year and Most Recent Result / Target for Recent Result / (Summary of Result)**	**FY 2020 Target**	**FY 2021 Target**	**FY 2021 Target +/-FY 2020 Target**
EPI-4 Number of requests for technical assistance including data requests for T/U organization, communities, or AI/AN individuals responded to. (Output)	FY 2018: 3,210 Target: 850[2] (Target Exceeded)	1,897	1,897	Maintain

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

EPI-5 Number of TEC-sponsored trainings and technical assistance provided to build tribal public health capacity. (Output)	FY 2018: 216 Target: 89 (Target Exceeded)	89	89	Maintain

DISCUSSION

The TECs provide critical support to the communities they serve. In FY 2018, TECs responded to 3,210 requests for technical support (EPI-4) and 216 TEC-sponsored trainings for tribal public health capacity building. Funding dedicated to increasing the TECs' direct support to Tribes to translate emerging public health strategies, resources, and information indirectly reduces the burden on the overall health system by supporting prevention.

Completed trainings and technical support to Tribes and Tribal organizations show the sustained efforts of the TECs to engage, train, and collaborate with the Tribes in their service area. These efforts are responsive to Tribal priorities as they are driven by Tribal requests and invitations, not dictated by the Division of Epidemiology and Disease Prevention.

GRANTS AWARDS

(whole dollars)	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Number of Awards	12	12	12
Average Award	$338,675	$422,000	$422,000
Range of Awards	$265,250 -$412,000	$265,250 -$460,000	$265,250 -$460,000

* 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 2019[1]	FY 2020	FY 2021	
	Final	Enacted	President's Budget	FY 2021 +/- FY 2020
BA	$2,178,088	$2,324,606	$2,432,384	+$107,778
HIT	*$182,149*	*$182,149*	*$182,149*	*+$0*

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

FY 2021 Authorization.....Permanent

Allocation Method .....Direct Federal; PL 93-638 Tribal Contracts/Compacts, Tribal shares

PROGRAM DESCRIPTION

The Indian Health Service (IHS) Health Information Technology (HIT) Portfolio uses secure and reliable information technology (IT) in innovative ways to improve health care delivery and quality, enhance access to care, reduce medical errors, and modernize administrative functions. IHS HIT provides support for the IHS, Tribal, and Urban (I/T/U) programs that care for 2.6 million American Indian and Alaska Native (AI/AN) people across the Indian health system. IHS provides the technology infrastructure for a nationwide health care system, including a secure wide area network, enterprise e-mail services, and regional and national Help Desk support for approximately 20,000 network users. IHS HIT also supports the mission-critical health care operations of the I/T/U with comprehensive health information solutions including an Electronic Health Record (EHR) and more than eighty applications. IHS' EHR received 2014 certification for meeting requirements set by the Centers for Medicare and Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC), which established standards and other criteria for structured data that EHRs must use. The IHS HIT portfolio directly supports better ways to: 1) care for patients, 2) pay providers, 3) refer care when needed, 4) recover costs, and 5) distribute information, resulting in better care, wiser spending of our health dollars, and healthier communities, economy, and country.

The HIT Portfolio is dedicated to providing the most innovative, effective, cost-efficient, and secure HIT system in the federal government. The HIT portfolio is comprised of two Mission Delivery IT investments: 1) Health Information Technology Systems and Support (HITSS); 2) National Patient Information Reporting System (NPIRS); and eight Standard investments: 1) IT Management; 2) IT Security and Compliance; 3) Data Center and Cloud Standard Investment; 4) Network Standard Investment; 5) Platform Standard Investment; 6) Delivery Standard Investment; 7) End User Standard Investment; and 8) Application Standard Investment.

[1] Reflects Services account adjustments related to formal reprogramming notifications submitted to Congress in FY 2019. Amounts by "Sub IHS Activity" will continue to be adjusted during the period of availability, which conclude on September 30, 2020, for impacted funds.

1) **Health Information Technology Systems and Support (HITSS)** investment provides an enterprise health information system supporting IHS Strategic Goal 2, *"To promote excellence and quality through innovation of the Indian health systems into an optimally performing organization" and* Goal 3, *"To strengthen IHS program management and operations."* The HITSS enterprise information system is the underlying Information Technology (IT) layer of the clinical, practice management and revenue cycle business processes at I/T/U facilities across the country and supports Objective 2.1, *"Creates quality improvement capability at all levels of the organization" and* Objective 2.2, *"Provides care to better meet the health care needs of American Indian and Alaska communities."* The HITSS investment encompasses the RPMS EHR that is certified according to criteria published by the ONC and is in use at approximately 430 health care facilities across the country in support of Objective*, "3.1 Improve communication within the organization with Tribes, Urban Indian Organizations and other stakeholders, and with the general public,* Objective, *"3.2 Secures and effectively manages the assets and resources",* and Objective, "*3.3 Modernizes information technology and the information systems to support data driven decisions."* In pursuit of expanding capabilities, the HITSS investment supports IHS Strategic Goal 1, *"To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people."* RPMS Network planning efforts continue in preparation for the implementation and deployment of new features such as health information sharing and patient engagement to support quality initiatives and the Medicare Access & Children's Health Insurance Program Reauthorization Act (MACRA) of 2015 in support of Objective 1.3, *"Increase access to quality health care services."*

2) **National Patient Information Reporting System (NPIRS)** investment supports IHS Strategic Goal 3, *"To strengthen IHS program management and operations"* as an enterprise-wide data warehouse and business intelligence environment that produces reports required by statute and regulation and provides a broad range of clinical and administrative information, and associated analytical tools, to managers at all levels of the Indian Health system. This investment is evolving to mature the analytic platform, adding additional data domains, defining a data governance framework, adopting industry standards and best practices to exploit Business Intelligence capabilities, and is enabling IHS to produce and make more informed, quality decisions against agency-level measurement, performance and enterprise data. The NPIRS enterprise business intelligence environment leverages technology and industry best practices for enterprise information and data management to promote data accuracy and availability in support of Objective 3.3, *"modernize information technology and information systems to support data driven decisions."*

3) **IT Operations Investments** support IHS Strategic Goal 3, *"To strengthen IHS program management and operations"* by providing the technical infrastructure for federal, and limited tribal, healthcare facilities that is the foundation upon which all health IT services are delivered. The IT Operations program consists of six IT investments: Data Center and Cloud Standard Investment, Network Standard Investment, Platform Standard Investment, Delivery Standard Investment, End User Standard Investment, and Application Standard Investment. These investments enhance and maintain critical IT infrastructure required for HIT modernization and support Objective 3.3, *"modernize information technology and information systems to support data driven decisions."* The IT Operations program includes a highly available and secure wide area network that includes locations with unique telecommunication challenges, a national e-mail and collaboration capability that is designed specifically to support health care communication and data sharing, enterprise application services and supporting hardware including servers and end-user devices in

support of Objective 3.1, *"improve communication within the organization with Tribes, Urban Indian Organizations, and other stakeholders, and with the general public."* This program incorporates government and industry standards for the collection, processing, storage, and transmission of information and is poised to respond to new and pioneering opportunities by adopting the IT Infrastructure Library (ITIL) IT Service Management (ITSM) framework to optimize the delivery of IT services in support of Objective 3.2, *"secure and effectively manage assets and resources."*

4) **IT Security and Compliance** investment supports IHS Strategic Goal 3, *"To strengthen IHS program management and operations"* as an enterprise-wide IT Security Program that creates information security policy, secures centralized resources, and provides cybersecurity training for employees and contractors. The IT Security Program supports Objective 3.2, "*secures and effectively manages the assets and resources"* and Objective 3.3, *"Modernizing information technology and information systems to support data driven decisions."*

5) **IT Management** investment supports IHS Strategic Goal 3, *"To Strengthen IHS program management and operations,* Objective 3.3, *"Modernize information technology and information systems to support data driven decisions."* This investment is an enterprise-wide IT Governance program that provides IT Management, Capital Planning Investment Control, Strategic Planning, Enterprise Architecture, IT Finance, and IT Vendor Management activities for all IHS IT investments. These essential activities promote compliance with federal laws and regulations to improve efficiency and effectiveness of all IHS HIT portfolio investments.

PROGRAM ACCOMPLISHMENTS

The IHS Division of Information Technology successfully provided a secure and effective suite of technology solutions to support the agency and its mission throughout the country. Collaboration with tribal health programs and other federal agencies is key to the success of the HIT Portfolio. IHS works closely with the ONC, CMS, Agency for Healthcare Research and Quality, VA, and other federal entities on IT initiatives to ensure that the direction of its HIT systems are consistent with other federal agencies. In addition, IHS has routinely shared HIT artifacts (e.g., design and requirement documents, clinical quality logic, etc.) with both public and private organizations.

The Health Information Technology Systems and Support (HITSS) program modernized the way provider credentialing and privileging is carried out across the Agency to facilitate the hiring of qualified providers and ensuring patient safety. IHS acquired and is now utilizing a centralized electronic credentialing database across all federally operated facilities. The program provided 148 HIT training courses to 3,280 I/T/U users as of April 2019. This included 62 classroom/satellite sessions with 1,025 participants and 86 eLearning/eLearning hands-on sessions with 2,255 participants. Added 167 training recordings in fiscal year (FY) 2018 for a total of 293 recordings since the FY 2015 recording repository inception. The OIT Training Recording Repository has more than 1,200 registered users. As of April 2019, completed the development and release of more than 54 software updates, including 5 versions, 40 patches, and 9 terminology content releases to date. Completed testing and progressing with development to implement the upgraded Intersystems HealthShare platform, replacing the previous Ensemble version with an expected completion early FY 2020. Completed and implemented v1.0 of the Electronic Clinical Quality Measures Engine supporting the import of Quality Reporting Document Architecture (QRDA) Category I (CAT-I) files generated by the eCQM Export Tool

(RPMS namespace BQRE); calculation of Eligible Provider (EP) and aggregate Eligible Hospital (EH) clinical quality measures and generating measure reports; generation of Quality Reporting Document Architecture (QRDA) Category III (CAT-III) files for CMS and/or Registry reporting; the ability to import the QRDA CAT-I in either JSON or XML format; and the automated pull of the QRDA CAT-I files from and automated push of the QRDA CAT-III files to the eCQM Export Tool (RPMS namespace BQRE). The program completed the development and certification of 2018 Clinical Quality Measures, including 6 new measures specific to diabetes care.

The National Patient Information Reporting System (NPIRS) continued to facilitate the improved Uniform Data System (UDS) reporting capabilities for the Urban Indian Health Program. UDS reporting is required performance reporting for HRSA-funded health centers. The program also created and enhanced the Data Warehouse Export System (BDW) extract – extensive analysis to improve data extraction for business intelligence (BI). This included efforts to mature the Business Intelligence Enterprise reporting environment and developed a Center of Excellence (COE) framework to support BI delivery standards and reuse across the agency. The program also Developed Clinical Efficiency and Effectiveness Indicators for the Division of Oral Health. GIS mapping was integrated with community based poverty levels for Division of Program Statistics (DPS) into an enterprise geoanalytics solution to standard geospatial reporting.

IT Operations implemented the ServiceNow Knowledge Management (KM) application to enable the sharing of information in knowledge bases related to Information Technology. These knowledge bases will contain articles that provide users with information such as self-help, troubleshooting, and task resolution. This capability will improve continuity processes and knowledge sharing of critical employee, administrative, and operational functions through written communications and documentation within the IHS. Migrated all 1,300+ VPN users across the IHS enterprise from the use of Citrix to the more robust and flexible RDS solution. Designed and implemented enterprise solution to support successful deployment of IHS's primary EHR on Windows 10. Implemented virtual server snapshot automation: Implemented automation to manage user self-requested snapshots by either deleting or reverting the snapshot after 14 days depending on user selection. Replaced Iron Mountain offsite services and tape backup system with a modern Dell EMC RecoverPoint solution to improve disaster recovery operations.

- Maintained a 99.97 percent domain controller uptime service level
- Greater than 99.9 percent network availability
- Closed over 25,000 service tickets

IT Operations completed the acquisition to start migrating all IHS email to the Office365 Cloud. Upgraded the IHS Tribal Wide Area Network (WAN) network circuits to improve network communications between IHS datacenters and Tribal facilities. This upgrade doubled the network capacity in IHS data centers supporting Tribal partners. IHS completed 15 network upgrades and IHS facilities to modernize network infrastructure and meet a critical need for more bandwidth. An additional 35 site upgrades are planned for FY19. IT Operations replaced end-of-life network equipment at all HQ managed facilities and implemented firewalls between IHS and each tribal facility connected to the IHS Tribal Wide Area Network.

IT Security and Compliance maintained a 98.79 percent compliance rate on distributing virus definitions to all IHS managed computers. Maintained Enterprise Patch Management services by deploying critical Windows security patches to systems that remain unpatched the 1st Tuesday of the following month that the patch is released. Sustained Continuous Diagnostics and Mitigation tools to fortify the cybersecurity of computer networks and systems and provide a standard toolset across IHS and Government giving insight to network security and the IHS and Federal level.

This aids IHS in identifying vulnerabilities rapidly, provides a common operational picture of network health/ integrity, allows comparison of cross-agency performance using common objective data and reduces total costs for purchasing cybersecurity tools/ services through commodity of scale. Continuous Diagnostics and Mitigation - Projects are underway to fortify the cybersecurity of computer networks and systems by providing a standard toolset across IHS that provides insight into network security. This aids IHS in identifying vulnerabilities rapidly, provides a common operational picture of network health/ integrity, allows comparison of cross-agency performance using common objective data and reduces total costs for purchasing cybersecurity tools/ services through commodity of scale. IHS is currently deploying and utilizing several CDM tools provided by DHS in order to gain visibility into federal assets and monitor vulnerabilities. We are also receiving up to date intel regarding security threats from DHS, HHS, CISA and other sources. IHS requires additional staffing resources to fully utilize the CDM toolsets. Enterprise Patch Management - IHS Patch Management policy was incorporated into the Configuration Management (CM) policy in the Indian Health Manual.

IHS submitted a new Cybersecurity Part 10 for the Indian Health Manual (IHM) that consists of 19 chapters relating to specific cybersecurity activities. The implementation of these new policies will ensure information security activities are defined and executed consistently across the IHS enterprise to protect both information and systems.

IT Management implemented the Planview System that provides an enterprise IT portfolio and project management capability and enables IHS to improve project performance oversight, and monitor corrective actions through to completion. Office of Information Technology (OIT) staff presented current HIT initiatives at various tribal or tribal health board conferences and meetings such as TribalNet; National Tribal Health Conference, Tribal Technical Advisory Group, National Indian Health Board (NIHB), NIHB Medicare, Medicaid, and Health Reform Policy Committee; IHS Tribal Self Governance Advisory Committee; and the Direct Service Tribes Advisory Committee quarterly meetings, etc. OIT staff regularly participated in Tribal Delegation Meetings at IHS Headquarters and attended the Alaska Area Pre-negotiation/Negotiation meetings to address IT/HIT issues. The program collaborated and supported five Self-Governance Compacts/Contracts with Oglala Sioux, Cheyenne River Sioux, Rosebud Sioux, Iowa Tribe of Kansas and Nebraska, and the Sac and Fox of Missouri to assist these tribes in transitioning ownership of their health IT systems from federally operated to tribally operated systems. IT Operations provided Rural Health Care (RHC) Program support to over 150 Tribal locations FY 2019. IHS enrolled 10 new Tribal sites into the IHS Consortium. Developed and implemented Phase 2 of the New Medicare Card initiative facilitating the documentation and reporting in RPMS of newly issued Medicare Beneficiary ID numbers.

Over 400,000 messages were exchanged between patients, providers, administrators, message agents and received from external HISPs through approximately 29,590 unique direct e-mail addresses since Sept 2015. The IHS Personal Health Record (PHR) has approximately 26,000 total users. 62 percent of these registered PHR users were verified/linked to their IHS Medical Record. The remaining 38 percent are registered but not yet verified/linked. The Master Patient Index/Health Information Exchange completed onboarding 171 of the 174 requesting sites. Additional sites continue to be on boarded as agreements are established.

Immediate Priorities and Challenges

The IHS HIT Portfolio continues to face increased demand for systems improvements and enhancements, rising costs, and increased IT security requirements driven in part by medical advances, and ever-growing and more complex requirements for health information technology

capabilities. These requirements come from government and industry initiatives, program needs of health programs, and operational requests of I/T/U health care facilities. Each new program initiative has information technology requirements for functionality, modality, data collection, and reporting which then must be added to a clinician's work flow and managed within the HIT portfolio.

The largest priority and challenge involves the IHS RPMS system and its dependency on the VA for software development. RPMS is impacted by the VA's announcement to adopt the Military Health System "Genesis" solution to replace its current legacy Health IT platform, VistA. This move will impact IHS as the RPMS system is dependent on the VA's VistA system through shared software development. The IHS adopts software developed by the VA and adapts it for use in RPMS. Thus, the VA's decision means that a significant supplier of software source code that modernizes and supports RPMS will decline over time. The IHS previously adopted the VA software with minimal funding expenditure in support of a similar but different agency mission. The loss of the VA as a source of software code will raise the cost of continuing to use the RPMS system, and/or require IHS to procure commercial-off-the-shelf replacements for RPMS.

CyberSecurity challenges include minimizing unsecured systems and data to reduce the possibility of identity theft, risk to patient health data, system breaches and loss of business continuity in the event of a disaster. System breach or intrusion into an unsecure network puts patient data at risk, impacts the IHS mission by delaying or halting patient care and harms IHS patients which may lead to a lack of trust in patient services.

Human resource shortages and slow staff backfill contributes to challenges in keeping up with evolving technology and new Federal, Department and Agency projects/initiatives including FITARA Implementation.

FUNDING HISTORY/REQUEST

Fiscal Year	Amount[2]
2017	$182,149,000
2018	$182,149,000
2019	$182,149,000
2020 Enacted	$182,149,000
2021 President's Budget	$182,149,000

TRIBAL SHARES

H&HC (IT is funded out of H&HC) funds are subject to tribal shares and are transferred to Tribes when they assume the responsibility for carrying out the associated programs, functions, services, and activities. A portion of the overall H&HC budget line is reserved for inherently federal functions and is therefore retained by the IHS to perform the basic operational services of the Agency.

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

BUDGET REQUEST

The FY 2021 budget submission for Health Information Technology of $182.1 million is the same as the FY 2020 Enacted level.

This funding will continue progress made in past years by minimizing infrastructure costs and maintaining a high level of productivity and commitment by both federal and contractor staff supporting the IHS-developed health information solutions. IHS uses open source tools where possible to minimize acquisition costs and is reducing use of more costly assisted acquisition providers such as the General Services Administration. However, following the announcement by the VA, the IHS is considering the sustainability of the entire RPMS HIT platform. Efforts are underway to examine alternatives to replace or modify RPMS as the IHS HIT platform. The IHS must conduct thorough analysis activities that result in informed decision making regarding any replacement option. Any change in EHR platforms will impact the quality of direct patient care, increase cost recovery and promote continuous health improvements such as, expanded telehealth care services and predictive population health analytics. These potential returns highlight the value of health IT and its impact on the agency mission.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2020 Target	FY 2021 Target	FY 2021 Target +/-FY 2020 Target
HIT-1 OMB IT Dashboard - All IHS Major Investments will Maintain a score of 4/5 or greater (Outcome)	FY 2019: 3.0 Target: 4.0[3] (Target Not Met)	4.0	4.0	Maintain
HIT-2 HHS CIO Workplan - The IHS will score 90% or greater on the annual scoring of the HHS CIO Workplan (Outcome)	FY 2019: 97 % Target: 90% (Target Met)	90%	90%	Maintain

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

[3] >=out of 5 for all investments.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
ELECTRONIC HEALTH RECORD SYSTEM

(Dollars in Thousands)

	FY 2019[1]	FY 2020	FY 2021	
	Final	Enacted	President's Budget	FY 2021 +/- FY 2020
BA	$0	$8,000	$125,000	+$117,000
FTE*	0	0	6	+6

* 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 2021 Authorization.....Permanent

Allocation Method .....Direct Federal; PL 93-638 Tribal Contracts/Compacts, Tribal shares

PROGRAM DESCRIPTION

Electronic Health Record System Modernization - The Indian Health Service (IHS) Health Information Technology (HIT) Portfolio uses a secure, certified Electronic Health Record (EHR) system in innovative ways to improve health care delivery and quality, enhance access to care, reduce medical errors, and modernize administrative functions. The IHS modernization plan must address many systems that include Dentrix for Dental services, Health Information Exchange connections, Picture Archiving and Communication System (PACS) for radiology, data analysis and healthcare analytics, population health reporting, laboratory equipment, biomedical equipment, and numerous interfaces to enable coordination of care and efficient workflows for providers. The IHS HIT infrastructure and is used to provide critical support for the Indian Health Service/Tribal/Urban (I/T/U) health care system that cares for 2.6 million American Indian and Alaska Native (AI/AN) people.

In September 2018, HHS awarded a contract to Emerging Sun, LLC for an IHS HIT Modernization Research Project. The Department of Health and Human Services (HHS) HIT Modernization Project provides a comprehensive assessment of the people, process, and technology that comprise the existing IHS HIT system, including the Resource and Patient Management System (RPMS). The project delivered a detailed Analysis of Alternatives[2] and Roadmap for HIT Modernization to support this funding request in late September of 2019.

IT Infrastructure and Operations Modernization - Significant improvements are required for the current IT infrastructure in order to support the deployment of a new or modernized EHR solution. IHS must enhance cybersecurity, improve IT service management, expand storage and computing capacity, and increase network bandwidth at dozens of rural locations to enable a successful EHR transformation. IT operations throughout IHS will need to be managed and

[1] Reflects Services account adjustments related to formal reprogramming notifications submitted to Congress in FY 2019. Amounts by "Sub IHS Activity" will continue to be adjusted during the period of availability, which conclude on September 30, 2020, for impacted funds.

[2] The Analysis of Alternatives (AoA) for the modernization project will be made public later in FY 2020.

coordinated more effectively to successfully execute a complex modernization project. The final report can be found at https://www.hhs.gov/sites/default/files/ihs-hit-final-report-C-102019.pdf

The Electronic Health Record System investment is the primary mechanism IHS will utilize to modernize HIT in support of IHS Goal 3, Objective 3.3, *"Modernize information technology and information systems to support data driven decisions"* to evaluate electronic health record requirements and create a modernized system to support quality care. This investment also supports HHS Goal 5, Objective 5.3, *"Optimize information technology investments to improve process efficiency and enable innovation to advance program mission goals"* through innovation and modernization of the core applications that support the IHS and HHS missions to improve health outcomes.

FUNDING HISTORY

Fiscal Year	Amount
2017	$0
2018	$0
2019	$0
2020 Enacted	$8,000,000
2021 President's Budget	$125,000,000

BUDGET REQUEST

The FY 2021 budget submission for the EHR of $125.0 million is $117.0 million above the FY 2020 Enacted level. These funds will be used at the discretion of the IHS Director, and available until expended. This funding will lay the groundwork to improve the quality of care, reduce the cost of care, promote interoperability, simplify IT service management, increase the security of patient data, enhance cybersecurity, and update infrastructure across rural locations to enable a successful Electronic Health Record transition. This will include the continuation of project management operations, acquisition planning, EHR selection, additional tribal consultation, initial infrastructure build, site implementation planning, and continued RPMS stabilization and support. The project will follow industry standards for modernization or replacement of Electronic Health Record systems to leverage expertise and experience in the private sector. This effort directly supports IHS's entire Strategic Goals structure.

- Health Information Technology Modernization - This project holds an extremely high degree of mission criticality given the ability to provide much-anticipated clinical and administrative capabilities used in modern systems for the delivery of timely and impactful healthcare. Expected benefits from adopting and implementing a modernized system include but are not limited to improved patient safety, improved patient outcomes, better disease management, enhanced population health, improved clinical quality measures, opioid tracking, patient data exchange, third party revenue generation, agency performance reporting, etc. By identifying and properly selecting the best match for proposed system capabilities, the system will support the mission of the IHS. Additionally, the IHS aims to obtain interoperability with the Department of Veterans Affairs, Department of Defense, tribal and urban programs, academic affiliates, and community partners, many of whom are on different IT platforms. The IHS must consider an integrated EHR system that will allow for a meaningful integration to create a system that serves I/T/U beneficiaries in the best possible way.

  During the estimated 10-year implementation, IHS expects to temporarily increase the HIT workforce to acquire and implement this system.

- IHS Legacy EHR System Modernization - The current IHS EHR, Resource and Patient Management System (RPMS), has been identified by the Government Accountability Office as one of HHS's top three systems in most need of modernization due to lack of development and enhancement work over the past decade. IHS must maintain the existing EHR system until implementation of the new system is complete.

- IT Infrastructure and Operations Modernization - These IT Infrastructure Modernization initiatives are required to provide the platform for which the EHR operates and support redundancy capacity.

IHS Strategic Goal 1, Objective 1.2, *"Build, strengthen, and sustain collaborative relationships."* IHS will build a mature governance body to ensure the enterprise HIT investment is properly maintained and configured nationwide.

IHS Strategic Goal 2, Objective 2.1 *"Create quality improvement capability at all levels of the organization"*, and Objective 2.2, *"Provide care to better meet the health care needs of American Indian and Alaska Native communities."*

The Dentrix software will be upgraded nationwide to coordinate care in a national enterprise HIT environment. Additionally, funding will allow for improved recruitment and retention of providers and reduced industry risk by adopting standards and systems used by a broader base of healthcare systems

IHS Strategic Goal 3, Objective 3.3, *"Modernize information technology and information systems to support data driven decisions."*

Funding will allow for improved revenue from third party payers, improved training through standardized user interfaces and integration across health facilities, reduced workload to support the infrastructure, and improved quality and operational oversight through improved national reporting and data analytics.

OUTPUTS/OUTCOMES

As IHS reviews options, costs, and potential benefits; output and outcome measures will be developed.

GRANT AWARDS

Not applicable to this funding.

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

(Dollars in Thousands)

	FY 2019[1]	FY 2020	FY 2021	
	Final	Enacted	President's Budget	FY 2021 +/- FY 2020
BA	$197,949	$210,590	$219,380	+$8,790
FTE*	579	579	579	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 2021 Authorization.....Permanent

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

PROGRAM DESCRIPTION

The purpose of the Indian Health Service (IHS) Dental Health Program (DHP) is to raise the oral health status of the American Indian/Alaska Native (AI/AN) population to the highest possible level through the provision of quality preventive and treatment services, at both community and clinic sites. The DHP is a service-oriented program providing basic dental services (e.g., diagnostic, emergency, preventive, and basic restorative care), which represents approximately 90 percent of the dental services provided. In FY 2018, the dental program provided a total of 3,855,924 basic dental services. More complex rehabilitative care (e.g., root canals, crowns and bridges, dentures, and surgical extractions) is provided where resources allow and account for the additional 278,131 dental services provided in FY 2018. The DHP provided these services through 1,386,821 dental visits in FY 2018, in 404 dental programs in 37 states.

Across all age groups, AI/ANs suffer disproportionately from dental disease. When compared to other racial or ethnic groups, AI/AN children 2-5 years old have more than double the number of decayed teeth and overall dental caries experience as the next highest ethnic group, U.S. Hispanics, and more than four times that of U.S. white children.[2] In the 6-9 year-old age group, 8 out of 10 AI/AN children have a history of dental caries compared with only 45 percent of the general U.S. population, and almost half of AI/AN children have untreated tooth decay compared to just 17 percent of the general U.S. population in this age group.[3] In the 13-15 year-old age

[1] Reflects Services account adjustments related to formal reprogramming notifications submitted to Congress in FY 2019. Amounts by "Sub IHS Activity" will continue to be adjusted during the period of availability, which conclude on September 30, 2020, for impacted funds.

[2] Phipps KR, Ricks TL, Mork NP, and Lozon TL. The oral health of American Indian and Alaska Native children aged 1-5 years: results of the 2018-19 IHS oral health survey. Indian Health Service data brief. Rockville, MD: U.S. Department of Health and Human Services. Indian Health Service, 2019.

[3] Phipps KR and Ricks TL. The Oral Health of American Indian and Alaska Native children aged 6-9 years: results of the 2016-2017 IHS oral health survey. Indian Health Service data brief. Rockville, MD: U.S. Department of Health and Human Services. Indian Health Service 2017.

group, eight out of ten AI/AN dental clinic patients have a history of tooth decay, compared to just 44 percent in the general U.S. population, and almost five times as many 13-15 year-old AI/AN youth have untreated decay compared to the general U.S. population.[4] In adults, the disparity in disease is equally as pronounced. 64 percent of AI/AN adults 35-49 years have untreated decay compared to just 27 percent of the general U.S. population, and across all other age groups studied (50-64 years, 65-74 years, and 75 and older), AI/AN adults have more than double the prevalence of untreated tooth decay as the general U.S. population. In addition, the rate of severe periodontal disease in AI/AN adults is almost double that of the general U.S. population.[5]

Prevention activities improve health and reduce the amount and cost of subsequent dental care. The DHP measures performance in part through the delivery of preventive services. The DHP maintains data and tracks three key program objectives:

1. Increase the proportion of 2-15 year-olds with dental sealants;
2. Increase the proportion of 1-15 year-olds receiving at least one application of topical fluorides; and
3. Increase access to care across all age groups.

The DHP funds provide critical support for direct health care services focused upon strengthening the collaborative partnerships among direct care providers, patients, communities, and internal and external stakeholders. Funds are utilized to ensure IHS, Tribal, and urban Indian health organizations have comprehensive, culturally appropriate services and personnel available and accessible, promotes excellence and quality through implemented quality improvement strategies, and strengthens the IHS program management and operations to address health disparities and raise the health status of AI/AN populations to the highest level possible

The DHP provides critical services in support of the IHS Strategic Plan FY 2019-2023 (IHS SP) and the HHS Strategic Plan FY 2018-2022 (HHS SP). Dental services are important in ensuring comprehensive, culturally appropriate personal and public health services are available to AI/AN people (IHS SP Goal 1). DHP implements several efforts to improve quality (IHS SP Goal 2) of dental health services and in strengthening management and operations (IHS SP Goal 3). Central to DHP efforts is support of cross-collaboration and partnerships among I/T/U stakeholders (IHS SP Objective 1.2). The DHP provides essential services to increase dental health access and education which supports the HHS SP Goal 1: Reform, strengthen, and modernize the nation's healthcare system, and Goal 5: Promote effective and efficient management and stewardship. The program accomplishments section below provides details about DHP efforts.

PROGRAM ACCOMPLISHMENTS

Early Childhood Caries Collaborative

The IHS Early Childhood Caries (ECC) Collaborative was a nationwide initiative that was conducted from 2009 to 2017 and focused on preventing tooth decay in AI/AN children under the age of 71 months. Dental caries are the most common health problem in children, almost eight times more common than childhood asthma, and have significant consequences such as delayed speech development, more missed school days when children begin school, poor self-esteem, and

[4] Phipps KR, Ricks TL, Blahut P. The Oral Health of 13-15 year old American Indian and Alaska Native children compared to the general U.S. population and Healthy People 2020 targets. Indian Health Service data brief. Rockville, MD: Indian Health Service 2014.

[5] Phipps KR and Ricks TL. The Oral Health of American Indian and Alaska Native adult dental patients; results of the 2015 IHS oral health survey. Indian Health Service data brief. Rockville, MD: Indian Health Service 2016.

a greater chance of tooth decay in permanent teeth.[6] As previously described, AI/AN children suffer disproportionately from this disease, with more than double the number of decayed teeth as the next highest minority population, U.S. Hispanics, and more than 3 times the number of decayed teeth as U.S. White children.[7] The ECC Collaborative began with the goal of reducing dental caries in the AI/AN population through a coordinated, nationwide collaborative utilizing not only dental programs but also medical and community partners such as medical providers, public health nurses, community health representatives, pharmacists, and Head Start teachers. (*Supports IHS SP 1.2 and HHS SP Objective1.2: Expand safe, high quality healthcare options, and encourage innovation and competition*.) By the end of this collaborative, the IHS had increased access to dental care for AI/AN children under 71 months by 7.9 percent and significantly increased prevention and early intervention efforts (sealants increased by 65.0 percent, the number of children receiving fluoride varnish increased by 68.2 percent, and the number of therapeutic fillings increased by 161 percent). (*Supports IHS SP Objective 1.3: Increase access to quality health care services; and HHS SP Objective 1.3: Improve Americans' access to healthcare and expand choices of care and service options.*) This resulted in a 5 percent reduction in caries (tooth decay) experience from 2010 to 2019, and a 14 percent reduction in untreated decay in 1-5 year-olds (with statistical significance) at a national level; in addition, the Navajo, Oklahoma City, and Phoenix Areas had statistically significant reductions in caries experience from 2010 to 2019. (*Supports the IHS SP Goal 2: To promote excellence and quality through innovation of the Indian health system into an optimally performing organization, IHS Objective 2.2: Provide care to better meet the health care needs of American Indian and Alaska Native communities; and HHS SP Objective1.2.)* This represents the first recorded decrease in tooth decay in young children in the IHS and is evidence of success of the Early Childhood Caries Collaborative. Furthermore, this success has impacted older children: the 2016-17 survey of 6-9 year-old children showed that caries experience decreased from 92 percent to 87 percent in this age group from 1999 to 2016-17, while untreated caries decreased from 73 percent to 47 percent over the same time period. These data represent the first recorded decrease in tooth decay in this age group as well and reflects positively on the ECC Collaborative and the ongoing prevention efforts of the DHP focusing on schoolchildren.

Dental Clinical and Preventive Support Centers

In recent years, the DHP has utilized field dental programs in conjunction with its Dental Clinical and Preventive Support Centers (DSC) to achieve national performance objectives, support IHS Area initiatives, and support the IHS Strategic Plan for FY 2019-2023. (*Supports IHS SP Objective 1.2 and HHS SP Objective1.2*.) The DSCs were designed and implemented in FY 2000 to augment the dental public health infrastructure necessary to best meet the oral health needs of AI/AN communities. The current five-year cycle ends September 14, 2020. A total of eight DSCs serve 10 of the 12 IHS Geographic Areas; three are funded by program awards and five are funded through grants. Expansion of the DSCs, utilizing best practices learned from programs of the existing DCSs would assist in controlling oral disease and oral health disparities experienced in susceptible or high-risk populations. The primary purpose of a DSC is to provide technical support, training, and assistance in clinical and preventive aspects of dental programs providing care to AI/AN communities. As a direct result of the advocacy efforts of the DSCs, the number of key preventive procedures has increased significantly in recent years. For example, the number of dental sealants placed per year has tripled in the last decade, and the number of patients receiving topical fluoride treatments has more than doubled in the last five years. In FY 2013, the DHP began tracking the coverage or prevalence of children and adolescents receiving sealants and topical fluoride, rather than simply counting procedures. These

assessments allow improved comparisons with data from the U.S. population compiled by the Healthy People 2020 initiative.

DSCs were initially funded in FY 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 Government Performance and Results Act (GPRA) performance objectives to increase specific clinical services.
- All centers provided continuing education opportunities to enhance the quality of care delivered.
- Several centers provided on-site clinical and community based program reviews to enhance the quality of care, assuring that field programs maintained a high level of expertise with respect to challenges such as infection control, preparing for accreditation and certification reviews, and patient scheduling practices aimed at maximizing access to care.
- Several centers provided an array of health education materials or designed materials customized to the specific needs of the IHS Areas they serve. These materials have increased the quality of IHS oral health education efforts throughout Indian Country.
- Several centers provided or arranged for direct clinical services that otherwise would not have been provided.
- The aggregate accomplishments of the DSCs have resulted in an increase in clinical preventive care, an increase in overall clinical services, and an enhancement of the quality of clinical and community based care delivered by the dental field programs.

Dental Health Data

Access to dental services is a prerequisite to the control of oral disease in susceptible or high-risk populations. The access to care GPRA objective is currently aligned with Healthy People 2020 methodology as a percentage of patients who have visited the dentist within the previous 12 months. (*GPRA measure data supports the IHS SP Objective 1.3 and HHS SP Objective1.3.*) The access to care goal in FY 2019, was 27.2 percent and the DHP achieved 30 percent, meeting the goal for the first time in two years and increasing from FY 2017 when the final result was 28.24 percent. The dentist to population ratio in the IHS system continues to be very low when compared to the ratio in the U.S. private sector. This low dentist to population ratio and an increase in population growth in the AI/AN population will continue to present a challenge in achieving the access rate goal. The IHS has 1,023 dentists (including part-time) in the system, according to the IHS Dental Directory.[8] In 2017, there were 2,895,571 AI/AN in the U.S., according to the most recent user population estimate.[9] That means that the IHS system has approximately 1 dentist per 2,830 patients served. According to the U.S. Bureau of Labor Statistics, there were an estimated 153,500 dentists in the U.S. in 2016[10] serving a population of 325,719,178,[11] meaning that there is approximately 1 dentist per 2,122 people served.

Topical fluorides and dental sealants have been extensively researched and documented in the dental literature as safe and effective preventive interventions to reduce tooth decay. In FY 2013, the tracking of dental sealants and the tracking of patients receiving topical fluoride measures changed from simple counts of procedures or patients to the percentage of children receiving

[8] Indian Health Service, Department of Health and Human Services. IHS Dental Directory Report. www.ihs.gov/doh, accessed 13 January 2018.
[9] Indian Health Service, Department of Health and Human Services. User Population Estimates – FY 2017 Final, Revised 12/27/17.
[10] Bureau of Labor Statistics, U.S. Department of Labor. Occupational Outlook Handbook: Dentists. https://www.bls.gov/ooh/healthcare/dentists.htm, accessed 13 January 2018.
[11] U.S. Census Bureau. Population Estimates, July 1, 2017. https://www.census.gov/quickfacts/fact/table/US/PST045217, accessed 13 January 2018.

either sealants or topical fluorides. New annual targets were set for these two objectives as of July 1, 2013. In FY 2019, 32.10 percent of 1-15 year-old children received topical fluoride, an increase from 16.3 percent when this measure was first tracked in FY 2015, and surpassing the annual goal of 30.0 percent. In FY 2019, 15.9 percent of 2-15 year-old children received sealants, a slight decrease from 16.04 percent in FY 2018, barely missing the national goal of 16 percent.

The DHP continues to assess the care provided by its programs through a robust, continuing oral health surveillance program that started in 2010 and is planned through 2025. (*Supports the IHS SP Goal 3: To Strengthen IHS program management and operations through Objective 3.3: Modernize information technology and information systems to support data driven decision. It also supports the HHS Strategic Plan Goal 4: Foster sound, sustained advances in the sciences through HHS Objective 4.1: Improve surveillance, epidemiology, and laboratory services.)* 0-5 year-old AI/AN children were surveyed in 2010, 2014, and 2018-19; 6-9 year-old children were surveyed in 2011-12 and 2016-17: 13-15 year-old youth were surveyed in 2013 and 2019-20; and AI/AN adults were surveyed in 2015. The surveillance program has been used as a model nationally and helps highlight disparities in disease burden and distribution in the AI/AN population. Results of all surveys can be found in data briefs located on the IHS Dental Portal at www.ihs.gov/doh, and data from this surveillance program is also included in the CDC National Oral Health Surveillance System, allowing public health advocates to compare AI/AN disease prevalence with individual state or national data.

Dental Health Service Delivery Improvements

The DHP has also made significant improvements in the way dental services are delivered. Through the implementation of an electronic dental record (EDR), over 70 percent of IHS and tribal dental programs have been transitioned to an electronic dental record system that will support the delivery of effective quality dental services. The IHS Dentrix Enterprise (DXE) Electronic Dental Record EDR program has been successfully implemented at 244 IHS Federal, Tribal, and Urban dental clinics. The EDR provides accurate data collection and dissemination through the IHS National Data Warehouse. This data supports evaluation of Oral Health Initiatives such as the Early Childhood Caries collaborative and future data development could improve outcome measurements. Further improvements in billing capabilities could increase third party collections. (*Supports IHS SP Goal 3: To Strengthen IHS program management and Operations through Objective 3.3: Modernize information technology and information systems to support data driven decisions. It also supports the HHS Strategic Plan Goal 5: Promote Effective and Efficient Management and Stewardship through Objective 5.3: Optimize information technology investments to improve process efficiency and enable innovation to advance program mission goals.)* A second improvement was the release of 20 new dental clinic efficiency and effectiveness standards by which IHS and tribal dental programs can measure clinical productivity, staffing ratios, and specific clinical efficiency indicators against national averages. A third way the DHP has improved the delivery of care is through the development of new national protocols for the early screening and treatment of periodontal disease in adults. (*The implementation of dental clinical and efficiency standards and the national periodontal health screening protocols support the IHS SP Objective 2.1: Create quality improvement capability at all levels of the organization through strategies that focus on providing training, coaching, and mentoring to ensure quality improvement and accountability of staff at all levels of the organization. These 2 accomplishments also support the HHS SP Objective 1.2: Expand safe, high quality healthcare options, and encouraging innovation and competition.)* A fourth way the DHP has improved the delivery of care is through ongoing support of long-term training (LTT) of general dentist to build the cadre of dental specialists in the IHS and tribal dental programs. (*The DHP LTT program supports the IHS SP Objective 1.1: Recruit, develop, and retain a dedicated, competent, and caring workforce, and HHS SP Objective1.4: Strengthen and expand the*

healthcare workforce to meet America's diverse needs.) Dentists completing DHP- sponsored LTT to become specialist such as pediatric dentists, periodontists, and endodontists have a service payback obligation to serve AI/AN patients. In the past 4 years, an Oral Maxillofacial Surgeon, an endodontist, four pediatric dentists, and periodontist have returned from LTT to serve AI/AN patients. A fifth way the DHP is improving the delivery of services is through the adoption of an integrated care model, specifically in promoting depression screenings by dental health providers through a collaboration with the IHS Behavioral Health Program. (*The collaborative efforts between the DHP and the IHS Behavioral Health Program to improve the delivery of services support the IHS SP Objective 2.1. These 2 accomplishments also support the HHS SP Objective 1.2: Expand safe, high quality healthcare options, and encouraging innovation and competition.)*

The DHP continues to improve the delivery of services is through a sustained (20+ years) continuing dental education (CDE) program. The IHS CDE program provides American Dental Association Commission for Continuing Education Provider Recognition approved quality education with over 250 clinical and public health courses to IHS and tribal dentists, dental hygienists, dental assistants, and dental public health leadership. The total number of CDE courses offered has increased from 149 in FY 2014, to over 250 in FY 2019. Between 2016 and 2019, a total of over 120,000 hours of CDE were awarded, an estimated value of up to $24 million ($200/hour). In addition, through a concentrated effort to train alternative dental workforce models, since 2016 the CDE Program has trained over 350 dental assistants in expanded functions, thereby increasing productivity and efficiency of IHS and tribal clinics. The models of expanded function dental assistants have been shown to increase access to dental care in the DHP by up to 3.0 percent, increase total services delivered by dental programs up to 5.1 percent, and increase the total services per patient visit by up to 14 percent. *(The DHP CDE program supports the IHS SP Objective 2.1 through strategies that focus on providing training, coaching, and mentoring to ensure quality improvement and accountability of staff at all levels of the organization. The DHP continues to evaluate training efforts and staff implementation of improvements, as appropriate. The DHP CDE program also supports the HHS SP Objective 1.2.)*

The DHP continues to be on the forefront of hot issues in public health dentistry. For example, in 2018 the DHP worked in collaboration with the IHS Heroin, Opioids, and Pain Efforts (HOPE) Committee to develop the IHS Dental Pain Management Guidelines in an effort to lessen the impact of dental professionals prescribing habits on the ever-growing opioid epidemic in the U.S. The guidelines are available at the IHS Dental Portal at www.ihs.gov/doh. Another hot issue is the lack of understanding patients have regarding their own oral health, and the DHP has worked to promote oral health literacy through outreach activities and educational materials developed for AI/AN patients. (*The IHS Pain Management Guidelines and promotion of health literacy support the IHS SP Objective 1.3 and HHS SP Objective1.3.*)

FUNDING HISTORY

Fiscal Year	Amount
2017	$182,597,000
2018	$193,283,000
2019	$197,949,000
2020 Enacted	$210,590,000
2021 President's Budget	$219,380,000

TRIBAL SHARES

Dental funds are subject to tribal shares and are transferred to tribes when they assume the responsibility for operating the associated programs, functions, services, and activities. A portion of the overall Dental budget line is reserved for inherently federal functions and is therefore retained by the IHS to perform the basic operational services of the Agency.

BUDGET REQUEST

The FY 2021 budget submission for Dental is $219.4 million, which is $8.8 million above the FY 2020 Enacted level.

FY 2020 Base Funding of $210.6 million will support oral health care services provided by IHS and tribal programs, maintain the program's progress in raising the quality of and access to oral care through continuing recruitment of oral health care professionals to meet workforce needs, and to meet or exceed agency targets.

FY 2021 Funding Increase of $8.8 million includes:

- Current Services: +$1.7 million for current services including:
    - Inflation +$1.7 million - to fund inflationary costs of providing health care services.
- Staffing for New Facilities +$3.8 million – These funds will support staffing and operating costs for new and replacement projects listed below. Funding for new/renovated facilities allows IHS to expand provision of health care in those areas where capacity has been expanded to address health care needs. The following table displays this request.

New Facilities	Amount	FTE/Tribal Positions
Yukon-Kuskokwim Primary Care Center (JV), Bethel, AK	$1,677,000	12
Naytahwaush Health Center (JV), Naytahwaush, MN	$1,153,000	8
Yakutat Tlingit Health Center (JV), Yakutat, AK	$647,000	2
Ysleta Del Sur Health Center (JV), El Paso, TX	$331,000	3
Grand Total:	**$3,808,000**	**25**

- Program Adjustment +$3.3 million - to maximize funding for direct patient care services.

OUTPUTS / OUTCOMES

Measure	**Year and Most Recent Result / Target for Recent Result / (Summary of Result)**	**FY 2020 Target**	**FY 2021 Target**	**FY 2021 Target +/-FY 2020 Target**
61 Topical Fluorides (Outcome)	FY 2019: 32.1 % Target: 30 % (Target Exceeded)	34.5 %	TBD	N/A
62 Access to Dental Services (Outcome)	FY 2019: 30.0 % Target:	29.7 %	TBD	N/A

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2020 Target	FY 2021 Target	FY 2021 Target +/-FY 2020 Target
	27.2 % (Target Exceeded)			
63 Dental Sealants (Outcome)	FY 2019: 15.9 % Target: 16 % (Target Not Met)	17.2 %	TBD	N/A

GRANTS AWARDS

The DHP is soliciting, through a Notice of Funding Opportunity, applications for the Dental Preventive and Clinical Support Centers Program. As many as five grant awards may be made, at an annual funding level of $250,000 each, with the purpose being to establish Dental Preventive and Clinical Support Centers Programs (also known as Dental Support Centers or DSCs). The DSCs combine IHS and tribal resources and infrastructure in order to address broad challenges and opportunities associated with preventive and clinical dental programs. Centers also rigorously measure and evaluate their work with the goal of demonstrably improving dental health outcomes through the technical assistance and services they provide. Centers may work simultaneously to improve many different dental programs in a region, providing support, guidance, training, and enhancement to these programs, which then provide services to patients.

(whole dollars)	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Number of Awards	5	5	5
Average Award	$250,000	$250,000	$250,000
Range of Awards	$250,000	$250,000	$250,000

AREA ALLOCATION

Dental Health

(dollars in thousands)

DISCRETIONARY	FY 2019 Final 1/			FY 2020 Estimated			FY 2021 Estimated			FY'21 +/- FY'20
SERVICES	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$348	$34,934	$35,282	$370	$37,165	$37,535	$386	$38,717	$39,102	$1,567
Albuquerque	4,860	3,989	8,849	5,171	4,244	9,414	5,386	4,421	9,807	$393
Bemidji	2,073	2,519	4,592	2,206	2,680	4,885	2,298	2,791	5,089	$204
Billings	5,889	1,816	7,705	6,265	1,932	8,197	6,527	2,013	8,539	$342
California	386	1,908	2,294	410	2,030	2,440	427	2,115	2,542	$102
Great Plains	10,413	7,755	18,168	11,078	8,251	19,328	11,540	8,595	20,135	$807
Nashville	737	6,354	7,090	784	6,759	7,543	816	7,041	7,858	$315
Navajo	25,461	8,797	34,258	27,087	9,359	36,446	28,218	9,749	37,967	$1,521
Oklahoma	9,677	34,341	44,018	10,295	36,534	46,829	10,724	38,059	48,784	$1,955
Phoenix	8,790	8,995	17,785	9,351	9,570	18,921	9,741	9,969	19,710	$790
Portland	4,421	3,670	8,091	4,703	3,904	8,608	4,900	4,067	8,967	$359
Tucson	39	2,107	2,146	41	2,242	2,283	43	2,335	2,378	$95
Headquarters	7,670	0	7,670	8,160	0	8,160	8,500	0	8,500	$341
Total, Dental	**$80,763**	**$117,186**	**$197,949**	**$85,921**	**$124,669**	**$210,590**	**$89,507**	**$129,873**	**$219,380**	**$8,790**

1/ Reflects Services account adjustments related to formal reprogramming notifications submitted to Congress in FY 2019. Amounts by "Sub IHS Activity" will continue to be adjusted during the period of availability, which conclude on September 30, 2020, for impacted funds.

Note: FY 2020 through 2021 are estimates.

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

(Dollars in Thousands)

	FY 2019[1]	FY 2020	FY 2021	
	Final	Enacted	President's Budget	FY 2021 +/- FY 2020
BA	$101, 255	$108,933	$128,228	+$19,295
FTE*	191	191	198	+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 2021 Authorization.....Permanent

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

PROGRAM DESCRIPTION

The Indian Health Service (IHS) Mental Health/Social Services (MH/SS) program is a community-based clinical and preventive service program that provides ongoing vital outpatient mental health counseling and access to dual diagnosis services, mental health crisis response and triage, case management services, community-based prevention programming, and outreach and health education activities. The MH/SS program supports the *IHS Strategic Plan Goal 2, Objective 2.2, to provide care that better meets the health care needs of American Indians and Alaska Native communities.* The most common MH/SS program model is an outpatient service staffed by one or more mental health professionals providing individual, family, and group psychotherapeutic services and case management. After hours emergency services are generally provided through local emergency departments and contracts with non-IHS hospitals and crisis centers. Inpatient services are generally purchased from non-IHS hospitals or provided by state or county hospitals providing mental health services. Intermediate level services such as group homes, transitional living support, intensive case management, and related activities are typically offered through state and local resources. Additionally, slightly more than one-half of the tribes administer and deliver their own mental health programs.

IHS continues to support tribal communities in their ability to address the mental health disparities experienced among the AI/AN population. IHS Mental Health initiatives and grant programs support the *IHS Strategic Plan Goal 1 that ensures comprehensive, culturally appropriate personal and public health services are available and accessible*. In partnership with tribal community partners, a collaborative community of learning will support IHS efforts to

[1] Reflects Services account adjustments related to formal reprogramming notifications submitted to Congress in FY 2019. Amounts by "Sub IHS Activity" will continue to be adjusted during the period of availability, which conclude on September 30, 2020, for impacted funds.

promote excellence and quality through the development of innovative, community-based projects to expand mental health services and treatment in integrated clinical settings.

PROGRAM ACCOMPLISHMENTS

Suicide Prevention: Suicide rates among AI/ANs are historically higher than those of the total U.S. population. In 2016, the suicide rate for AI/AN adolescents and young adults ages 15 to 34 (19.5 per 100,000) was 1.3 times higher than the national average for that age group (14.5 per 100,000). Suicide is the eighth leading cause of death among all AI/AN across all ages.[2] Strategies to address behavioral health, alcohol, substance use disorder, and suicide prevention require comprehensive clinical strategies, and approaches. The IHS utilizes and promotes collaborations and partnerships with patients and their families, including tribes and tribal organizations, Urban Indian organizations, federal, state, and local agencies, as well as public and private organizations. The 2017–2022 National AI/AN Suicide Prevention Strategic Plan advances the 2012 National Suicide Strategic Plan with culturally relevant approaches and strategies specific for AI/AN communities.[3]

The IHS utilizes a suicide surveillance reporting tool to document incidents of suicide in a standardized and systematic fashion. The suicide surveillance tool captures data related to specific incidents of suicide ideation with plan; suicide attempts; and suicide deaths through the use of the Suicide Report Forms (SRF) which includes date and location of act, method, contributing factors, and other useful epidemiological information to better understand the issue, identified risk factors and target resources appropriately. In FY 2019, tribal communities submitted 2,387 completed Suicide Report Forms.

Zero Suicide Initiative:
The "Zero Suicide" philosophy is a key concept of the National Strategy for Suicide Prevention (NSSP) and is a priority of the National Action Alliance for Suicide Prevention (Action Alliance). Zero Suicide focuses on developing a system-wide approach to improving care for individuals at risk of suicide who are currently utilizing health and behavioral health systems. Health care systems are uniquely poised to identify those struggling with thoughts of suicide by considering the following data:

- 50 percent of those who die by suicide had contact with a primary care provider within 1 month of suicide
- 80 percent of those who die by suicide had contact with a primary care provider within 1 year of suicide
- 20 percent of those who die by suicide had visited with behavioral health within 1 year of suicide
- 10 percent of those who die by suicide had visited the emergency department within 2 months of suicide

In FY 2017, IHS received $3.6 million to fund 8 pilot IHS and tribal sites to participate in its first cohort of the Zero Suicide Initiative, five tribal and three federal facilities, funded at

[2] US Department of Health and Human Services, Centers for Disease Control and Prevention. Morbidity and Mortality Weekly Report, June 8, 2018. Vital Signs: Trends in State Suicide Rates – United States, 1999-2016 and Circumstances Contributing to Suicide – 27 States, 2015.

[3] Centers for Disease Control and Prevention (CDC). Web-based Injury Statistics Query and Reporting System (WISQARS) [Online]. (2016) National Center for Injury Prevention and Control, CDC (producer). Available from http://www.cdc.gov/injury/wisqars/index.html

$400,000 to implement the Zero Suicide Model within their healthcare system. Each project plan includes utilizing evidence-based treatments in suicide care, initiating safety plans with patients at risk for suicide, implementing intensive follow-up upon missed or cancelled appointments, universal suicide screening of all at-risk patients, increasing restriction of lethal means, implementing intensive case management, and initiating follow up with patients within 24 hours of transition of care. In year two, all project sites have successfully established a Zero Suicide policy and have developed suicide risk screening procedures, clinical pathways, and data collection plans to enhance surveillance and analysis capabilities. By the end of Year 2, sites participating in the Zero Suicide Initiative reported more than 200,000 outpatient contacts.

In FY 2019, the IHS and the National Institute of Mental Health (NIMH) partnered by way of a Memorandum of Understanding (MOU) to address the high rates of suicide impacting the AI/AN communities. With this three year partnership (FY 2019- 2021), IHS and NIH will work together to implement the Ask Suicide Screening Questions (ASQ) and its accompanying toolkit for universal screening within IHS Emergency Departments (EDs). ASQ is a suicide screening resource developed by NIMH for medical settings to help nurses or physicians successfully identify individuals at risk for suicide. In FY 2019, IHS conducted a site visit and staff training on the ASQ, and partnered with IHS OIT to fully integrate the validated suicide risk screening instrument into the IHS electronic health records system for field implementation. These efforts support several IHS Strategic Plan *including Goal 1 Objective 1.2 to build, strengthen, and sustain collaborative relationships and Goal 3, Objective 3.3 to modernize information technology and information systems to support data driven decisions*.

Trauma-Informed Care:
Trauma Informed Care supports the *IHS Strategic Goal 2, Objective 2.2, by providing care to better meet the health care needs of American Indian and Alaska Native communities*. IHS has worked to implement the principles of trauma informed care to ensure its system understands the prevalence and impact of trauma, facilitates healing, avoids re-traumatization, and focuses on strength and resilience. Developing and implementing a trauma informed care approach to address childhood trauma, including historical trauma, is necessary to comprehensively address the root causes of violence, suicide, depression, anxiety, self-harm, and chronic physical diseases.

In September 2016, the MH/SS and Improving Patient Care and the Johns Hopkins University developed the Pediatric Integrated Care Collaborative (PICC) pilot project. The PICC focused on increasing the quality and accessibility of child trauma services by integrating behavior and physical health services in patient-centered medical homes. Initially, ten PICC pilot sites were selected to attend in-person and virtual quality improvement learning collaborative sessions where they received tailored technical assistance to integrate trauma informed care into pediatric primary care. The goal of the pilot project was to harvest lessons learned that improve implementation of screening for trauma among the pediatric population, engaging families, and developing policy recommendations for the Indian health system. In FY 2019, IHS continued to support seven sites established in FY 2018, alongside the previously selected tribal and IHS sites to develop a quality improvement model. In addition, these supported sites completed site assessments, developed implementation plans and have shared best and promising practices for trauma informed care. In FY 2020, lessons learned from the PICC will be used by IHS to incorporate into a standalone trauma informed care policy in the Indian Health Manual, accompanied by on-demand online training for clinical and non-clinical staff.

In 2019, IHS continued to partner with the University of New Mexico (UNM) to develop an online training curriculum related to trauma and trauma-informed care tailored for IHS staff, clinical staff, and supervisors. UNM adapted the Creating Cultures of Trauma Informed Care

(CCTIC) model to be culturally appropriate and for use within AI/AN communities. The training seeks to increase staff knowledge of the impact of historical trauma on American Indian/Alaska Native populations, the types of trauma, the impacts of trauma on physical and behavioral health, and the principles and implementation of Trauma Informed Care. The UNM CCTIC is now available as an online on-demand webinar series for clinical and non-clinical staff. The goal of the CCTIC is to facilitate organizational change built around five core values: safety, trustworthiness, choice, collaboration, and empowerment. Staff training focused on recognizing trauma and its impact, becoming trauma informed, treating trauma, and ensuring supervisors at all managerial levels understand the impact of trauma and historical trauma in employee performance, coworker relationships, and well-being. In FY 2021, IHS will expand the training to incorporate additional modules and continuing education credits for healthcare professions.

Behavioral Health Integration Initiative (BH2I): IHS supports changing the paradigm of mental health and substance abuse disorder services from being episodic, fragmented, specialty, and/or disease focused to incorporating it into the patient-centered medical home. The statistics facing AI/AN peoples for suicide, alcohol-related deaths, domestic and sexual violence, and homicide require the Indian health system to develop a system of comprehensive screening and effective intervention to reduce morbidity and early mortality.

In FY 2017, IHS received $6 million to launch the Behavioral health Integration Initiative, which is on a three-year funding cycle through FY 2020. BH2I supports *the IHS Strategic Goal 1, Objective 1.3, to increase access to quality health care services*. In FY 2019, IHS continued funding for 12 IHS, tribal, and urban Indian organizations to integrate behavioral health with primary care services in their local health facilities. Additionally, IHS contracted with a technical assistance (TA) provider to guide this pilot project through the implementation of their integrated care efforts with expertise from psychiatrists, primary care physicians, and social workers. A primary goal of the BH2I is to formalize integration across the system, develop care teams, strengthen infrastructure, and enhance clinical processes including increased depression screenings in primary care clinics. The TA provider has also developed and implemented a cross-site evaluation of the BH2I initiative to help IHS determine the impact of BH2I. While the initiative focuses on increased implementation of depression screening in primary care clinics, this project will include additional measures that reflect organizational change for behavioral health integration beyond focusing solely on screening rates. Thus far, BH2I projects have reported successes such as same day access to behavioral health providers and reduction in wait times to see a psychiatrist.

Reflective of the Agency priority to raise the mental health of the AI/AN population, in FY 2019, IHS reported 42.6 percent of AI/AN adults over the age of 18 screened for depression using a standardized screening assessment for depression. In FY 2019, this same measure was reported for youth ages 12-17 and data indicated 37.3 percent of eligible youth were screened for depression. For FY 2019, targets were based on prior year results and both measures exceeded their targets.

TeleBehavioral Health and Workforce Development: The IHS TeleBehavioral Health Center of Excellence (TBHCE) was established in 2009, utilizing funds from the Methamphetamine and Suicide Prevention Initiative, to assess the feasibility of providing behavioral health services via televideo. Due to the rural nature of many IHS and tribal facilities, I/T/U patients face many issues surrounding access to care, particularly specialty care. Providers working in these remote areas often face barriers to maintaining the required continuing education (CE)/Continuing Education Unit (CEU) credits required for licensure and remaining up to date on current clinical guidelines. The TBHCE assists IHS, tribal, and urban Indian organizations providers and

facilities in overcoming these challenges by providing a range of telebehavioral health services and training. There are 25 sites receiving direct care services through the TBHCE. These services include, adult counseling, child counseling, family counseling, trauma/Post Traumatic Stress Disorder (PTSD) counseling, child psychiatry, adult psychiatry, and addiction psychiatry. In FY 2019, the TBHCE provided more than 4,627 hours of telebehavioral health services.

Additionally, the TBCHE hosts a robust weekly, tele-education schedule designed to meet the specific training needs of IHS, Tribal, and Urban Indian (I/T/U) health care providers. The tele-education program supports *the IHS Strategic Plan Goal 1, Objective 1.1, to recruit, develop, and retain a dedicated, competent, and caring workforce*. More specifically, IHS utilizes tele-education (otherwise known as distance learning) to deliver national continuing education (CE) programming to I/T/U healthcare providers. In FY 2019, TBHCE provided 105 webinars that resulted in a total of 2,747 overall training hours and 1,431 CE hours. Additionally, TBHCE now hosts four online courses that were accessed for a total of 1,844.25 overall training hours and 923 CE hours.

The TBHCE also developed and supports the online IHS Essential Training on Pain and Addiction. In FY 2019, 302 I/T/U providers completed this five-hour training. Additionally, 251 I/T/U clinicians completed the TBHCE hosted Essential Training on Pain and Addiction Refresher course.

Evaluation data of the TBHCE "Trainings in Pain Management and Opioid Substance Use Disorder" indicated a positive change in the knowledge, self-efficacy, and attitude among IHS clinicians toward virtual educational trainings focused on pain management and best practices to effectively manage chronic pain.

FUNDING HISTORY

Fiscal Year	Amount
2017	$94,080,000
2018	$98,900,000
2019	$101,255,000
2020 Enacted	$108,933,000
2021 President's Budget	$128,228,000

TRIBAL SHARES

Mental Health funds are subject to tribal shares and are transferred to tribes when they assume the responsibility for operating the associated programs, functions, services, and activities. A portion of the overall Mental Health budget line is reserved for inherently federal functions and is therefore retained by the IHS to perform the basic operational services of the Agency.

BUDGET REQUEST

The FY 2021 budget submission for Mental Health is $128.2 million, which is $19.3 million above the FY 2020 Enacted level.

FY 2020 Base Funding of $108.9 million – This funding will maintain the program's progress in addressing mental health needs by improving access to behavioral health services through tele-behavioral health efforts and providing a comprehensive array of preventive, educational, and treatment services.

FY 2021 Funding Increase of $19.3 million includes:

- Current Services: +$961,000 for current services including:
    - Inflation +$961,000 – to fund inflationary costs of providing health care services.
- Staffing for New Facilities +$1.9 million - These funds will support staffing and operating costs for new and replacement projects listed below. Funding for new/renovated facilities allows IHS to expand provision of health care in those areas where capacity has been expanded to address health care needs. The following table displays this request.

New Facilities	Amount	FTE/Tribal Positions
Yukon-Kuskokwim Primary Care Center (JV), Bethel, AK	$1,157,000	9
Naytahwaush Health Center (JV), Naytahwaush, MN	$415,000	4
Yakutat Tlingit Health Center (JV), Yakutat, AK	$158,000	1
Ysleta Del Sur Health Center (JV), El Paso, TX	$200,000	2
Grand Total:	**$1,930,000**	**16**

- Telebehavioral Health Center +$2.9 million to expand telehealth services provided through the Tele Behavioral Health Center of Excellence (TBHCE) to have a significant impact on sustainable access to care. This includes:
    - Facilities - A new space specifically designed for telehealth is needed to rent, lease or be constructed with an estimated need of 4000 square feet.
    - Equipment and Hardware – Much of the equipment currently used is near or past recommended "end-of-life" and needs updating. This includes infrastructure such as, hardware, servers, and maintenance agreements. Also needed is the end-point equipment used by the providers and sites.
    - Behavioral Health Provider Staff - Demand from AI/AN communities for telebehavioral services has outstripped TBHCE's capacity, and there is a waitlist for new communities until additional capacity can be developed. Though current telebehavioral health services are self-sustaining through third party billing, there are no additional funds for expansion of staff capacity. The requested funds support hiring of additional provider FTEs to support the TBHCE. These include 8 clinical FTEs: 4 FTE psychiatrists (GS-14/15), 3 FTE social worker/psychologist (GS-12/13), and 1 FTE psychiatric nurse practitioner (GS-12/13).
    - Support Staff - TBHCE has a very small number of support staff. To meet the demand for services and expand, additional support staff are required. The requested funds support hiring of additional support FTEs to support the TBHCE. This would include: 1 FTE IT Network Specialist (GS-14), 1 Project Management Specialist (GS-13), 1 Management Analyst (GS-11), 1 FTE Data and QA/QI Specialist (GS-12).

- Program Adjustment +$13.5 million - to maximize funding for direct patient care.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2020 Target	FY 2021 Target	FY 2021 Target +/-FY 2020 Target
29 Suicide Surveillance: Increase the incidence of suicidal behavior reporting by health care (or mental health) professionals (Outcome)	FY 2019: 2,468 completed reporting forms Target: 2,586 completed reporting forms (Target Not Met but Improved)	Discontinued	Discontinued	N/A
65 Proportion of American Indian and Alaska Native adults 18 and over who are screened for depression. (Outcome)	FY 2019: 42.6 % Target: 42.2 % (Target Exceeded)	45.7 %	49.4%	+3.7%
85 Depression Screening ages 12-17. (Outcome)	FY 2019: 37.3% Target: 27.6 % (Target Exceeded)	38.0 %	43.2%	+5.2%
MH-1 Increase Tele-behavioral health encounters nationally among American Indians and Alaska Natives (Output)	FY 2019: 17,933 Target: 13,600 (Target Exceeded)	21,860	26,647	+4,787
MH-2 Suicide Screen and Assessment (Outcome)	FY 2020: Result Expected Oct 1, 2021 Target: Set Baseline (Pending)	Set Baseline	Maintain Baseline	N/A

GRANTS AWARDS

The proposed FY 2021 budget increases will be used, in part, for grants for IHS facilities, tribes, tribal organizations, and urban Indian organizations to develop innovative programs to address behavioral health services and deliver those services within and outside of the traditional health care system. The actual number of non-competitive grants are included below:

(whole dollars)	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Number of Awards	20	20	20
Average Award	$450,000	$450,000	$450,000
Range of Awards	$400,000 - $500,000	$400,000 - $500,000	$400,000 - $500,000

AREA ALLOCATION

Mental Health

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2019 Final 1/			FY 2020 Estimated			FY 2021 Estimated			FY'21 +/- FY'20
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$73	$12,917	$12,991	$78	$13,898	$13,976	$92	$16,359	$16,452	$2,476
Albuquerque	1,739	2,891	4,629	1,870	3,110	4,980	2,202	3,661	5,862	$882
Bemidji	321	2,190	2,511	345	2,356	2,701	407	2,773	3,180	$478
Billings	2,563	1,399	3,962	2,757	1,506	4,262	3,245	1,772	5,017	$755
California	111	2,314	2,425	119	2,489	2,608	140	2,930	3,070	$462
Great Plains	7,018	2,790	9,808	7,551	3,001	10,552	8,888	3,533	12,421	$1,869
Nashville	320	2,532	2,852	344	2,724	3,068	405	3,207	3,612	$543
Navajo	8,891	7,281	16,172	9,565	7,833	17,398	11,260	9,220	20,480	$3,082
Oklahoma	3,082	13,911	16,993	3,316	14,966	18,282	3,903	17,617	21,520	$3,238
Phoenix	3,303	6,236	9,539	3,554	6,709	10,262	4,183	7,897	12,080	$1,818
Portland	490	4,058	4,548	527	4,365	4,893	621	5,139	5,759	$867
Tucson	11	1,627	1,639	12	1,751	1,763	14	2,061	2,075	$312
Headquarters	13,187	0	13,187	14,188	0	14,188	16,701	0	16,701	$2,513
Total, Mental	**$41,109**	**$60,145**	**$101,255**	**$44,227**	**$64,706**	**$108,933**	**$52,061**	**$76,167**	**$128,228**	**$19,295**

1/ Reflects Services account adjustments related to formal reprogramming notifications submitted to Congress in FY 2019. Amounts by "Sub IHS Activity" will continue to be adjusted during the period of availability, which conclude on September 30, 2020, for impacted funds.

Note: FY 2020 through 2021 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 2019[1]	FY 2020	FY 2021	
	Final	Enacted	President's Budget	FY 2021 +/- FY 2020
BA	$234,421	$245,603	$235,745	-$9,858
FTE*	242	242	242	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 2021 Authorization.....Permanent

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

PROGRAM DESCRIPTION

Alcohol and substance abuse and addiction are among the most severe public health and safety problems facing American Indian and Alaska Native (AI/AN) individuals, families, and communities. The purpose of the Indian Health Service (IHS) Alcohol and Substance Abuse Program (ASAP) is to raise the health status of AI/AN communities to the highest possible level through a comprehensive array of preventive, educational, and treatment services that are community-driven and culturally competent. The ASAP addresses the IHS Strategic Plan *Goal 1, Objective 1.2 by building, strengthening, and sustaining collaborative relationships with I/T/Us and 1.3 increasing access to quality health care services*. These collaborative activities strive to integrate substance abuse treatment into primary care. For instance, the Substance Abuse and Suicide Prevention Program provides prevention and intervention resources developed and delivered by local community partners to address the dual crises of substance abuse and suicide in AI/AN communities.

In general, AI/AN populations suffer disproportionately from substance abuse disorders compared with other racial groups in the United States. Research has consistently found that AI/AN experience high rates of substance use compared with the U.S. general population. As one example, a study from Koss et al. reported levels of alcohol dependence ranging from 21 to 56 percent for men and 17 to 30 percent for women, both higher when compared to the U.S. national averages for men and women (19 percent and 8.9, respectively In 2016, Centers for Disease Control and Prevention (CDC) reported that the American Indian and Alaska Native (AI/AN) population had the highest overdose rates from all opioids (13.9 deaths/ 100,000 population), including the largest percentage increase in the number of deaths between 1999-2015

[1] Reflects Services account adjustments related to formal reprogramming notifications submitted to Congress in FY 2019. Amounts by "Sub IHS Activity" will continue to be adjusted during the period of availability, which conclude on September 30, 2020, for impacted funds.

compared to other racial and ethnic groups. In 2017, the age-adjusted rate of drug overdose deaths was 9.6 percent higher than the rate for 2016. During that time, deaths rose more than 500 percent among AI/ANs. In addition, due to misclassification of race and ethnicity on death certificates, the actual number of deaths for AI/ANs may be underestimated by up to 35 percent.[2]

The services and functions of the IHS Alcohol and Substance Abuse program supports the IHS Strategic Plan *Goal 2, Objective 2.2 to provide care to better meet the health care needs of AI/AN communities and Goal 1 to ensure comprehensive, culturally appropriate services in the prevention, treatment and recovery of alcohol and substance use disorders*.

PROGRAM ACCOMPLISHMENTS

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

Integrated Substance Abuse Treatment in Primary Care: IHS continues to support the integration of substance abuse treatment into primary care and emergency services. Integrating treatment into health care offers immediate and same-day opportunities for health care providers to identify patients with substance use disorders, provide them with medical advice, help them communicate the health risks and consequences, obtain substance abuse consultations, and refer patients with more severe substance use-related problems to treatment.[3] One integration activity is the implementation of the Screening, Brief Intervention, Referral to Treatment (SBIRT) instrument, which is an early intervention and treatment service for people with substance use disorders and those at risk of developing these disorders. IHS has broadly promoted SBIRT as an integral part of a sustainable, primary care-based activity that will support and integrate behavioral health into care. SBIRT is eligible for reimbursement from the Centers for Medicare and Medicaid Services (CMS). IHS has incorporated SBIRT as a national measure to be tracked and reported. In FY 2019, the SBIRT screening measure was utilized in 14.9 percent of the patient visits for those between ages 9 through 75. The target for this measure was 8.9 percent, therefore IHS efforts exceeded the expected percent of patients to be screened using the SBIRT. IHS continues to provide annual national training on SBIRT including guidelines for improved clinical documentation in the electronic health record. In FY 2020, IHS continues to increase efforts that broadly promote the SBIRT measure to achieve targets at the regional and local levels including a more focused education campaign on the importance of early detection and intervention using SBIRT screening among IHS operated programs.

Increasing access to Medication Assisted Treatment (MAT): The Indian Health Service is committed to assuring access to Medication Assisted Treatment for patients struggling with Opioid Use Disorder. The IHS continues to host training sessions for clinicians to receive their Drug Addiction Treatment Act (DATA) waiver to prescribe buprenorphine and in FY 2018 added buprenorphine-containing medication and injectable naltrexone to the IHS National Core Formulary. In June 2019, the IHS released the Special General Memorandum *Assuring Access to MAT* that requires Federal Indian Health Service Facilities to create an action plan to identify local medication assisted treatment (MAT) resources and coordinate patient access to these

[2] https://www.cdc.gov/mmwr/volumes/66/ss/pdfs/ss6619.pdf
[3] U.S. Office of National Drug Control Policy. Integrating Treatment into Healthcare. *Available at* http://www.whitehouse.gov/ondcp/integrating-treatment-and-healthcare.

services when indicated to assure equitable access to MAT services. In addition, the IHS has created workforce development strategies that include substance use disorder training for healthcare workers and technical assistance materials to support sites with creating integrated substance use disorder approaches to care.

To address challenges that limit access to recovery services in remote and rural IHS locations and villages, the IHS released an *Internet Eligible Controlled Substance Prescriber Designation* Policy in the Indian Health Manual (Chapter 38) to assure access to MAT using telemedicine models for remotely located Tribal members. In March 2019, the IHS released the *Recommendations to the Indian Health Service on American Indian/Alaska Native Pregnant Women and Women of Childbearing Age with Opioid Use Disorder* developed in collaboration with the American College of Obstetricians and Gynecologists' (ACOG) Committee on American Indian and Alaska Native Women's Health. This resource will help providers improve maternal participation in early prenatal care, improve screening for substance use disorder, and increase access to MAT for pregnant women and women of child-bearing age. The goal of these clinical recommendations is to foster relationships and improve awareness surrounding trauma-informed approaches to maternal opioid use that may lead to recovery, hope, and healing. Additionally, the IHS and the American Academy of Pediatrics Committee on Native American Child Health (CONACH) recently released the *Recommendations to the Indian Health Service on Neonatal Opioid Withdrawal Syndrome* that includes clinical recommendations on the prevention and management of neonatal opioid withdrawal syndrome. These recommendations provide standards of care for screening, diagnosing, support, and treatment of pregnant mothers and infants affected by prenatal opioid exposure

Finally, IHS has partnered with the Northwest Portland Area Indian Health Board and the Clinician Consultation Center to facilitate I/T/U clinician access to free Opioid Use Disorder tele-consultation services. These services are intended to assist clinicians with patient treatment planning, facilitate didactic learning, and provide support for health systems that desire to create local protocols.

Proper Pain Management and Opioid Stewardship and Training:
The IHS has created and released a comprehensive Opioid Stewardship workbook to assist sites with creating best practices surrounding safe opioid prescribing and increasing access to integrative pain treatments. The workbook emphasizes utilizing opioid surveillance strategies to evaluate population health outcomes, target opioid interventions, enhance clinical decision support, and create professional practice evaluation strategies. The IHS opioid stewardship program evaluation considers metrics that evaluate trends in Morphine Milligram Equivalents versus a restricted focus on total opioid prescription fills.

The IHS has also created a robust workforce development strategy to include didactic training. In September 2019, the IHS launched its Pain Management and Opioid Use Disorder Continuing Medical Education webinar series. The IHS has hosted learning sessions in this series that include buprenorphine prescribing in pregnancy as well as an auricular acupuncture-training program. Additional sessions are scheduled in FY 2020. The IHS has also recently facilitated dedicated access to tele-consultation services for IHS clinicians to receive on-demand substance use expert recommendations and tailored clinical guidance for IHS healthcare providers of all experience levels. This service is also available to assist IHS health systems with creating clinic policies and procedures to support creation of integrated MAT services in IHS facilities.

In May 2016, the IHS implemented a policy on mandatory opioid training requiring all federally controlled substance prescribers to complete the "IHS Essential Training on Pain and Addiction"

with required refresher training every 3 years. This training is now available on demand with continuing medical education credits. The IHS released its Refresher training course in January 2018 including four sessions of its mandatory five-hour training course for providers on proper opioid prescribing. In FY 2019, 302 new clinicians completed this course. The mandate also includes an additional refresher training after three years. In FY 2019, 7251 clinicians completed the Essential Training on Pain and Addiction Refresher course.

In FY 2019, IHS provided Pain Skills Intensive trainings in the Phoenix and Tucson Area and the Navajo Area. These trainings focus on assessment and treatment of myofascial pain, including non-pharmacological interventions. Additionally, they include the half-and-half DATA Waiver training for buprenorphine MAT. A total of 35 clinicians attended these trainings. In FY 2020, IHS will provide additional Pain Skill Intensive trainings covering new IHS Areas.

In FY 2019, IHS provided three webinars that addressed pain management, opioids, and opioid misuse with a total of 108 attendees.

- Opioid Use and the Adolescent Brain
- Initiating Buprenorphine as Medication Assisted Treatment for Pregnant Women with Opioid Use Disorder
- Medication Assisted Treatment -MAT

The IHS has created agency policy and clinical practice recommendations to improve patient outcomes and reduce unnecessary opioid exposure. In June 2014, the IHS implemented IHM Chapter 30 policy titled Chronic Non-Cancer Pain Management to promote appropriate pain management. Finally, the Indian Health Service released new clinical guidelines to assist dentists with selecting the safest pain control options. The *Recommendations for Management of Acute Dental Pain* will limit opioid prescribing to patients who cannot safely use alternative pain medication. The guidelines also include a decision tree for pre- and post-operative pain management, as well as recommended dosing of systemic analgesics based on anticipated operative pain.

Pain and Opioid Use Disorder Case Consultation Services: To provide ongoing clinical support for providers, IHS, in partnership with the University of New Mexico Pain Center, provides a weekly Chronic Pain and Opioid Management ECHO. ECHO is a case-based learning model in which consultation is offered through virtual clinics to primary care clinicians by an expert team to share knowledge and elevate the level of specialty care available to patients. In FY 2019, 178 IHS, tribal, and urban clinicians participated in 34 ECHO sessions with over 1,000 attendees.

Youth Regional Treatment Centers (YRTCs): YRTCs provide residential substance abuse and mental health treatment services to AI/AN youth. Congress authorized the establishment of these YRTCs in each of the 12 IHS Areas, with two (northern and southern) specifically authorized for the California Area. These YRTCs provide quality holistic behavioral health care for AI/AN adolescents that integrate traditional healing, spiritual values and cultural identification. The Alaska and Portland Areas divided their funds to provide residential treatment services for two programs. The second treatment facility for the Portland Area opened in October 2017. In FY 2019 all federal YRTCs in operation 18 months or longer have achieved accreditation status.

Indian Children's Program (formerly, Fetal Alcohol Spectrum Disorders (FASD)): Training and technical assistance on FASD is provided through the IHS TeleBehavioral Health Center of Excellence (TBHCE) Indian Children Program (ICP). The focus of the ICP is training clinicians on developmental and neurobiological issues that can affect AI/AN children. To this end, ICP

developed and posted a nine-session training series on FASD in AI/AN populations. ICP is currently piloting a four-hour, introductory course on FASD and another course on Autism Spectrum Disorder. The target audience of these trainings are Community Health Representatives, school staff, and other community members. In FY 2019, ICP produced a nine-session training series, Substance Use and the Adolescent Brain. The ICP also provides additional clinician supports. For example, clinicians can take advantage of the bi-weekly, Pediatric Neurodevelopmental & Behavioral Health Consultation Clinic. This virtual clinic is designed to help clinicians successfully diagnose, manage, and/or treat AI/AN youth with FASD, ASD, and other neurodevelopmental issues.

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

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

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

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

In April 2019, the IHS expanded collaboration with the Defense Veterans Center for Integrated Pain Management to explore feasibility of creating an IHS auricular acupuncture program utilizing the Veterans Health Administration Battlefield Acupuncture protocol. The IHS has created a pilot program that includes credentialing and privileging processes, clinical practice

protocols, documentation standards, patient education materials, and a sustainability plan. The initial training session was hosted in November 2019 and 23 IHS clinicians were certified in this modality.

The IHS has expanded access to harm reduction interventions that include increased access to the opioid overdose reversal medication, naloxone. In 2015, the IHS signed a memorandum of agreement with the Bureau of Indian Affairs (BIA). The agreement allows IHS to provide BIA Law Enforcement Officers (LEO) with training and naloxone rescue kits for responding to incidents of opioid overdose. Between 2015 and 2017, this partnership trained and put naloxone in the hands of 324 BIA LEOs, who are often the first responders to incidents of opioid overdose in Tribal communities. In 2017, IHS turned the naloxone training program over to the BIA after certifying 48 BIA LEOs as naloxone trainers. The IHS continues to support this program by re-supplying naloxone rescue kits to BIA LEO first responders as needed. In 2019, IHS conducted first-responder train-the-trainer sessions on naloxone and harm reduction strategies for community health workers from IHS and tribal sites from across the country. During that training 86 community workers were supplied with naloxone kits and certified to offer naloxone training within their local communities. The IHS also supports naloxone co-prescribing and has created sample collaborative practice agreements to engage pharmacists in naloxone distribution efforts and has hosted an IHS 'Grand Rounds' on naloxone co-prescribing to increase provider awareness of this life-saving procedure. A "First Responder Toolkit" that includes a training video, a law enforcement testimonial video, customizable forms, and a train-the trainer curriculum was created to support naloxone deployment in tribal communities. The IHS formally expanded access to naloxone in March 2018 through a policy titled "Prescribing and Dispensing of Naloxone to First Responders" that require IHS Federal pharmacies to provide naloxone to all Tribal law enforcement agencies and other trained first responders. These efforts have resulted in a 143 percent increase in naloxone procurement across IHS facilities that utilize the Prime Vendor.

The IHS has further adapted the toolkit and strategy to equip community first responders and paraprofessionals with training on opioid overdose response and naloxone. These expanded collaborations with local law enforcement and community first responders resulted in an initial pilot community-health naloxone train-the-trainer program to include naloxone distribution. Ninety-six community-health workers completed training as naloxone trainers for their tribal communities in one week.

ASA Grant and Federal Award Programs

The IHS Division of Behavioral administers community-based grants that promote the use and development of evidence-based and practice-based models that represent culturally-appropriate prevention and treatment approaches to substance use from a community-driven context. In particular, the IHS Opioid Grant Program and the Substance Abuse and Suicide Prevention program (SASP) will support the IHS Strategic Plan Goal 1, Objective 1.2 to build, strengthen, and sustain collaborative relationships and Objective 1.3 to increase access to quality health care services.

IHS Opioid Grant Program: In FY 2019, IHS received $10 Million in FY 2019 funding under the Special Behavioral Health Pilot Program (SBHPP) for American Indians and Alaska Natives to be targeted at opioid specific activities. In FY 2019, IHS held Tribal Consultation and Urban Confer to support the development of a grant program that will promote the documentation, and sharing of locally-designed, culturally-appropriate prevention, treatment, recovery, and aftercare

services for mental health and substance use disorders in American Indian and Alaska Native communities. A funding opportunity for the SBHPP will be released in FY 2020.

Substance Abuse and Suicide Prevention Program (SASP): The SASP is a nationally-coordinated $31.97 million program providing funds for culturally appropriate substance use and suicide prevention programming in AI/AN communities. The program funds 175 projects. IHS administration of the SASP grants supports the HHS Strategic Plan, *Goal 2 to protect the health of Americans where they live, learn, work, and play*. In August of 2019, IHS initiated Tribal Consultation and an Urban Confer regarding behavioral health initiatives and the National Tribal Advisory Committee on Behavioral Health recommendations regarding the distribution of funding for the SASP program. In total 22 comments and recommendations were received and DBH is reviewing all comments and recommendations to provide recommendations to the IHS Director.

The goals of SASP are to:

1. Increase IHS, Tribal, and Urban (I/T/U) capacity to operate successful substance abuse prevention, treatment, and aftercare and/or suicide prevention, intervention, and postvention services through implementing community and organizational needs assessment and strategic plans;
2. Develop and foster data sharing systems among I/T/U behavioral health service providers to demonstrate efficacy and impact;
3. Identify and address suicide ideations, attempts, and contagions among AI/AN populations through the development and implementation of culturally appropriate and community relevant prevention, intervention, and postvention strategies;
4. Identify and address substance use among AI/AN populations through the development and implementation of culturally appropriate and community relevant prevention, treatment, and aftercare strategies;
5. Increase provider and community education on suicide and methamphetamine use by offering appropriate trainings; and
6. Promote positive AI/AN youth development and family engagement through the implementation of early intervention strategies to reduce risk factors for suicidal behavior and substance use.

SASP projects were awarded funding in at least one of four purpose areas and work to address the corresponding SASP goal listed above. SASP Purpose Areas are:

1. Community Needs Assessment and Strategic Planning;
2. Suicide Prevention, Intervention, and Postvention;
3. Substance Use Prevention, Treatment, and Aftercare; and
4. Generation Indigenous (Gen-I) Support.

Of the projects funded, 19 projects specifically focus on substance use prevention, treatment, and aftercare, while 108 focus on substance use and suicide prevention among Native youth. IHS established the Universal Alcohol Screening (UAS) as a national measure to increase screening and improve detection and intervention strategies among patients' ages 9 through 75 years of age. In FY 2019, 40.7 percent of eligible patients were screened for risky alcohol use, exceeding the IHS target of 37.0 percent.

The SASP program is currently in its fifth and final year of implementation. In the fourth year, 100 percent of projects submitted progress reports as a requirement of funding. Positive strides in the delivery of substance use services have been accomplished and reported in preliminary

data monitoring for SASP program activities. Successful outcomes during the fourth year of the program include expanded behavioral health services offered through school settings and home visiting with a total of 3,757 patients receiving care. Over 240 providers were trained in behavioral health integration with 133 of those providers located within a primary care setting. Project accomplishments include 79,803 individuals screen for suicide ideation, 64 percent of the SASP program suicide prevention projects implemented an enhanced process for suicide screening, and over 16,500 community members have been trained in suicide and/or substance use prevention. Sixty three percent of projects hosted a successful prevention education community event, and 59 percent reported their trainings to have expanded staff knowledge (a 12 percent increase from year 2). Seventy one percent reported implementation and documentation of a system change. In addition, among projects supported, a total of 10,595 individuals received cultural services, a high percentage of projects have continued to offer integrated traditional healing into care, extended service hours, provision of follow-up care, new counseling and case management services. In summary, the SASP program continues to support tribes, tribal organizations, urban Indian organizations, and federal facilities offering care.

Preventing Alcohol-Related Deaths (PARD): In the 2017 Senate Appropriations Committee Report 114-281, the Committee directed IHS to "allocate $2,000,000 of the increase provided for the alcohol and substance abuse program to fund essential detoxification and related services." Specifically, in the report the number of alcohol related deaths in the community of Gallup, New Mexico was addressed with the report stating, "these deaths underscore the urgent need for substance abuse treatment, residential services and detoxification services" in this community. In response, the IHS used the increased appropriated funds provided to address this urgent need in the city of Gallup, New Mexico. In addition to Gallup, New Mexico, IHS was aware of the urgent need for alcohol detoxification services in the Great Plains Area after the removal of liquor licenses in White Clay, Nebraska, leading to the potential for increased mortality if services were unavailable for alcohol detoxification. As a result, funds were also made available to address this urgent need. The funds provided to Gallup, New Mexico and the Great Plains Area (specifically the Oglala Sioux Tribe) to address the need for social detox services were made available in FY 2017 through a competitive cooperative agreement. The funding announcement was released in FY 2017 and two projects were selected and funded. The project period is for 5 years and will run from September 15, 2017, to September 14, 2022. With the additional funding, the Gallup NM site reported detoxification services to 9,482 unique individuals with over 75 percent of those clients including males. In addition to services offered for monitoring, supervising and managing detoxification, this site has increased coordination and transportation with the Emergency Department; and established a contract with the Gallup Police Department to transport patients to the detoxification center. The Great Plains' site has used the funding to increase coordination with behavioral health programs, provide screenings and brief interventions to individuals incarcerated in jails, and serve as an immediate placement for individuals who are in need of treatment services following detoxification. In FY2019, the Great Plains' site completed diagnostic alcohol and substance abuse assessments for nearly 1,000 individuals with an estimated 58 percent of those individuals connected to an appropriate level of care for follow-up.

YRTC Aftercare Pilot Project: In December 2017, IHS utilized $1.8 million to implement a pilot project for aftercare services for Native youth discharged from residential substance abuse treatment. The Project focus is to identify appropriate aftercare services that can be culturally adapted to support AI/AN youth in their recovery journey once they leave YRTC care. Two YRTCs, Desert Sage and Healing Lodge of the Seven Nations, were selected and to develop approaches to aftercare, recovery, and other support services for Native youth that can be used across other IHS and tribal YRTCs. These facilities are tasked with implementing best practices

around effective reintegration processes while establishing a collaborative partnership community-based approach to reduce substance use relapse. With the additional funding the two YRTCs have engaged tribal and urban programs that refer adolescents to the YRTCs, to identify best practices for aftercare. This has resulted in improved coordination around aftercare and case management, increased training of community supports for the adolescents, improved identification of transitional living, increased awareness of the use of social media, and improved follow-up with data collection after discharge.

FUNDING HISTORY

Fiscal Year	Amount	SASP	Gen I
2017	$218,353,000	($15,475,000)	($10,000,000)
2018	$224,188,000	($15,475,000)	($16,500,000)
2019	$234,421,000	($15,475,000)	($16,500,000)
2020 Enacted	$245,306,000	($15,475,000)	($16,500,000)
2021 President's Budget	$235,745,000	($15,475,000)	($16,500,000)

TRIBAL SHARES

Alcohol and Substance Abuse funds are subject to tribal shares and are transferred to tribes when they assume the responsibility for operating the associated programs, functions, services, and activities. A portion of the overall Alcohol and Substance Abuse budget line is reserved for inherently federal functions and is therefore retained by the IHS to perform the basic operational services of the Agency.

BUDGET REQUEST

The FY 2021 budget submission for Alcohol and Substance Abuse is $235.7 million, which is $9.9 million below the FY 2020 Enacted level.

FY 2020 Base Funding of $245.6 million – This funding will maintain the program's progress in addressing alcohol and substance abuse needs by improving access to behavioral health services through tele-behavioral health efforts and providing a comprehensive array of preventive, educational, and treatment services.

FY 2021 Funding Decrease of $9.9 million includes:

- Current Services +$2.3 million for current services including:
    - Inflation +$2.3 million – to fund inflationary costs of providing health care services.

- Staffing for New Facilities +$586,000 - These funds will support staffing and operating costs for new and replacement projects listed below. Funding for new/renovated facilities allows IHS to expand provision of health care in those areas where capacity has been expanded to address health care needs. The following table displays this request.

New Facilities	Amount	FTE/Tribal Positions
Yukon-Kuskokwim Primary Care Center (JV), Bethel, AK	$299,000	2
Naytahwaush Health Center (JV), Naytahwaush, MN	$209,000	2

Ysleta Del Sur Health Center (JV), El Paso, TX	$78,000	0
Grand Total:	**$586,000**	**4**

- Program Adjustment -$12.8 million - to maximize funding for direct patient care services.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2020 Target	FY 2021 Target	FY 2021 Target +/-FY 2020 Target
10 YRTC Improvement/Accreditation: Accreditation rate for Youth Regional Treatment Centers (in operation 18 months or more). (Outcome)	FY 2019: 100 % Target: 100 % (Target Met)	100 %	100 %	Maintain
80 Universal Alcohol Screening (Outcome)	FY 2019: 40.7 % Target: 37.0 % (Target Exceeded)	42.4 %	39.0%	-3.4%
82 Screening, Brief Intervention, and Referral to Treatment (SBIRT) (Outcome)	FY 2019: 14.9 % Target: 8.9 % (Target Exceeded)	12.2 %	14.3%	+2.1%

GRANTS AWARDS

(whole dollars)	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Number of Awards	143	178	178
Average Award	$150,000	$150,000	$150,000
Range of Awards	$150,000	$150,000	$150,000

AREA ALLOCATION

Alcohol and Substance Abuse

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2019 Final 1/			FY 2020 Estimated			FY 2021 Estimated			FY'21 +/- FY'20
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$600	$34,694	$35,294	$629	$36,349	$36,978	$604	$34,890	$35,494	-$1,484
Albuquerque	2,831	10,318	13,149	2,966	10,810	13,776	2,847	10,376	13,224	-$553
Bemidji	1,802	9,080	10,882	1,888	9,513	11,401	1,812	9,131	10,943	-$458
Billings	481	11,684	12,165	504	12,242	12,745	484	11,750	12,234	-$512
California	3,188	15,085	18,272	3,340	15,804	19,144	3,206	15,170	18,376	-$768
Great Plains	3,612	11,487	15,099	3,785	12,035	15,820	3,633	11,552	15,185	-$635
Nashville	2,940	6,804	9,744	3,080	7,128	10,209	2,957	6,842	9,799	-$410
Navajo	1,636	19,769	21,405	1,714	20,712	22,426	1,646	19,881	21,526	-$900
Oklahoma	4,186	13,371	17,556	4,385	14,008	18,394	4,209	13,446	17,655	-$738
Phoenix	6,937	11,542	18,479	7,268	12,092	19,360	6,976	11,607	18,583	-$777
Portland	1,952	15,710	17,662	2,045	16,460	18,505	1,963	15,799	17,762	-$743
Tucson	51	3,379	3,430	53	3,541	3,594	51	3,399	3,449	-$144
Headquarters	41,282	0	41,282	43,251	0	43,251	41,515	0	41,515	-$1,736
Total, ASA	**$71,499**	**$162,922**	**$234,421**	**$74,909**	**$170,694**	**$245,603**	**$71,903**	**$163,842**	**$235,745**	**-$9,858**

1/ Reflects Services account adjustments related to formal reprogramming notifications submitted to Congress in FY 2019. Amounts by "Sub IHS Activity" will continue to be adjusted during the period of availability, which conclude on September 30, 2020, for impacted funds.

Note: FY 2020 through 2021 are estimates.

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

(Dollars in thousands)

	FY 2019[1]	FY 2020	FY 2021	
	Final	Enacted	President's Budget	FY 2021 +/- FY 2020
BA	$964,819	$964,819	$964,783	-$36
FTE*	0	0	0	0

* PRC Funds are not used for Federal or Tribal Staff

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

FY 2020 Authorization.....Permanent

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

PROGRAM DESCRIPTION

The Snyder Act provides the formal legislative authority for the expenditure of funds for the "relief of distress and conservation of health of Indians."[2] In 1934, Congress provided the specific authority to enter into medical services contracts for American Indians and Alaska Natives.[3] These, among other authorities[4] established the basis for the Indian Health Service (IHS) and the Purchased/Referred Care (PRC) Program.[5]

The PRC Program is integral to ensure comprehensive health care services are available and accessible to eligible American Indians and Alaska Natives (AI/AN) (IHS Strategic Plan Goal 1). The Indian health system delivers care through direct care services provided in an IHS, Tribal or Urban Indian Health Program (I/T/U) facility (e.g., hospitals, clinics) and through PRC services delivered by non-IHS providers to increase access to quality health care services (IHS Strategic Plan 1.3). The general purpose of the PRC Program is for IHS or Tribal facilities to purchase services from private health care providers in situations where:

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

[1] Reflects Services account adjustments related to formal reprogramming notifications submitted to Congress in FY 2019. Amounts by "Sub IHS Activity" will continue to be adjusted during the period of availability, which conclude on September 30, 2020, for impacted funds.

[2] The Snyder Act, Public Law 67-85, November 2, 1921, 25 U.S.C § 13.

[3] The Johnson O'Malley Act of April 16, 1934, as amended, 25 U.S.C. § 452.

[4] Transfer Act, 42 U.S.C. § 2001; Indian Health Care Improvement Act, as amended, 25 U.S.C § 1601, et seq.

[5] The Consolidated Appropriation Act of 2014, Public Law 113-76, January 18, 2014, adopted a new name for the IHS Contract Health Services (CHS) program to Purchased/Referred Care (PRC). The IHS will administer PRC in accordance with all law applicable to CHS.

In addition to meeting the eligibility requirements for direct services at an IHS or Tribal facility, PRC eligibility is determined based on residency within the service unit or Tribal PRC delivery Area; authorization of payment for each recommended medical service by a PRC authorizing official; medical necessity of the service and inclusion within the established Area IHS/Tribal medical/dental priorities; and full expenditure of all alternate resources (i.e., Medicare, Medicaid, private insurance, state or other health programs, etc.). Alternate resources must pay for services first because the IHS PRC Program is the payer of last resort.[6] Services purchased may include hospital, specialty physician, outpatient, and laboratory, dental, radiological, pharmaceutical, or transportation services. When funds are not sufficient to purchase the volume of PRC services needed by the eligible population residing in the PRC delivery area of the local facility, IHS PRC regulations require IHS or Tribal PRC programs to use a medical priority system to fund the most urgent referrals first.

Medical priority (MP) levels of care are defined as follows:

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

A PRC rate, a capitated rate based on Medicare payment methodology, is used to purchase care, and Medicare participating hospitals are required to accept this rate as payment in full for all hospital-based health care services (Public Law 108-173). This allows IHS to purchase care at a lower cost than if each service were negotiated individually increasing access to quality health care services and provide care to better meet the health care needs of AI/ANs (*IHS Strategic Plan 1.3.4 – Increase access to quality community, direct, specialty, long-term care and support services, and referred health care services and identify barriers to care for AI/AN stakeholders*). Physician and non-hospital providers of supplies and services are purchased at the PRC rate. However, if a physician or non-hospital provider does not accept the PRC capitated rate, agreements or contracts can be negotiated with individual providers of supplies or services using the provider's most favored customer rate as a ceiling for negotiation (42 CFR 136 Subpart I) (*IHS Strategic Plan 3.2.7 – Develop policies, use tools, and apply models that ensure efficient use of assets and resources*). Program funds are administered and managed at IHS Headquarters, at each of the 12 IHS Areas, and at IHS and Tribal facilities across the nation. The regulation has demonstrated that IHS is able to stretch the same amount of money to cover additional necessary health care services and improve access to care. This meets *the IHS Strategic Plan Goal 1: To ensure that comprehensive culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people. Objective 1.3 Increase access to quality health care services.*

The PRC Program also administers the Catastrophic Health Emergency Fund (CHEF). Created in 1988, the CHEF was established for the sole purpose of meeting extraordinary medical costs associated with treatment of victims of disasters or catastrophic illnesses.[7]The CHEF is used to reimburse PRC programs for high cost cases (e.g., burn victims, motor vehicle crashes, high risk obstetrics, cardiology, etc.) after a threshold payment amount is met, the current threshold is $25,000. The CHEF is centrally managed at IHS Headquarters.

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

[7]25 U.S.C. § 1621a

The PRC Program contracts with a fiscal intermediary (FI), currently Blue Cross/Blue Shield of New Mexico, to ensure payments are made in accordance with IHS' payment policy, and coordinate benefits with other payers to maximize PRC resources.(*IHS Strategic Plan 3.2.7 – Develop policies, use tools, and apply models that ensure efficient use of assets and resources*) All IHS-managed PRC programs and some tribally-managed PRC programs use the FI to ensure the use of PRC rates for inpatient services and PRC or negotiated rates for physician and non-hospital providers of supplies and services.

PRC funding provides critical access to essential health care services and remains a top request by Tribes in the budget formulation recommendations. (*IHS Strategic Plan 1.3 Increase access to quality health care services)*

Note: On February 28, 2019, IHS updated the *Indian Health Manual,* Part 2, Services to Indians and Others, Chapter 3, Purchased/Referred Care. In this IHM update IHS adopted the policy that PRC funds may be used for staff administrating the PRC program at administrative levels. This adopts the GAO recommendation for the use of PRC funds for PRC staff where appropriate. This policy change requires Areas to ensure they are funding requests through Priority Level II before these PRC administrative expenses can be charged. This policy meets the (*IHS Strategic Plan 1.1 Recruit, develop, and retain a dedicated, competent, and caring workforce.)*

PROGRAM ACCOMPLISHMENTS

Purchased/Referred Care (PRC) Rates – The PRC rates for all hospital-based services implemented in 2007 and the PRC rates for physicians and non-hospital providers of supplies and services implemented in 2016 have increased access to care by allowing I/T/Us to purchase additional services with these Medicare methodology capitated rates, referred to as PRC rates. PRC rates were originally referred to as Medicare-like rates (MLR) for hospital based services but are now identified as PRC rates. PRC rates are based on the Medicare payment methodology for all hospital based services, physician and non-hospital providers of supplies and services. The PRC rates rule (42 CFR 136 Subpart I) for physicians and non-hospital providers of supplies and services applies to I/T/Us but only to the extent the tribally-operated PRC programs agree to "opt-in" via its Indian Self Determination and Education Assistance Act contract or compact. The rule has flexibility that allows PRC programs to negotiate rates that are higher than the PRC rate based on Medicare methodology, but equal to or less than the rates accepted by the provider or supplier's most favored customer rate; in the absence of Medicare payment methodology for a service, the IHS payment amount is calculated at 65 percent of billed charges from the provider or supplier.

Medical Priorities – Recent PRC program increase in purchasing power through the PRC rates described above have allowed most of the IHS and Tribally-managed PRC programs to approve referrals in priority categories other than Medical Priority I (life or limb), including some preventive care services, thus increasing access to patient care services. In FY 2019, 90 percent of IHS-operated PRC programs were able to purchase services beyond Medical Priority I – Emergent or Acutely Urgent Care Services. Prior funding increases and Medicaid expansion have enabled programs to purchase preventive care beyond emergency care services, such as mammograms or colonoscopies.

The IHS PRC Workgroup helped IHS develop a more accurate form for annually reporting denied and deferred PRC services. In FY 2019, PRC programs denied and deferred an estimated $615,982,865 for an estimated 155,842 services for eligible AI/ANs. Because Tribally-managed programs are not required to report denials data, it is difficult to provide a verifiable and complete measure of the total unmet need for the entire I/T/U system. Therefore, the denied services estimate is based on actual data from federal programs and estimated Tribal data.

Catastrophic Health Emergency Fund (CHEF) – In FY 2019, all high cost cases submitted for reimbursement from the CHEF have been reimbursed. It is estimated that more cases may qualify for CHEF reimbursement but were not reported by local IHS and Tribally-managed PRC programs. Catastrophic case requests are reimbursed from the CHEF until funds are depleted. The implementation of PRC rates for inpatient and non-hospital providers of supplies and services as well as the increase of I/T/U beneficiaries enrolled in Medicaid, Medicare and Private Insurance has enabled the CHEF to reimburse PRC programs for high cost catastrophic events and illnesses that occur through the end of the fiscal year.

FUNDING HISTORY

Fiscal Year	PRC	CHEF	Total
2017	$875,830,000	$53,000,000	$928,830,000
2018	$909,695,000	$53,000,000	$962,695,000
2019	$911,819,000	$53,000,000	$964,819,000
2020 Enacted	$911,819,000	$53,000,000	$964,819,000
2021 President's Budget	$911,783,000	$53,000,000	$964,783,000

TRIBAL SHARES

Purchased and Referred Care funds are subject to tribal shares and are transferred to Tribes when they assume the responsibility for operating the associated programs, functions, services, and activities. The CHEF management is inherently federal and no part of CHEF or its administration can be subject to contract or grant under any law, including the Indian Self-Determination and Education Assistance Act. CHEF fund cannot be allocated, apportioned, or delegated on an Area Office, Service Unit or other similar basis (25 U.S.C. 1621(a)(c)).

BUDGET REQUEST

The FY 2021 budget submission for Purchased/Referred Care is $964.8 million, which is $36,000 below the FY 2020 Enacted level.

The FY 2020 Enacted base funding will provide for the following approximate services:

- 40,573 Inpatient admissions
- 942,316 Outpatient visits
- 45,320 Patient travel trips

The FY 2021 Funding decrease of $36,000 will provide for the following estimated decreased services:

- 2 Inpatient admissions
- 35 Outpatient visits
- 2 Patient travel trips

FY 2021 overall funding decrease of $36,000 includes:

Current Services +$9.8 million for current services

- Inflation +$9.8 million - to fund inflationary costs of providing health care services.

New Tribe +$2.6 million: to fund the delivery of health care services for the newly federally recognized Little Shell Tribe of Chippewa of Montana, recognized in the National Defense Authorization Act for Fiscal Year 2020.

Program Adjustment -$12.4 million- to maximize funding for additional direct patient care services.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2020 Target	FY 2021 Target	FY 2021 Target +/-FY 2020 Target
PRC-2 Track IHS PRC referrals (Outcome)	FY 2019: 68.0 days Target: 60.0 days (Target not met)	60.0 days	60.0 days	Maintain
PRC-3 Track PRC self-referrals (Outcome)	FY 2019: 58.0 days Target: 45.0 days (Target not met)	45.0 days	45.0 days	Maintain

GRANT AWARDS. This program does not fund grant awards.

AREA ALLOCATION

Purchased/Referred Care

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2019 Final 1/			FY 2020 Estimated			FY 2021 Estimated			FY'21 +/- FY'20
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$0	$97,908	$97,908	$0	$97,908	$97,908	$0	$97,904	$97,904	-$4
Albuquerque	27,594	18,247	45,841	27,594	18,247	45,841	27,593	18,247	45,840	-$2
Bemidji	14,223	53,018	67,241	14,223	53,018	67,241	14,223	53,016	67,238	-$3
Billings	44,838	20,713	65,551	44,838	20,713	65,551	44,836	20,712	65,549	-$2
California	745	54,073	54,818	745	54,073	54,818	745	54,071	54,816	-$2
Great Plains	69,079	22,926	92,005	69,079	22,926	92,005	69,076	22,925	92,001	-$3
Nashville	6,314	33,971	40,285	6,314	33,971	40,285	6,314	33,970	40,284	-$2
Navajo	59,259	44,599	103,859	59,259	44,599	103,859	59,257	44,598	103,855	-$4
Oklahoma	47,088	73,451	120,540	47,088	73,451	120,540	47,087	73,449	120,535	-$4
Phoenix	45,512	32,054	77,566	45,512	32,054	77,566	45,511	32,053	77,563	-$3
Portland	13,544	91,698	105,242	13,544	91,698	105,242	13,543	91,695	105,238	-$4
Tucson	287	20,796	21,083	287	20,796	21,083	287	20,795	21,082	-$1
Headquarters	72,880	0	72,880	72,880	0	72,880	72,877	0	72,877	-$3
Total, PRC	**$401,365**	**$563,454**	**$964,819**	**$401,365**	**$563,454**	**$964,819**	**$401,350**	**$563,433**	**$964,783**	**-$36**

1/ Reflects Services account adjustments related to formal reprogramming notifications submitted to Congress in FY 2019. Amounts by "Sub IHS Activity" will continue to be adjusted during the period of availability, which conclude on September 30, 2020, for impacted funds.

Note: FY 2020 through 2021 are estimates.

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

(Dollars in Thousands)

	FY 2019[1]	FY 2020	FY 2021	
	Final	Enacted	President's Budget	FY 2021 +/- FY 2020
BA	$169,723	$177,567	$141,627	-$35,940
FTE*	222	222	228	+6

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

SUMMARY OF THE BUDGET REQUEST

The FY 2021 Indian Health Service (IHS) Budget submission for Preventive Services is $141.6 million, which is $36.0 million below the FY 2020 Enacted level. Included in this budget is funding of $2.2 million for Staffing of New and Replacement Healthcare Facilities, funding of $736,000 for Current Services, and the new line item of Community Health, incorporating Community Health Representatives, Health Education, and Community Health Aide Program.

The detailed explanation of the request is described in each of the budget narratives that follow:

- **Public Health Nursing** (PHN) to support prevention-focused nursing care interventions for individuals, families, and community groups as well as improving health status by early detection through screening and disease case management. The PHN Program home visiting service provides primary, secondary, and tertiary prevention focused health interventions.

- **Health Education** will be incorporated into the new Community Health budget line item, and will continue to support the provision of community health, school health, worksite health promotion, and patient education.

- **Community Health Representatives** (CHRs) will be incorporated into the new Community Health budget line item, and will continue to help bridge the gap between AI/AN individuals and health care resources through outreach by specially trained indigenous community members.

- **Community Health**, a new budget line item, which will include the Community Health Aide Program (CHAP), the Community Health Representatives (CHR) program, and the Health Education (HE) program. Merging funding for these programs increases flexibility for community health programs that are primarily administered by tribes and is requested in response to tribal input.

- **Hepatitis B and Haemophilus Immunization Programs (Alaska)** will support the provision of vaccines for preventable diseases, immunization consultation/education,

[1] Reflects Services account adjustments related to formal reprogramming notifications submitted to Congress in FY 2019. Amounts by "Sub IHS Activity" will continue to be adjusted during the period of availability, which conclude on September 30, 2020, for impacted funds.

research, and liver disease treatment and management through direct patient care, surveillance, and education for Tribal facilities throughout Alaska. The Immunization Alaska Program budget supports these priorities through direct patient care, surveillance, and educating Alaska Native patients.

These Preventive Health services contribute widely to the performance measures that fall under the auspices of Hospitals & Health Clinics.

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

(Dollars in Thousands)

	FY 2019[1]	FY 2020	FY 2021	
	Final	Enacted	President's Budget	FY 2021 +/- FY 2020
BA	$86,354	$91,894	$95,353	+$3,369
FTE*	201	201	201	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 2021 Authorization.....Permanent

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

PROGRAM DESCRIPTION

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

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

The PHN program aligns with the *IHS Strategic Plan FY 2019-2023 Goal 1 to ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to AI/AN people by increasing access to quality health care services (Goal 1, objective 1.3).* The PHN Program funds provide critical support for direct health care services in the community which improve Americans' access to health care and expand choices of care and service *options (The HHS Strategic Plan FY 2018-2022, Goal 1: Reform, Strengthen, and*

[1] Reflects Services account adjustments related to formal reprogramming notifications submitted to Congress in FY 2019. Amounts by "Sub IHS Activity" will continue to be adjusted during the period of availability, which conclude on September 30, 2020, for impacted funds.

Modernize the Nation's Health Care System, objective 1.3). PHNs support population-focused services to promote healthier communities through community based direct nursing services, community development, and health promotion and disease prevention activities. PHNs are licensed, professional nursing staff available to improve care transitions by providing patients with tools and support that promote knowledge and self-management of their condition as they transition from the hospital to home. The PHN expertise in communicable disease assessment, outreach, investigation, and, surveillance helps to manage and prevent the spread of communicable diseases. PHNs contribute to several agency's primary prevention efforts such as providing community immunization clinics, administering immunizations to homebound AI/AN individuals, and through public health education, inspiring AI/AN people to engage in healthy lifestyles and ultimately live longer lives. PHNs conduct nurse home visiting services via referral for such activities as follows:

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

PHNs perform a community assessment to identify high-risk populations and implement evidenced based interventions to address identified areas of need. This activity targets fragmentation in patient care services and improves care continuums, including patient safety. Interventions are monitored with data collection and evaluated for outcome with an emphasis on producing a good return on investments in terms of service(s) provided.

PROGRAM ACCOMPLISHMENTS

The PHN Program aligns with the Agency's priorities and contributes to patient care coordination activities and access to quality, culturally competent care that aims to promote health and quality of life through a community population focused nurse visiting program which serves the patient and family in the home and in the community *(IHS Strategic Plan FY 2019-2023, Goal 1, Objective 1.3)*. The PHN Program assesses the services provided in meeting the agency's priority Government Performance and Results Act (GPRA) measures and integrates the Department's Strategic Goal to protect the health of Americans where they live, learn, work, and *play (HHS Strategic Plan FY 2018-2022, Goal 2, Objective 2.1, to empower people to make informed choices for healthier living). Using a variety of methods to educate the AI/AN population such as via individual and group patient education sessions, screening activities and referring high-risk patients, and immunizing individuals to prevent illnesses*, the PHN works to improve the overall wellness of Americans. Preventative health care informs populations, promotes healthy lifestyles and provides early treatment for illnesses. The PHN Data Mart report for GPRA year 2018 reflects a total number of individual PHN patient related encounters was 329,980; PHN accomplishments in GPRA screening documented activities include the following encounter numbers:

- Tobacco Screening (4,065)
- Domestic Violence Screening (11,111)
- Depression Screening (12,359)
- Alcohol Screening (12,728)
- Adult Influenza Vaccines (40,487)

In 2019, the PHN Program continued efforts to meet the IHS's goal to decrease childhood obesity and prevent diabetes by supporting Baby Friendly re-designation by accomplishing the following

activities: providing patient education, assessment and referral services for prenatal, postpartum and newborn clients during home visits, and utilizing a standardized PHN electronic health record template to document intervention *(IHS Strategic Plan FY 2019-2023, Goal 2 to promote excellence and quality through innovation of the Indian health system into an optimally performing organization, Objective 2.2: provide care to better meet the health care needs of AI/AN communities)*. The PHN data mart provides a mechanism to evaluate how the PHN program delivers this evidence-based prevention service of promoting breastfeeding during the nurse patient encounter. For GPRA year 2018, there were a total of 12,111 PHN patient encounters related to the Baby Friendly Hospital Initiative. These patient encounters included 29,065 documented patient education topics provided by the PHN during prenatal, postpartum and newborn encounters, which included the following topics: breastfeeding, child health for the newborn, immunizations, family planning, sudden infant death syndrome, tobacco use/prevention, postpartum depression, formula feeding, and child health. As part of this initiative, IHS is encouraging clinicians in Indian Country to support policies and practices that foster breastfeeding as the exclusive feeding choice for infants during their first six months of life. By doing so, clinicians will reduce current and future medical problems and decrease health care costs. In 2019, the Clinton PHN Program, Clinton, OK, initiated a PHN best practice project to promote breastfeeding. The Clinton PHNs are addressing access to care by seeking lactation certification to support breastfeeding education services to patients in various settings including the home. They are now completing 90 hours of lactation management courses (60 hours of online education followed by 32 hours of classroom) to become International Board Certified Lactation Consultants (IBCLCs) specializing in breastfeeding management. The goal is to ensure that all Clinton PHNs be IBCLC certified by October 2020.

To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to AI/AN people by increasing access to quality health care services *(IHS Strategic Plan FY 2019-2023, Goal 1)*, the PHN Program continues to support caregivers of individuals suffering from dementia. Caregivers supported by the PHN program includes screening for depression, the effect of depression on daily life, and caregiver burden and frustration. For GRPA year 2018, there have been 5,146 PHN encounters to patients with dementia, and services provided at these PHN encounters include the following:

- Immunizations (847)
- Medications (846)
- Life adaptation (371)
- Safety and fall prevention (484)

During these visits, a total of 12,363 patient education topics were documented by the PHN and included the following: medication, repeat prescription, wound dressing, long term drug therapy, opioid dependence, and vitamin deficiency. The goal to implement these service in 50 Tribal communities by 2018 was met in December 2017 and resulted in this service being available in 52 communities. Future efforts to adapt this intervention to deliver and sustain the program in AI/AN communities is ongoing.

The Pine Ridge PHN Mental Health Case Management Program was established to focus on suicide prevention in the local community during 2016 to 2018. This intervention serves as a best practice for improved health outcomes of high risk patients through a community case management model that utilized the PHN as a case manager. In FY 2018 the program billed for this service, leveraging revenue to support services in the community; served to supplement data collection reports on the PHN data mart to report outcome; and, in FY 2019 collaborated to establish similar services at the Standing Rock Service Unit PHN Program. During FY 2019-2020, this activity will be shared as a best practice resource for the PHN grant program for tribal and urban grant recipients *(IHS Strategic Plan FY 2019-2023, Goal 3, Objective 3.2)*.

In support of the Million Hearts campaign to prevent heart attacks and strokes, PHNs provided 35,561 patient encounters in the 2018 GPRA year that encompassed patient education on tobacco cessation at 4,464, hypertension at 28,113, and sodium reduction at 3,002. Additional education provided during these PHN encounters include tobacco use, immunizations, diabetes, and medications.

PHNs provide services to enhance quality care and support patient safety during transitions of care settings by follow up on hospital discharges in an effort to decrease hospital readmissions. In 2018 GPRA year, PHNs documented 67,184 patient encounters with patients who were discharged from the hospital and provided a total of 12,498 follow-up visits; some of these patients had multiple post discharge follow-up visits. Top patient education topics provided during these encounters include immunizations, lifestyle adaptation and medication.

In FY 2019, the PHN Program aligned efforts to integrate Relationship Based Care (RBC) as a means of improving quality care and meeting the needs of the AI/AN population *(IHS Strategic Plan FY 2019-2023, Goal 2, Objective 2.2)*. To build, strengthen, and sustain collaborative relationships, RBC is linked to the 2019-2023 IHS Strategic Plan which is to ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to the AI/AN people. Investing in a transformation of the program's culture will promote cost-savings with decreased cost burden of staff turnover and labor relations issues. RBC promotes a healing culture in organizations by focusing on three key relationships: the relationship with self, with the care team, and with patients and families. The PHN program coordinated efforts to support RBC leadership practicum training in August 2019 by hosting PHN attendance at this centralized opportunity. In addition, to support staff retention and staff development, an evidenced based preceptorship program with proven training materials, preceptor development, and an evidenced based repository of training material will be implemented in 2020. The Vermont Nurses in Partnership activity will be available to establish evidence-based transition programs, competence validation, and experiential learning for the PHNs. Beginning in 2020 training on a comprehensive Clinical Transition Framework will support this activity.

The PHN program continues to review the delivery of service for safe and quality standards of various accrediting bodies. This activity will focus on the Joint Commission to define the PHN services as an integrated IHS service for review and continued efforts to host webinars to share practices on safe and quality care with a focus on the Accreditation Association for Ambulatory Health Care survey. This activity will continue into FY 2020 to promote quality PHN services are provided in a safe manner. As the primary care system is foundational to achieving high-quality, accessible, efficient health care for AI/AN clients, expanded PHN engagement will be made to support the patient-centered medical home (PCMH) efforts to enhance quality care. PHN programs will engage in FY 2019-2020 efforts to meet the IHS national target of one hundred percent of IHS ambulatory care facilities achieving PCMH by 2021.

In 2019, the PHN program continued identification of interventions which targeted prevention of sexually transmitted diseases (STD) to improve quality care. In collaboration with the IHS STD Consultant (Office of the Public Health Service), this activity was monitored with the use of the PHN data mart tool as a performance measurement in support of practicing population based health management. The PHN data mart provides critical support in assessing improvement activities such as the provision of patient education, and the surveillance and treatment of STDs. In 2020 PHN support of the Elimination of Hepatitis C and HIV/AIDS in Indian Country

Initiative will be developed, and the data mart will be used to monitor prevention and treatment activities provided by PHNs.

In FY 2017, the PHN grant program awarded 9 grants; these awards have a narrow and defined area of focus, seeking to improve specific behavioral health outcomes and to support the efforts of AI/AN communities toward achieving excellence in holistic behavioral health treatment, rehabilitation, and prevention services for individuals and their *families (IHS Strategic Plan FY 2019-2023, Goal 3, Objective 3.2)*. The purpose of this IHS PHN grant is to improve specific behavioral health outcomes through a case management model with the PHN as a case manager. In addition to reducing the cost of health care, case management has worth in terms of improving rehabilitation, improving quality of life, increasing client satisfaction and compliance by promoting client self-determination. The community based case management model addresses the PHN scope of practice of working with individuals and families in a population-based practice to provide nursing care services in the community setting. Currently, there are only 8 grant programs which are focusing on patient care services for behavioral health and coexisting conditions such as chronic disease management, maternal child health care, and medication patient education services. A PHN Consultant is being hired to oversee the PHN grant program particularly to provide technical assistance and share best practice for replication. In 2019, the program increased home visits for behavioral health follow up and increased coordination and collaboration with the local Behavioral Health Department to improve overall patient services.

The FY 2018 target for the PHN Program measure was 381,314 encounters. The final result of 329,980 encounters did not meet the target by 51,334 encounters, a 13 percent decrease. Data exporting processes have impacted the overall PHN performance outcome as several tribal programs have migrated away from the IHS Patient Management System (RPMS) resulting in less visits being exported to the agency's National Data Warehouse database. The end result has been a decrease in the number of PHN activities being reported. In FY 2018, additional PHN data briefs are being created and posted on the PHN data mart to reflect the PHN activity in meeting several Agency goals (such as decreasing STI rates, childhood immunizations) and to supplement the PHN program's accomplishments report. These reports provide an avenue to monitor the PHN program's support of the health care delivery services in the community, and provides available data to inform I/T/U decision-making (IHS Strategic Plan FY 2019-2023, Goal 3, Objective 3.3). In FY 2019 and continuing into 2020, the PHN Documentation Manual is being updated to include PHN electronic health record templates and information on the PHN data mart reports to improve reporting of outcome.

FUNDING HISTORY

Fiscal Year	Amount
2017	$78,701,000
2018	$84,043,000
2019	$86,354,000
2020 Enacted	$91,984,000
2021 President's Budget	$95,353,000

TRIBAL SHARES

Public Health Nursing funds are subject to tribal shares and are transferred to Tribes when they assume the responsibility for operating the associated programs, functions, services, and activities. A portion of the overall Public Health Nursing budget line is reserved for inherently

federal functions and is therefore retained by the IHS to perform the basic operational services of the Agency.

BUDGET REQUEST

The FY 2021 budget submission for Public Health Nursing $95.4 million, which is $3.4 million above the FY 2020 Enacted level.

FY 2020 Base Funding of $92.0 million – This funding will support the public health nursing services provided by IHS and Tribal programs, maintain the programs progress in raising the quality of and access to public health nursing care through continuing recruitment of nursing professionals to meet workforce needs, and to meet or exceed agency targets.

FY 2021 Funding Increase of $3.4 million includes:

- Current Services: +$713,000 million for current services includes:
    - Inflation +$713,000 to fund inflationary costs of providing health care services.
- Staffing for New Facilities +$2.0 million - These funds will support staffing and operating costs for new and replacement projects listed below. Funding for new/renovated facilities allows IHS to expand provision of health care in those areas where capacity has been expanded to address health care needs. The following table displays this request.

New Facilities	Amount	FTE/Tribal Positions
Yukon-Kuskokwim Primary Care Center (JV), Bethel, AK	$1,317,000	7
Naytahwaush Health Center (JV), Naytahwaush, MN	$922,000	6
Yakutat Tlingit Health Center (JV), Yakutat, AK	$346,000	2
Ysleta Del Sur Health Center (JV), El Paso, TX	$350,000	2
Grand Total:	**$2,047,000**	**13**

- Program Adjustment +$609,000- to increase funding for direct patient care services, including public health nursing services.

OUTPUTS / OUTCOMES

Measure	**Year and Most Recent Result / Target for Recent Result / (Summary of Result)**	**FY 2020 Target**	**FY 2021 Target**	**FY 2021 Target +/-FY 2020 Target**
23 Public Health Nursing: Total number of public health activities captured by the PHN data system; emphasis on primary, secondary	FY 2018: 329,980 Target: 381,314 (Target Not Met)	381,314	330,000	-51,314

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2020 Target	FY 2021 Target	FY 2021 Target +/-FY 2020 Target
and tertiary prevention activities to individuals, families and community groups. (Outcome)				

GRANTS AWARDS

(whole dollars)	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Number of Awards	8	8	10
Average Award	$150,000	$150,000	$150,000
Range of Awards	$150,000	$150,000	$150,000

AREA ALLOCATION

Public Health Nursing

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2019 Final 1/			FY 2020 Estimated			FY 2021 Estimated			FY'21 +/- FY'20
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	135	$11,524	$11,658	$143	$12,275	$12,418	$149	$12,725	$12,873	$455
Albuquerque	1,877	1,743	3,621	2,000	1,857	3,857	2,073	1,925	3,998	$141
Bemidji	33	2,446	2,479	35	2,606	2,641	36	2,701	2,738	$97
Billings	1,746	2,804	4,550	1,860	2,987	4,847	1,928	3,096	5,024	$178
California	13,637	1,168	1,181	15	1,244	1,258	15	1,289	1,304	$46
Great Plains	4,916	5,104	10,020	5,237	5,436	10,673	5,429	5,635	11,064	$391
Nashville	428	1,776	2,204	456	1,892	2,348	472	1,961	2,434	$86
Navajo	8,856	7,897	16,753	9,434	8,412	17,846	9,779	8,720	18,499	$654
Oklahoma	3,640	12,973	16,613	3,877	13,819	17,696	4,019	14,325	18,344	$648
Phoenix	4,150	5,345	9,495	4,421	5,693	10,114	4,583	5,902	10,484	$370
Portland	637	2,634	3,271	678	2,806	3,484	703	2,908	3,612	$128
Tucson	17	1,148,490	1,166	18	1,223	1,242	19	1,268	1,287	$45
Headquarters	3,343	0	3,343	3,561	0	3,561	3,691	0	3,691	$130
Total, PHN	**$29,792**	**$56,562**	**$86,354**	**$31,734**	**$60,250**	**$91,984**	**$32,896**	**$62,457**	**$95,353**	**$3,369**

1/ Reflects Services account adjustments related to formal reprogramming notifications submitted to Congress in FY 2019. Amounts by "Sub IHS Activity" will continue to be adjusted during the period of availability, which conclude on September 30, 2020, for impacted funds.

Note: FY 2020 through 2021 are estimates.

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

(Dollars in Thousands)

	FY 2019[1]	FY 2020	FY 2021	
	Final	Enacted	President's Budget	FY 2021 +/- FY 2020 PB
BA	$0	$0	$44,109	+$44,109
FTE*	0	0	27	+27

* 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 2021 Authorization.....Permanent

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

PROGRAM DESCRIPTION

The Indian Health Service (IHS) proposes a new funding line item, Community Health, which will include the Community Health Aide Program (CHAP), the Community Health Representatives (CHR) program, and the Health Education (HE) program. Merging funding for these programs increases flexibility for community health programs that are primarily administered by Tribes and is requested in response to Tribal input. The new Community Health line aligns with the IHS Strategic Plan FY 2019-2023 by supporting the goals to ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native (AI/AN) people (IHS Strategic Plan Goal 1, Objective 1.1 *Recruit, develop, and retain a dedicated, competent, and caring workforce*, 1.2 *Build, strengthen, and sustain collaborative relationships*, & 1.3 *Increase access to quality health care services*; and Goal 2, Objective 2.1 *Create quality improvement capability at all levels of the organization* & 2.2 *Provide care to better meet the health care needs of American Indian and Alaska Native communities*). The collaborative approach also aligns with the HHS Strategic Plan FY 2018-2022 by expanding safe, high-quality healthcare options, and encouraging innovation and competition; improving Americans' access to healthcare and expanding choices of care and service options; and strengthening and expanding the healthcare workforce to meet America's diverse needs and increase access to quality healthcare services (Goal 1, Objective 1.2 *Expand safe, high-quality healthcare options, and encourage innovation and competition*, 1.3 *Improve Americans' access to healthcare and expand choices of care and service options,* & 1.4 *Strengthen and expand the healthcare workforce to meet America's diverse needs*).

The National CHAP will provide a network of health aides trained to support licensed health professionals while providing direct health care, health promotion, and disease prevention services. These providers work within a referral relationship under the supervision of licensed

[1] Reflects Services account adjustments related to formal reprogramming notifications submitted to Congress in FY 2019. Amounts by "Sub IHS Activity" will continue to be adjusted during the period of availability, which conclude on September 30, 2020, for impacted funds.

clinical providers that includes clinics, service units, and hospitals. The program will increase access to direct health services, including inpatient and outpatient visits. The funding level directly supports IHS's efforts to provide high quality health care across the Indian health system.

The CHAP has become a model for efficient and high quality health care delivery in rural Alaska providing approximately 300,000 patient encounters per year[2] and responding to emergencies twenty-four hours a day, seven days a week. Specialized providers in dental and behavioral health were later introduced to respond to the needs of patients and address the health disparities in oral health and mental health amongst American Indian and Alaska Natives.

The funding would allow for this community-based, culturally responsive, and efficient model of health care to be expanded nationally, to the contiguous 48 states to federal and Tribal facilities, consistent with the 2010 Indian Health Care Improvement Act (IHCIA) amendments, at 25 U.S.C. §§ 1616l(d)(l)-(3), which authorizes the HHS Secretary acting through the IHS to establish a national CHAP outside of Alaska.

The Community Health Representatives (CHRs) program began in 1968 and was established to meet the following four goals: (1) greater involvement of AI/AN people in their own health and in the identification and treatment of their health problems; (2) greater understanding between AI/AN people and IHS staff; (3) improving cross-cultural communication between the AI/AN community and health service providers; and, (4) increasing basic health care and instruction in AI/AN homes and communities. The CHR program supports the HHS Strategic Plan Goal 2, Objective 2.1 and 2.2 to *empower* CHR patients *to make informed choices for healthier living* through the *prevention, treatment, and control of communicable diseases and chronic conditions.*

Today, CHRs play a role in the health care delivery system to link the patient to the Indian health care system and are intended to prevent avoidable hospital readmissions and emergency department visits through home visits to patients with chronic health conditions such as asthma, diabetes, and hypertension. The aim of the CHR Program is to help AI/AN patients and communities achieve an optimal state of well-being by providing health promotion and disease prevention, wellness and injury prevention education, translation and interpretation, transportation to medical appointments, and delivery of medical supplies and equipment within their tribal community (IHS Strategic Plan, Goal 1, Objective 1.2 *Build, strengthen, and sustain collaborative relationships*, & 1.3 *Increase access to quality health care services*).

The Health Education Program has been in existence since 1955 to educate American Indian/Alaska Native (AI/AN) patients, school age children and communities about their health HHS Strategic Plan FY 2018-2022 Goal 3, Objective 3.3 *Support strong families and healthy marriage, and prepare children and youth for healthy, productive lives*). The program focuses on the importance of educating patients in a comprehensive, culturally appropriate manner that empowers them to make positive choices in their lifestyles and how they utilize health services (IHS Strategic Plan FY 2019-2023, Goal 1, Objective 1.2 *Build, strengthen, and sustain collaborative relationships*). Accreditation requirements at IHS and tribal facilities specifically require the provision and documentation of patient education as evidence of the delivery of quality care (IHS Strategic Plan FY 2019-2023, Goal 3, Objective 3.1 *Improve communication within the organization with Tribes, Urban Indian Organizations, and other stakeholders, and with the general public* & 3.2 *Secure and effectively manage the assets and resources*.). The

[2] FY 2017 data from the CHAP electronic health records portal https://www.ihs.gov/ehr/chap/

Health Education Program provides critical support for direct health care services relating to health promotion and disease prevention focused on strengthening the collaborative partnerships among direct care providers, patients, communities, and internal and external stakeholders. The collaborative efforts of the Health Education Program supports the agency's priority and integrates the Department's Strategic Goal *to protect the health of Americans where they live., learn, work, and play* (HHS Strategic Plan FY 2018-2022, Goal 2, Objective 2.1 *Empower people to make informed choices for healthier living, 2.2 Prevent, treat, and control communicable diseases and chronic conditions, 2.3 Reduce the impact of mental and substance use disorders through prevention, early intervention, treatment, and recovery, & 2.4 Prepare for and respond to public health emergencies*).

In FY 2018, there was a decline of 12.84 percent or 411,365 patient visits from the previous year. Staffing shortages significantly impacted provision of patient services, which was reflected in the decrease in documented patient education encounters for FY 2018. Data exporting processes have impacted the overall Health Education patient education encounters as several tribal programs have migrated away from the IHS Resource Patient Management System (RPMS), resulting in less encounters being exported to the agency's National Data Warehouse database. The end result of the migration has been a decrease in the number of Health Education patient education encounters being reported.

PROGRAM ACCOMPLISHMENTS

Community Health Aide Program: CHAP as it currently exists in Alaska, is a robust network of health aides trained to support licensed health professionals while providing direct patient care, health promotion, and disease prevention services to patients. The CHAP was authorized by Congress to promote the achievement of the health status objectives in the Indian Health Care Improvement Act (IHCIA) in rural Alaska. These objectives are broad in scope and address virtually every aspect of health care, access, delivery, and status. Specialized training (medical, dental, and behavioral health) and certification furthers those objectives by creating opportunities for these health aides to focus their training and practice on particular health issues and delivery strategies.

The CHAP model has not only proven to be an effective model of expanding access to care in the country's most rural and remote areas, but it has also provided a great return for Tribal communities and exponential benefit. In 2012, two dental health aide providers saw over 1,300 patients who received oral health care for the first time. These providers provided an added reimbursement value to the Tribal organizations in excess of over $200,000 above their salary. In Minnesota, one dental health aide provider saw over 1,700 patients and generated over $30,000 in revenue for the local clinic. CHAP providers address needs in areas where there may be a healthcare shortage and provide a great return of investment in both health outcomes for patients and for healthcare facilities across the US.

The continued expansion of the CHAP to include the lower 48 would lead to increased access to care and a reduction in health disparities faced by American Indians and Alaska Natives in primary care, oral, and behavioral health. The IHS National CHAP program will include Behavioral Health Aides, Community Health Aides and Dental Health Aides who will work directly under the supervision of a licensed provider at both IHS and Tribally-operated facilities in the contiguous 48 states. This program will establish a network of health Aides to improve access to care, health, wellness and the overall quality of life.

Community Health Representatives: As CHR programs have transitioned from IHS direct care services to local community control via Tribal contracting and compacting, IHS's role has transitioned to providing support for training CHRs and providing technical assistance to expand and enhance high-quality culturally-informed programs (IHS Strategic Plan Goal 1 *to ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people*).

CHRs are frontline public health workers who are trusted members of the community and serve as a link between the Indian health system, including associated health programs, and AI/AN patients and communities. In FY 2018, tribes who provided data reported 999,421 CHR patient contacts. In addition, CHR reported patient contacts for visits made to patients with chronic diseases was 423,151. In FY 2019 IHS trained 442 CHRs in basic CHR training, in-person and specialty training (e.g. diabetic care, dressing changes, and blood pressure readings). The training better equipped CHRs to assist patients by increasing health knowledge and providing care to prevent avoidable hospital readmissions and emergency department visits. Additionally, the training allowed CHRs to be more effective in home visits, case finding and case management of patients with chronic health conditions such as asthma, diabetes and hypertension.

With "*Protecting the Health of Americans Where They Live, Learn, Work and Play*" as one of the priorities identified in the Department of Health and Human Services 2019-2023 Strategic Plan, IHS offered training to CHRs across the nation in the Family Spirit curriculum, an evidence-based home visiting program with the goal of assisting paraprofessionals in their ability to help young parents learn skills to address emotional and behavioral functioning including substance abuse prevention.. In addition, this training provides CHRs established curriculum with positive parenting techniques and health promotion material to strengthen families.

Health Education: In FY 2019, the National Patient Education Committee continued to collaborate with the Office of Information Technology to update the RPMS/Electronic Health Record (EHR) coding, to streamline the patient education documentation process (IHS Strategic Plan FY 2019-2023, Goal 3, Objective 3.3 *Modernize information technology and information systems to support data driven decisions*; HHS Strategic Plan 2018-2022 Goal 5, Objective 5.4 *Protect the safety and integrity of our human, physical, and digital* assets). The Health Education Program maintains data tracking of key program objectives. Tracked data includes educational encounters, the number of patients who received patient education services, provider credentials of who delivered the patient education, site location where patient education was provided, health information provided, amount of time spent providing patient health education, patient understanding, and behavior goals.

The Health Education program targeted the following activities in FY 2019 which aligns with the IHS Strategic Plan 2019-2023, Goal 1, *Objective 1.1: Recruit, develop, and retain a dedicated, competent, and caring workforce.*

- Provided site visit/program reviews to the following IHS Service Units and Tribal Programs; Wewoka Service Unit, Lawton Service Unit, and Navajo Nation to strengthen collaborative relationships, improve patient education and coordination of prevention activities, and address health disparities unique to those communities.
- Provided technical assistance related to cancer prevention, digital storytelling, and the development of position descriptions for Health Education and Health Promotion for the Peach Springs Health Center, Sisseton-Wahpeton Oyate of the Lake Traverse Reservation, and Fort Yuma Health Center.

IHS Strategic Plan 2019-2023, Goal 1, *Objective 1.2: Build, strengthen, and sustain collaborative relationships.*

- Provided digital storytelling training, in collaboration with the Albuquerque Area Health Promotion and Disease Prevention Consultant, and the Albuquerque Area Southwest Tribal Epidemiology Center's (AASTEC) National Injury Prevention Program Director, to the AASTEC grantees focusing on the development of public service announcements targeting motor vehicle accidents.
- Provided digital storytelling training, in collaboration with the Sisseton-Wahpeton Oyate of the Lake Traverse Reservation Health Education Program, and the Great Plains Tribal Chairman's Health Board (GPTCHB), to the GPTCHB "Good Health and Wellness in Indian Country grantees focusing on injury prevention.
- Maintained a professional relationship with the Healthcare Partnership of Arizona to provide Basic Tobacco Intervention Skills for Native Communities and Basic Tobacco Intervention Skills for Native Communities Instructor Certification to increase commercial tobacco cessation.
- Provided Adult Mental Health First Aid "train the trainer" workshops to address suicide prevention in collaboration with the Portland Area Indian Health Service and the Billings Area Indian Health Service.
- Provided funding to Tribes and Service Units to address health disparities, including prevention of diabetes and obesity though increased physical activity and diabetes prevention education, increased colorectal cancer screening and access to health education services in remote locations such as the Havasupai Tribe located in the Grand Canyon, health screens for school aged children, cancer prevention (including breast and cervical) activities, Sexually Transmitted Disease education, commercial tobacco prevention and cessation education, and suicide prevention education.

IHS Strategic Plan 2019-2023, Goal 3, *Objective 3.3: Modernize information technology and information systems to support data driven decisions.*

- National Patient Education Committee met in December 2018, June 2019 and July 2019, to streamline and modernize the documentation of health education to identify general patient education protocols and nationally recognized codes, reduce the time and burden for clinicians who are documenting patient education, and standardize health education documentation within the Electronic Health Record (EHR).

FUNDING HISTORY

Fiscal Year	Amount
2017	$0
2018	$0
2019	$0
2020 Enacted	$0
2021 President's Budget	$44,109,000

TRIBAL SHARES

CHAP, CHR, and HE funds are subject to tribal shares and are transferred to Tribes when they assume the responsibility for operating the associated programs, functions, services, and activities. A portion of the overall budget line is reserved for inherently federal functions and is therefore retained by the IHS to perform the basic operational services of the Agency.

BUDGET REQUEST

The FY 2021 budget submission for Community Health is $44.1 million, which is $44.1 million above the FY 2020 Enacted level.

FY 2021 Funding Increase of $44.1 million includes:

- Community Health Aide Program +$20.0 million – transfer of CHAP funds from the Hospitals and Health Clinics line to the Community Health line.
- Community Health Representatives +$24.0 million – transfer of CHR funds from the CHR line to the Community Health line.
- Health Education +$109,000 – transfer from Health Education for staffing, 1 position at the Yukon-Kuskokwim Primary Care Center (JV) in Bethel, Alaska.

OUTPUTS/OUTCOMES

As IHS reviews, output and outcome measures will be developed.

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

AREA ALLOCATION[3]

Community Health
(dollars in thousands)

DISCRETIONARY SERVICES	FY 2019 1/ Final			FY 2020 Estimated			FY 2021 Estimated			FY '21 +/- FY '20
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$	$	$	$	$	$	$72	$6,393	$6,465	$6,465
Albuquerque							615	2,161	2,775	2,775
Bemidji							126	1,400	1,527	1,527
Billings							497	2,361	2,858	2,858
California							66	749	815	815
Great Plains							715	3,942	4,657	4,657
Nashville							352	1,509	1,861	1,861
Navajo							79	7,022	7,101	7,101
Oklahoma							1,610	5,154	6,765	6,765
Phoenix							1,893	2,558	4,451	4,451
Portland							217	2,063	2,279	2,279
Tucson							8	549	557	557
Headquarters							1,999		1,999	1,999
Total, Comm Health	**$**	**$**	**$**	**$**	**$**	**$**	**$8,248**	**$35,862**	**$44,109**	**$44,109**

1/ Reflects Services account adjustments related to formal reprogramming notifications submitted to Congress in FY 2019. Amounts by "Sub IHS Activity" will continue to be adjusted during the period of availability, which conclude on September 30, 2020, for impacted funds.

Note: FY 2021 is an estimate.

This includes the consolidation of the Community Health Aide Program (except Alaska CHAP), Health Education, and Community Health Representatives.

[3] Estimated amounts by area. Subject to change.

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

(Dollars in Thousands)

	FY 2019[1]	FY 2020	FY 2021	
	Final	Enacted	President's Budget	FY 2021 +/- FY 2020
BA	$19,698	$20,568	$0	-$20,568
FTE*	18	18	0	-18

* 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 2021 Authorization.....Permanent

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

PROGRAM DESCRIPTION

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

In FY 2018, there was a decline of 12.84 percent or 411,365 patient visits from the previous year. Staffing shortages significantly impacted provision of patient services, which was reflected in the decrease in documented patient education encounters for FY 2018.

The Health Education funds provide critical support for direct health care services focused on strengthening the collaborative partnerships among direct care providers, patients, communities, and internal and external stakeholders. Funds are utilized to ensure IHS, Tribal, and Urban Indian health care programs have comprehensive, culturally appropriate services, available and accessible personnel, promotes excellence and quality through implemented quality improvement strategies, and strengthens the IHS program management and operations to address health disparities and raise the health status of AI/AN populations to the highest level possible.

[1] Reflects Services account adjustments related to formal reprogramming notifications submitted to Congress in FY 2019. Amounts by "Sub IHS Activity" will continue to be adjusted during the period of availability, which conclude on September 30, 2020, for impacted funds.

PROGRAM ACCOMPLISHMENTS

In FY 2019, the National Patient Education Committee continued to collaborate with the Office of Information Technology to update the Resource Patient Management System (RPMS)/Electronic Health Record (EHR) coding, to streamline the patient education documentation process. The Health Education Program maintains data tracking of key program objectives. Tracked data includes educational encounters, the number of patients who received patient education services, provider credentials of who delivered the patient education, site location where patient education was provided, health information provided, amount of time spent providing patient health education, patient understanding, and behavior goals.

National Patient Education Committee met in December 2018, June 2019 and July 2019, to streamline and modernize the documentation of health education to identify general patient education protocols and nationally recognized codes, reduce the time and burden for clinicians who are documenting patient education, and standardize health education documentation within the Electronic Health Record (EHR).

FUNDING HISTORY

Fiscal Year	Amount
2017	$18,663,000
2018	$18,663,000
2019	$19,698,000
2020 Enacted	$20,568,000
2021 President's Budget	$0

TRIBAL SHARES

Health Education funds are subject to tribal shares and are transferred to Tribes when they assume the responsibility for operating out the associated programs, functions, services, and activities. A portion of the overall Health Education budget line is reserved for inherently federal functions and is therefore retained by the IHS to perform the basic operational services of the Agency.

BUDGET REQUEST

IHS is proposing to consolidate Health Education along with Community Health Representatives and Community Health Aide Program into a new line item, Community Health. The Health Education staffing request of $109,000 is now included in the Community Health line for FY 2021.

OUTPUTS / OUTCOMES

Measure	**Year and Most Recent Result / Target for Recent Result / (Summary of Result)**	**FY 2020 Target**	**FY 2021 Target**	**FY 2021 Target +/-FY 2020 Target**
HE-1 Number of visits with	FY 2018: 3,304,225 visits Target:	0 visits	N/A	N/A

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2020 Target	FY 2021 Target	FY 2021 Target +/-FY 2020 Target
Health/Patient Education (Output)	Not Defined (Target Not In Place)			

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

AREA ALLOCATION

Health Education

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2019 Final 1/			FY 2020 Estimated			FY 2021 Estimated			FY'21 +/- FY'20
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$32	$2,855	$2,887	$33	$2,981	$3,015	$	$	$	$0
Albuquerque	274	965	1,239	287	1,008	1,294				0
Bemidji	56	625	682	59	653	712				0
Billings	222	1,054	1,277	232	1,101	1,333				0
California	29	335	364	31	349	380				0
Great Plains	319	1,760	2,080	333	1,838	2,171				0
Nashville	157	674	831	164	704	868				0
Navajo	35	3,136	3,171	37	3,275	3,311				0
Oklahoma	719	2,302	3,021	751	2,403	3,154				0
Phoenix	845	1,143	1,988	883	1,193	2,076				0
Portland	97	921	1,018	101	962	1,063				0
Tucson	4	245	249	4	256	260				0
Headquarters	893		893	932		932				0
Total, Hlth Ed	**$3,683**	**$16,015**	**$19,698**	**$3,846**	**$16,722**	**$20,568**	**$**	**$**	**$**	**$0**

1/ Reflects Services account adjustments related to formal reprogramming notifications submitted to Congress in FY 2019. Amounts by "Sub IHS Activity" will continue to be adjusted during the period of availability, which conclude on September 30, 2020, for impacted funds.

Note: FY 2020 through 2021 are estimates.

FY 2021 and forward, this is included in the Community Health line item.

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

(Dollars in Thousands)

	FY 2019[1]	FY 2020	FY 2021	
	Final	Enacted	President's Budget	FY 2021 +/- FY 2020
BA	$62,613	$62,888	$0	-$62,888
FTE*	3	3	0	-3

* 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 2021 Authorization.....Permanent

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

PROGRAM DESCRIPTION

The Community Health Representatives (CHRs) program began in 1968 and was established to meet the following four goals: (1) greater involvement of American Indian/Alaska Native (AI/AN) people in their own health and in the identification and treatment of their health problems; (2) greater understanding between AI/AN people and IHS staff; (3) improving cross-cultural communication between the AI/AN community and health service providers; and, (4) increasing basic health care and instruction in AI/AN homes and communities. The CHR programs supports the *HHS Strategic Plan Goal 2, Objective 2.1 and 2.2 to empower CHR patients to make informed choices for healthier living through the prevention, treatment, and control of communicable diseases and chronic conditions*.

Today, CHRs play a role in the health care delivery system to link the patient to the Indian health care system and are intended to prevent avoidable hospital readmissions and emergency department visits through home visits to patients with chronic health conditions such as asthma, diabetes, and hypertension. The aim of the CHR Program is to help AI/AN patients and communities achieve an optimal state of well-being by providing health promotion and disease prevention, wellness and injury prevention education, translation and interpretation, transportation to medical appointments, and delivery of medical supplies and equipment within their tribal community.

CHRs increase access to quality health care for the AI/AN population by addressing health disparities related to chronic diseases and other health conditions. Importantly, this community based delivery of care is provided in coordination with tribal health departments and programs, thereby *supporting IHS Strategic Plan Goal 1, Objective to ensure that comprehensive, culturally*

[1] Reflects Services account adjustments related to formal reprogramming notifications submitted to Congress in FY 2019. Amounts by "Sub IHS Activity" will continue to be adjusted during the period of availability, which conclude on September 30, 2020, for impacted funds.

appropriate personal and public health services are available and accessible to American Indian and Alaska Native people.

PROGRAM ACCOMPLISHMENTS

As CHR programs have transitioned from IHS direct care services to local community control via Tribal contracting and compacting, IHS's role has transitioned to providing support for training CHRs and providing technical assistance to expand and enhance culturally-informed programs.

CHRs are frontline public health workers who are trusted members of the community and serve as a link between the Indian health system, including associated health programs, and AI/AN patients and communities. In FY 2018, tribes who provided data reported 999,421 CHR patient contacts. In addition, CHR reported patient contacts for visits made to patients with chronic diseases was 423,151.

In FY 2019 IHS trained 442 CHRs in basic CHR training, in-person and specialty training (e.g. diabetic care, dressing changes, and blood pressure readings). The training better equipped CHRs to assist patients by increasing health knowledge and providing care to prevent avoidable hospital readmissions and emergency department visits. Additionally, the training allowed CHRs to be more effective in home visits, case finding and case management of patients with chronic health conditions such as asthma, diabetes and hypertension.

With "Protecting the Health of Americans Where They Live, Learn, Work and Play" as one of the priorities identified in the Department of Health and Human Services 2019-2023 Strategic Plan, IHS offered training to CHRs across the nation in the Family Spirit curriculum, an evidence-based home visiting program with the goal of assisting paraprofessionals in their ability to help young parents learn skills to address emotional and behavioral functioning including substance abuse prevention. In addition, this training provides CHRs established curriculum with positive parenting techniques and health promotion material to strengthen families.

FUNDING HISTORY

Fiscal Year	Amount
2017	$60,325,000
2018	$61,888,000
2019	$62,613,000
2020 Enacted	$62,888,000
2021 President's Budget	$0

TRIBAL SHARES

Community Health Representatives funds are subject to tribal shares and are transferred to Tribes when they assume the responsibility for operating the associated programs, functions, services, and activities. A portion of the overall Community Health Representative's budget line is reserved for inherently federal functions and is therefore retained by the IHS to perform the basic operational services of the Agency.

BUDGET REQUEST

No funds are requested in the FY 2021 budget submission for Community Health Representatives. It is proposed to consolidate Community Health Representatives along with

Health Education and the Community Health Aide Program into a new line item, Community Health.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2020 Target	FY 2021 Target	FY 2021 Target +/-FY 2020 Target
CHR-1 Number of patient contacts (Output)	FY 2018: 999,421 patient contacts Target: 1,265,000 patient contacts (Target Not Met but Improved)	501,600 patient contacts	0	N/A
CHR-2 CHR patient contacts for Chronic Disease Services (Output)	FY 2018: 423,151 patient contacts Target: 505,900 patient contacts (Target Not Met but Improved)	201,400 patient contacts	0	N/A
CHR-3 Number of CHRs Trained (Output)	FY 2018: 606 CHRs Target: 600 CHRs (Target Exceeded)	235 CHRs	0	N/A

AREA ALLOCATION

Community Health Representatives

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2019 Final 1/			FY 2020 Estimated			FY 2021 Estimated			FY '21 +/- FY '20
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$32	$4,591	$4,623	$33	$4,686	$4,719	$	$	$	-$4,719
Albuquerque	26	3,610	3,636	26	3,685	3,711				-3,711
Bemidji	35	4,962	4,997	36	5,064	5,100				-5,100
Billings	32	4,592	4,624	33	4,687	4,720				-4,720
California	15	2,065	2,080	15	2,108	2,123				-2,123
Great Plains	167	7,156	7,322	170	7,304	7,474				-7,474
Nashville	177	3,278	3,455	181	3,345	3,526				-3,526
Navajo	50	7,102	7,152	51	7,249	7,300				-7,300
Oklahoma	66	9,358	9,424	68	9,551	9,619				-9,619
Phoenix	46	6,444	6,489	47	6,577	6,624				-6,624
Portland	34	4,827	4,862	35	4,927	4,962				-4,962
Tucson	14	2,028	2,042	15	2,070	2,085				-2,085
Headquarters	907		907	926	0	926		0		-926
Total, CHR	**$1,601**	**$60,011**	**$61,613**	**$1,635**	**$61,253**	**$62,888**	**$**	**$**	**$**	**-$62,888**

1/ Reflects Services account adjustments related to formal reprogramming notifications submitted to Congress in FY 2019. Amounts by "Sub IHS Activity" will continue to be adjusted during the period of availability, which conclude on September 30, 2020, for impacted funds.

Note: FY 2020 through 2021 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 2019[1]	FY 2020	FY 2021	
	Final	Enacted	President's Budget	FY 2021 +/- FY 2020
BA	$2,058	$2,127	$2,165	+$38
FTE*	0	0	0	0

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

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

FY 2021 Authorization.....Permanent

Allocation Method ..... Self-Governance Compact, Tribal Shares

PROGRAM DESCRIPTION

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

Haemophilus Immunization (Hib) Program – The Hib Program started in 1989 with a targeted Haemophilus Influenzae type b prevention project in the Yukon Kuskokwim Delta and now focuses on maintaining high vaccine coverage in a continued effort to prevent communicable disease by providing resources, training, and coordination to Tribal facilities throughout Alaska. Alaska's geography necessitates innovation in program delivery and use of technology as many Tribal facilities are located in remote areas off any continuous road system. The Program maintains immunization practice procedures in partnership with Alaska's statewide Community Health Aide Program to ensure Health Aides working in both urban and remote Tribal facilities have the resources needed to provide high quality vaccination services where Alaska Native families live and play (IHS Strategic Plan FY 2019-2023, Goal 1, Objective 1.3 *Increase access to quality health care services*; HHS Strategic Plan FY 2018-2022, Goal 2, Objective 2.2 *Prevent, treat, and control communicable diseases and chronic conditions*). Through strong collaboration with local Tribal health partners and regional immunization coordinators, the State of Alaska Immunization Program and the IHS Area Immunization Program, the Hib Program offers clinical expertise in advancing vaccine reporting and data management capacity in an environment of evolving and expanding electronic health record systems (IHS Strategic Plan FY 2019-2023, Goal 3, Objective 3.3 *Modernize information technology and information systems to support data driven decisions*). In collaboration with statewide partners, the Hib Program advocates for continued access to affordable vaccine through public vaccine funding programs (HHS Strategic

[1] Reflects Services account adjustments related to formal reprogramming notifications submitted to Congress in FY 2019. Amounts by "Sub IHS Activity" will continue to be adjusted during the period of availability, which conclude on September 30, 2020, for impacted funds.

Plan 2018-2022, Goal 1, Objective 1.2 *Expand safe, high-quality healthcare options, and encourage innovation and competition*). The program works with Tribal public relations to address parental immunization hesitancy and highlight the importance of vaccines, utilizing locally developed culturally appropriate marketing materials and social media campaigns (IHS Strategic Plan FY 2019-2023, Goal 1 Objective 1.2 *Build, strengthen, and sustain collaborative relationships*). In alignment with the President's Management Agenda priority of information technology modernization (PMA Goal 5.3), the Hib Program continues to focus on optimizing available information technology to advance capacity in maintaining high vaccine coverage rates, through refining electronic health record processes and expanding capacity for training, social marketing and consultation throughout Alaska statewide.

The Hepatitis B Program and the Hib Program of the Alaska Native Tribal Health Consortium, in collaboration with Alaska Tribal Health Care System partners, provides clinical expertise and consultation, trainings, research, evaluation and surveillance with the goal to reduce the occurrence of infectious disease and improve access to healthcare in the Alaska Native population. The programs support immunization, patient screening, development of electronic health record reminders and systems, providing an infrastructure to maintain high vaccine coverage, and high clinical management coverage of hepatitis B and C in Alaska Natives. The Program promotes semi-annual screening of chronic hepatitis patients for both liver cancer and liver function (enzyme testing). The programs' activities support the IHS priorities on quality and partnerships as delineated in the IHS Strategic Plan.

Working with partners with the Alaska Tribal Health System to meet IHS Strategic Plan FY 2019-2023 and the HHS Strategic Plan FY 2018-2022 the programs provide both direct and telehealth patient care and health provider education to not only increase access to quality care, but also expand the options available (IHS Strategic Plan FY 2019-2023, Goal 1, Objective 1.3 *Increase access to quality health care services,* IHS Strategic Plan FY 2019-2023, Goal 2, Objective 2.2 *Provide care to better meet the health care needs of American Indian and Alaska Native communities*, and HHS Strategic Plan 2018-2022, Goal 1, Objective 1.3 *Improve Americans' access to healthcare and expand choices of care and service options*). Both programs are actively engaged in preventing and treating communicable and chronic diseases (HHS Strategic Plan 2018-2022, Goal 2, Objective 2.2 *Prevent, treat, and control communicable diseases and chronic conditions*).

PROGRAM ACCOMPLISHMENTS

The Immunization Alaska Program comprised of both the Hepatitis B and Hib Programs has several performance measures to monitor progress in achieving the goal of high vaccine coverage for Alaska Native people as described below.

Hepatitis B Program

The Hepatitis B program continues to prevent and monitor hepatitis B infection among a large population of Alaska Natives with or susceptible to the disease. The program evaluates hepatitis A and hepatitis B vaccination coverage of Alaska Natives, and the total number of Alaska Native patients targeted for screening and the total number of patients screened for hepatitis B and hepatitis C as well as other liver disease that disproportionately affect the Alaska Native population. Due to the opioids crisis, new hepatitis C virus (HCV) infections have increased 69 percent from 2015-2018 compared to the 2011-2014 time period. In response to this crisis, the Program is actively engaged in a statewide hepatitis C elimination project. This involves recruiting patients for treatment through our local outpatient clinic, field clinics and video clinics

(IHS Strategic Plan FY 2019-2023, Goal 2, Objective 2.2 *Provide care to better meet the health care needs of American Indian and Alaska Native communities)* as well as performing provider in-person and webinar education seminars on treating hepatitis C to build capacity (IHS Strategic Plan FY 2019-2023, Goal 1, Objective 1.3 *Increase access to quality health care services)*. The Program website[6] provides online treatment documents and a treatment algorithm for Alaska Tribal healthcare providers. Also, Program staff conduct monthly Alaska HCV Extension for Community Healthcare Outcomes (ECHO) collaboratives providing remote assistance for hepatitis C case review and treatment recommendations. Since 2014, over 850 American Indian/Alaska Native persons have been treated for HCV through the Alaska Tribal Health System (HHS Strategic Plan 2018-2022, Goal 2, Objective 2.2 *Prevent, treat, and control communicable diseases and chronic conditions)*. The recent acquisition and fielding of two non-invasive elastography devices allows for the safe, non-invasive monitoring of liver disease progression without having to perform an invasive liver biopsy. One is a portable machine that is transported to field clinics thus reducing the need for patients to travel to Anchorage or alternative site for their care (HHS Strategic Plan 2018-2022, Goal 1, Objective 1.3 *Improve Americans' access to healthcare and expand choices of care and service options)*.

In FY 2019:

- Hepatitis A vaccination coverage did not achieve the target, and hepatitis B vaccination coverage exceeded the target. Hepatitis A vaccination coverage was 88 percent (90 percent target) and hepatitis B vaccination coverage was 95 percent (90 percent target).
- Overall, at least 73 percent of AI/ANs with either chronic hepatitis B (68.5 percent screened) or hepatitis C (78 percent screened) infection were screened for liver cancer and for liver aminotransferase (enzyme) levels.

Haemophilus Immunization (Hib) Program

The Hib program continues to provide resources, training and coordination to Tribes in Alaska to maintain high vaccine coverage among Alaska Native people. Vaccine coverage data is collected for each Tribal region and measured in collaboration with regional Tribal health immunization coordinators (IHS Strategic Plan FY 2019-2023, Goal 2, Objective 2.1 *Create quality improvement capability at all levels of the organization)*. Technical consultation for the varying electronic health record (EHR) systems within each Tribal health organization is provided to support improved vaccine coverage for all Tribes. Statewide Alaska Native vaccine coverage rates (including influenza) are reported to IHS National Immunization Program for infants 3-27 months, 19-35 months, adolescents, adults. Flu vaccine coverage rates for healthcare personnel working at Tribal facilities are also reported to IHS National Immunization Program. Efforts pursuing information technology to advance capacity in maintaining high vaccine coverage rates include: participation as clinical experts on national EHR advisory workgroups regarding immunization-related product development; local advocacy for implementation of clinical decision support system (vaccine forecaster) in electronic health record systems; and collaboration with the State of Alaska immunization program in expanding coverage reporting capacity in the state's Immunization Information System (SIIS) (HHS Strategic Plan FY 2018-2022, Goal 5, Objective 5.3 *Optimize information technology investments to improve process efficiency and enable innovation to advance program mission goals)*. Improvement in vaccine coverage relies on data capture and quality in electronic health record systems, facilitated by data interfaces, and in conjunction with clinical resources and training.

During FY 2019:

- Immunization Coverage for Alaska Natives age 19-35 months was 73 percent, which is approaching the Healthy People 2020 goal of 80 percent for child vaccine coverage with 4:3:1:3*:3:1:4 series (4 DTaP, 3 IPV, 1 MMR, 3 Hib, 3 Hep B, 1 Var, 4 PCV).
- Achieved 90 percent coverage with full series Haemophilus influenza type b (Hib) vaccine in children age 19-35 months, which is much higher than the US all-races rate of 80.7 percent in 2017, the most recent data available.
- Achieved 78 percent Tdap vaccine coverage in all patients 19 years and older who had received Tdap within the past 10 years.
- Achieved 90 percent pneumococcal vaccine coverage in patients 65 years and older who received pneumococcal vaccine in the past ever.
- Assisted Tribal facilities using new electronic health record (EHR) systems or the IHS EHR immunization package in maintaining or establishing interface connection with the State of Alaska Immunization Information System (SIIS) to share vaccine records.
    - Provided consultation with six facilities that implemented new EHRs on immunization documentation and facilitated SIIS interface implementation.
- Collaborated with the Alaska Community Health Aide Program in the development and implementation of immunization standing orders on the electronic Health Aide practice procedures to further increase access to vaccination in remote Tribal facilities.
- Collaborated with State of Alaska Immunization Program to improve capacity of Alaska SIIS in adult vaccine and flu vaccine coverage reporting; streamline processes for reporting 3-27 months, 19-35 months and adolescent's vaccine coverage.
- Assisted Tribal facilities in utilization of Alaska SIIS patient reminder system.
- Assisted Tribal facilities throughout Alaska to implement new State policy and procedures associated with vaccine electronic inventory management, delivery systems and documentation.

A summary of immunization results is included below:

Immunization Measure	Age Group	Alaska Native coverage as of 9/30/2018
4:3:1:3*:3:1:4	19-35 months	73%
4:3:1:3:3:1	19-35 months	74%
3 Hib vaccines doses		90%
3 PCV (pneumococcal conjugate vaccine)	19-35 months	92%
1+ HPV	13-17 years female	82%
Pneumococcal vaccine	65+ years	90%
Tdap	19 years and older	78%

IHS vaccination rates compare favorably with overall National vaccination rates. The CDC conducts National Immunizations Surveys which allows self-reporting of vaccines. https://www.cdc.gov/vaccines/vaxview/index.html

The Hib program continues to collaborate with Centers for Disease Control and Prevention in networking with IHS, State, and Tribal agencies to provide technical assistance regarding EHRs. Challenges include the diversity of EHRs employed by Tribal organizations that may result in temporary loss or delay of Area-wide reporting of vaccine coverage. Regular reporting of immunizations is critical in assuring sufficient monitoring and follow-up with facilities experiencing vaccination administration issues. Technical assistance to sites will continue to be addressed through coordinated efforts by the Hib Program, IHS, State, and Tribes.

FUNDING HISTORY

Fiscal Year	Amount
2017	$2,041,000
2018	$2,127,000
2019	$2,058,000
2020 Enacted	$2,127,000
2021 President's Budget	$2,165,000

TRIBAL SHARES

Alaska Immunization funds are paid out as tribal shares in their entirety.

BUDGET REQUEST

The FY 2021 budget submission for Alaska Immunization is $2.2 million, which is $38,000 above the FY 2020 Annualized CR level.

FY 2021 Funding Increase of $38,000 includes:

- Current Services: +$23,000 for current services including:
    - Inflation +$23,000 to cover inflationary costs of providing immunization services in Alaska.
- Program Adjustments: +$15,000 to maximize funding for direct patient care services.

The FY 2021 funding will provide coordination of vaccine coverage reporting for Tribal facilities, training of Tribal immunization coordinators, and clinic staff in vaccine recommendations and documentation, consultation in the migration to alternate EHRs, and regular notification to hepatitis patients of the need to complete liver function screenings so that program clinicians can identify serious liver disease or liver cancer when it is at an early and treatable stage.

Hepatitis B Program – The program will conduct outpatient clinics five days a week at the Alaska Native Medical Center, travel to regional health centers to conduct outpatient clinics, and will continue its web-based application for video-conferencing (Adobe Connect) that is accessible to the statewide Alaska Tribal Health System (ATHS) audience to provide relevant clinical information to assist in the care and management of hepatitis and liver disease patients. Continue AK HCV ECHO (Extension for Community Healthcare Outcomes) virtual field clinics where primary care physicians collaborate with program staff for the treatment of hepatitis C cases. Annual field clinics will be conducted across Alaska to provide direct patient care, clinical updates to ATHS staff, and to recruit and conduct follow-up on participants enrolled in the program's research studies. Hepatitis A and Hepatitis B vaccine coverage for Alaska Natives will be measured. In addition, the total number of Alaska Native patients targeted and screened will be measured for hepatitis B, hepatitis C, and other liver disease that affects Alaska Natives.

Haemophilus Immunization (Hib) Program – The budget request will allow staff to provide continued expertise and support to regional Tribal programs on-site and for many partner locations, including rural and isolated locations. 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. Activities include the maintenance of statewide Alaska Native vaccine coverage rate reporting to IHS Headquarters during current phase of evolving electronic health record systems. Expanding quality of services through provision of technical support for electronic clinical decision support systems (vaccine forecaster), coverage reporting and patient reminder systems. In addition, efficiency of consultations and trainings offered to Tribal facilities will improve through technology optimization through utilization of widely available video conferencing systems and local Distance Learning Network. Community outreach and patient education activities will continue to include limited print of media materials while also expanding to digital and electronic formats.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2020 Target	FY 2021 Target	FY 2021 Target +/-FY 2020 Target
AK-1 Chronic Hepatitis B Patients Screened/Targeted (Output)[2]	FY 2019: 678 Screened Target: 600 Screened (Target Exceeded)	600 Screened	600 Screened	Maintain
AK-2 Chronic Hepatitis C Patients Screened/Targeted (Output)[3]	FY 2019: 1334 Screened Target: 990 Screened[7] (Target Exceeded)	1300 Screened	1300 Screened	Maintain
AK-3 Other Liver Disease Patients Screened (Output)[4]	FY 2019: 234 Screened Target: 200 Screened (Target Exceeded)	200 Screened	200 Screened	Maintain
AK-4 Hepatitis A vaccination (Output)[5]	FY 2019: 88 % Target: 90 % (Target Not Met)	90 %	90 %	Maintain
AK-5 Hepatitis B vaccinations (Output)[6]	FY 2019: 95 % Target: 90 % (Target Exceeded)	90 %	90 %	Maintain

All data reported is from the Alaska Native Tribal Health Consortium.

GRANTS AWARDS -- The program does not award grants.

[2] Hepatitis Program (Known Cases Screened) Sum of known hepatitis B cases FY 2019: 989. Decline in hepatitis B cases due to an aging cohort and their deaths; discovery of new cases is rare given hepatitis B vaccinations.

[3] Hepatitis Program (Known Cases Screened) Sum of known hepatitis C cases FY 2019: 1,826. With DAA treatment regimens available screening rates have increased; from updated clinical guidelines treated cases with no/mild fibrosis no longer need to be followed for 5 years unless there's another underlying liver disease, treated cases with advanced fibrosis/cirrhosis being followed indefinitely; number of new hepatitis C cases identified increased in this reporting period.

[4] Hepatitis Program (Known Cases Screened) Sum of known other liver disease cases FY 2019: 259. Other liver disease includes autoimmune hepatitis and primary biliary cirrhosis.

[5] Hepatitis A/B Immunization rates for Alaska Native children who achieve Hepatitis A 1-dose completion and Hepatitis B 3-dose completion aged 19-35 months are compiled and reported throughout the Alaska Native Tribal Health System on a quarterly basis.

[6] The rates reported herein represent the most recent reporting period. Established target immunization rate for each vaccine is 90%.

[6] www.anthc.org/hep

[7] Target for number screened increased from 990 to 1300 in FY2020.

AREA ALLOCATION

Immunization Alaska

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2019 Final 1/			FY 2020 Estimated			FY 2021 Estimated			FY '21 +/- FY '20
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$0	$2,058	$2,058	$0	$2,127	$2,127	$0	$2,165	$2,165	$38
Total, Imm AK	**$0**	**$2,058**	**$2,058**	**$0**	**$2,127**	**$2,127**	**$0**	**$2,165**	**$2,165**	**$38**

1/ Reflects Services account adjustments related to formal reprogramming notifications submitted to Congress in FY 2019. Amounts by "Sub IHS Activity" will continue to be adjusted during the period of availability, which conclude on September 30, 2020, for impacted funds.

Note: FY 2020 through 2021 are estimates.

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

(Dollars in Thousands)

	FY 2019[1]	FY 2020	FY 2021	
	Final	Enacted	President's Budget	FY 2021 +/- FY 2020
BA	$50,533	$57,684	$49,636	-$8,048
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 2021 Authorization.....Permanent

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

PROGRAM DESCRIPTION

The Indian Health Service (IHS) Office of Urban Indian Health Programs (OUIHP) was established in 1976 to make health care services more accessible to Urban American Indians/Alaska Natives (AI/ANs). The IHS OUIHP 2017-2021 Strategic Plan guides, supports, and improves access to high quality, culturally appropriate health care services for Urban AI/ANs. The OUIHP Strategic Plan aligns with the IHS Strategic Plan FY 2019-2023 to support health care solutions that fit the diverse circumstances of Urban AI/ANs and the tribal communities they serve. The input from Urban Indian Organization Leaders through the Urban Confer process helped inform the development of the IHS Strategic Plan. The IHS Strategic Plan will guide the work of OUIHP as we continue to strengthen our partnership with UIOs to address the three overarching goals of the IHS Strategic Plan, including improving access to care, quality of care, and management and operations of the Agency.

The IHS enters into limited, competitive contracts and grants with 41 501(c)(3) non-profit organizations to provide health care and referral services for Urban AI/ANs in 22 states. These IHS contracts and grants with Urban Indian Organizations (UIOs) address the *IHS Strategic Plan Goal 1 by ensuring that comprehensive, culturally appropriate personal and public health services are available and accessible to AI/AN people*. Awarding of these contracts and grants to UIOs also addresses *HHS Strategic Plan Goal 2, to protect the health of Americans where they live, learn, work, and play*. UIOs define their scope of work and services based upon the service population, health status, and unmet needs of the Urban AI/AN community they serve. Each Urban Indian Organization is governed by a Board of Directors that must include at least 51 percent Urban AI/ANs. UIOs provide unique access to culturally appropriate and quality health care services for Urban AI/ANs.

The 41 UIOs are an integral part of the Indian health care system and serve as resources to both tribal and urban communities. Urban AI/ANs are often invisible in the urban setting and face

[1] Reflects Services account adjustments related to formal reprogramming notifications submitted to Congress in FY 2019. Amounts by "Sub IHS Activity" will continue to be adjusted during the period of availability, which conclude on September 30, 2020, for impacted funds.

unique challenges when accessing health care. A large proportion of Urban AI/ANs live in or near poverty and face multiple barriers such as the lack of quality and culturally relevant health care services in cities. UIOs are an important support to Urban AI/ANs seeking to maintain their tribal values and cultures and serve as a safety net for our urban patients. Social determinants of health play a key role in health and wellness and UIOs are addressing a range of factors which contribute to improved health outcomes. Urban AI/ANs in need of substance use disorder treatment commonly exhibit co-occurring disorders. UIOs integrate behavioral health into primary care offered within a culturally appropriate framework.

UIOs provided 653,614 health care visits for approximately 75,194 Urban AI/ANs who do not have access to the resources offered through IHS or tribally operated health care facilities because they do not live on or near a reservation. Urban Indian Organization program sizes and services vary from full ambulatory care, limited ambulatory care, outreach and referral, and residential and outpatient substance abuse treatment programs, as follows:

- Full Ambulatory Care: Programs providing direct medical care to the population served for 40 or more hours per week.
- Limited Ambulatory Care: Programs providing direct medical care to the population served for less than 40 hours per week.
- Outreach and Referral: Programs providing case management of behavioral health counseling and education services, health promotion/disease prevention education, and immunization counseling but not direct medical care services.
- Residential and Outpatient Substance Abuse Treatment: Programs providing residential and outpatient substance abuse treatment, recovery, and prevention services.

Included in the above 41 UIOs funded through contracts and grants, are the following:

- Oklahoma City Indian Clinic and Indian Health Care Resource Center of Tulsa: These two urban sites, initially demonstration projects, are now permanent programs within the IHS's direct care program and must continue to qualify as an Urban Indian Organization under the IHCIA definition, 25 U.S.C. § 1660b.
- Former National Institute on Alcohol Abuse and Alcoholism Programs: IHS has transitioned administrative oversight of five former National Institute on Alcohol Abuse and Alcoholism programs (former-NIAAA programs) that receive an award from IHS and have been confirmed to be an Urban Indian Organization as defined by the IHCIA at 25 U.S.C. § 1603(29) from the IHS Alcohol and Substance Abuse Program (ASAP) to the OUIHP. IHS's transition of management of the current award funds and the proposed transfer of funds from the ASAP to the OUIHP will fully implement the transfer authorized by IHCIA at 25 U.S.C. § 1660c – Urban NIAAA transferred programs. Awarding of these contracts to UIOs addresses *HHS Strategic Plan Goal 2, Objective 2.3, to reduce the impact of mental and substance use disorders through prevention, early intervention, treatment, and recovery support*. UIOs provide high quality, culturally relevant prevention, early intervention, outpatient and residential substance abuse treatment services, and recovery support to meet the needs of the Urban Indian communities they serve.

The other major Urban Indian Health focus areas and activities are:

- 4-in-1 Grant Program: In FY 2019, the OUIHP awarded 4-in-1 grants to 33 UIOs. The grantees are awarded for a three-year funding cycle from April 1, 2019 - March 31, 2022. These grants provide funding to UIOs to support four health program areas: health promotion and disease prevention services; immunization services; alcohol and substance abuse related

services; and mental health services. Grantees are required to participate in a national evaluation of the 4-in-1 grant program, which addresses *IHS Strategic Plan Goal 2 to promote excellence and quality through innovation of the Indian health system into an optimally performing organization*. The national evaluation includes reporting on the cultural interventions integrated into the 4-in-1 program activities, and practice based and evidence based approaches that are implemented to meet the needs of the Urban Indian service population. These grants expand *safe, high quality health care options, and encourage innovation and competition, which meets HHS Strategic Plan Goal 1, Objective 1.2.*

- Urban Indian Education and Research Organization Cooperative Agreement: Provides national education and research services for UIOs and OUIHP through a cooperative agreement. The cooperative agreement includes five project areas: (1) public policy; (2) research and data; (3) training and technical assistance; (4) education, public relations, and marketing; and (5) payment system reform/monitoring regulations. This cooperative agreement meets *IHS Strategic Plan Goal 1, Objective 1.2, to build, strengthen, and sustain collaborative relationships.*
- Albuquerque Indian Dental Clinic: Provides dental services through the Albuquerque Area IHS Dental Program. These services address *the IHS Strategic Plan Goal 1 by ensuring that comprehensive, culturally appropriate personal and public health services are available and accessible to AI/AN people. The provision of dental services also addresses HHS Strategic Plan Goal 2, to protect the health of Americans where they live, learn, work, and play.*

UIOs are evaluated in accordance with the IHCIA requirements. The program is administered by OUIHP at IHS Headquarters. OUIHP integrates Enterprise Risk Management by annually reviewing UIO progress with set goals and objectives. The IHS Urban Indian Organization On-Site Review Manual is used by the IHS Areas to conduct annual onsite reviews of the IHS funded UIOs to monitor compliance with Federal Acquisition Regulation contractual requirements that are established through legislation. The results are submitted to OUIHP for review and follow-up to ensure that corrective action plans are successfully completed prior to continuation of funding. The requirements in the manual are based on best-practice standards for delivering safe and high quality health care and are similar to standards used by accrediting organizations.

Many UIOs are seeking or maintaining accreditation from several accreditation organizations such as the Joint Commission, Accreditation Association for Ambulatory Healthcare (AAAHC), Commission on Accreditation of Rehabilitation Facilities, and National Committee for Quality Assurance. In Fiscal Year 2019, through an IHS contract with AAAHC, accreditation services were provided to 24 out of the 41 UIOs to meet *IHS Strategic Plan Goal 2, Objective 2.1, to create quality improvement capability at all levels of the organization; and HHS Strategic Plan Goal 1, to reform, strengthen, and modernize the Nation's health care system*.

PROGRAM ACCOMPLISHMENTS

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

From October 1, 2017, to September 30, 2018, the Urban Indian Organization 2018 GPRA cycle accomplishments included:

- 65 percent of the UIOs reported on 26 of the 26 performance measures;
- 35 percent of the UIOs reported through the Integrated Data Collection System Data Mart (IDCS DM);
- 23 UIOs reported through the Clinical Reporting System (CRS);
- 6 UIOs reported using 100 percent review of appropriate data source (as opposed to sampling a smaller percentage of records); and
- FY 2018 was the first year of reporting GPRA data through the IDCS DM so there is no comparable prior year data to determine performance improvement for the UIOs.

The IHS will proceed with plans to have all UIOs export data to the IHS National Data Warehouse (NDW). This includes working with UIOs utilizing commercial off the shelf systems to export data to the NDW. The OUIHP will continue to work with the IHS National Patient Information Reporting System (NPIRS) staff to improve the export and accuracy of data for UIOs. The OUIHP, with the assistance of the IHS Office of Information Technology, will continue to provide training and technical assistance to UIOs on accurate and uniform data collection, so as to achieve standardization throughout the system. This work aligns with *IHS Strategic Plan Goal 1, Objective 2.1.1, to improve the transparency and the quality of data collected regarding health care services and program outcomes. It also aligns with HHS Strategic Plan Goal 5, Objective 5.3, to optimize information technology investments to improve process efficiency and enable innovation to advance program mission goals*.

Design requirements for the IHS's IDCS DM, include an aggregate Urban report to provide the clinical measure results reported in the Outputs and Outcomes Table of the Urban program's budget narrative. An aggregate Urban report requires data from individual facility reports to produce national results. IHS expects the aggregate Urban reports to be ready by December 31, 2019.

FUNDING HISTORY

Fiscal Year	Amount
2017	$48,533,000
2018	$51,315,000
2019	$50,533,000
2020 Enacted	$57,684,000
2021 President's Budget	$49,636,000

BUDGET REQUEST

The FY 2021 budget submission for Urban Health is $49.6 million, which is $8.0 million below the FY 2020 Enacted level.

FY 2020 Budget Funding of $57.7 million – The base funding provides for the following:

- Improving Urban AI/AN access to health care to improve health outcomes in urban centers.
- Strengthening programs that serve Urban AI/ANs throughout the United States.
- Enhancing Urban Indian Organization third party revenue, implementing payment reforms such as the transition to a new prospective payment system, and increasing quality improvement efforts.
- Increasing the number of accredited Urban Indian Organization programs and patient centered medical homes for Urban AI/ANs.
- Implementing and utilizing advanced health information technology.

- Expanding access to quality, culturally competent care for Urban AI/ANs through collaboration with other federal agencies.
- Implementing IHCIA authorities specific to UIOs.

FY 2021 Funding Decrease of $8.0 million includes:

Current Services: +$630,000 million for current services includes:

- Inflation +$630,000 to fund inflationary costs of providing health care services.

Program Adjustment -$8.7 million - to maximize funding for direct patient care services.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2020 Target	FY 2021 Target	FY 2021 Target +/-FY 2020 Target
UIHP-7 Number of AI/ANs served at Urban Indian clinics. (Outcome)	FY 2017: 75,194 Target: 53,408 (Target Exceeded)	81,350	TBD	N/A
UIHP-8 Percentage of AI/AN patients with diagnosed diabetes served by urban health programs that achieve good blood sugar control (Outcome)	FY 2018: Result Expected December 31, 2020 Target: Set Baseline (Pending)	Discontinued	Discontinued	N/A
UIHP-9 Proportion of children, ages 2-5 years, with a BMI at or above the 95th percentile (Outcome)	FY 2018: Result Expected December 31, 2019 Target: Set Baseline (Pending)	Not Defined	Not Defined	Maintain
UIHP-10 Increase the number of diabetic AI/ANs that achieve blood pressure control (Outcome)	FY 2018: Result Expected December 31, 2020 Target: Set Baseline (Pending)	TBD	TBD	Maintain
UIHP-11 Reduce the proportion of American Indians/Alaska Natives with diagnosed diabetes who have poor glycemic control	FY 2019: Result Expected Dec 31, 2020 Target: Set Baseline (Pending)	TBD	TBD	Maintain

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2020 Target	FY 2021 Target	FY 2021 Target +/-FY 2020 Target
(A1c >9%) (Outcome)				

GRANTS AWARDS - Funding for UIOs for FY 2021 includes both grants and contracts awarded to the programs.

(whole dollars)	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Number of Awards	34	34	34
Average Award	$281,128	$281,128	$281,128
Range of Awards	$164,373 - $1,050,000	$164,373 - $1,050,000	$164,373 - $1,050,000

AREA ALLOCATION

Urban Health

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2019 Final 1/			FY 2020 Estimated			FY 2021 Estimated			FY '21 +/- FY '20
	Federal	Urban	Total	Federal	Urban	Total	Federal	Urban	Total	Total
Alaska	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Albuquerque	0	3,011	3,011	0	3,437	3,437	0	2,957	2,957	-$479
Bemidji	0	4,552	4,552	0	5,197	5,197	0	4,472	4,472	-$725
Billings	0	2,540	2,540	0	2,899	2,899	0	2,495	2,495	-$404
California	0	6,957	6,957	0	7,941	7,941	0	6,833	6,833	-$1,108
Great Plains	0	1,702	1,702	0	1,942	1,942	0	1,671	1,671	-$271
Nashville	0	1,014	1,014	0	1,158	1,158	0	996	996	-$161
Navajo	0	817	817	0	933	933	0	803	803	-$130
Oklahoma	0	2,352	2,352	0	2,685	2,685	0	2,310	2,310	-$375
Phoenix	0	2,797	2,797	0	3,193	3,193	0	2,748	2,748	-$446
Portland	0	6,165	6,165	0	7,037	7,037	0	6,055	6,055	-$982
Tucson	0	577	577	0	659	659	0	567	567	-$92
Headquarters	0	18,049	18,049	0	20,603	20,603	0	17,729	17,729	-$2,875
Total, Urban	**$0**	**$50,533**	**$50,533**	**$0**	**$57,684**	**$57,684**	**$0**	**$49,636**	**$49,636**	**-$8,048**

1/ Reflects Services account adjustments related to formal reprogramming notifications submitted to Congress in FY 2019. Amounts by "Sub IHS Activity" will continue to be adjusted during the period of availability, which conclude on September 30, 2020, for impacted funds.

Note: FY 2020 through 2021 are estimates.

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

(Dollars in Thousands)

	FY 2019[1]	FY 2020	FY 2021	
	Final	Enacted	President's Budget	FY 2021 +/- FY 2020
BA	$56,363	$65,314	$51,683	-$13,631
FTE*	24	24	24	--

*FTE numbers reflect only Federal staff and do not include increases for 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 2021 Authorization.....Permanent

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

PROGRAM DESCRIPTION

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

The IHP programs work synergistically and directly supports *IHS' FY 2019-2023 Strategic Plan, Goal 1, Objective 1.1 through the recruitment and retention of health care professionals to provide high-quality primary care and clinical preventive services to American Indians and Alaska Natives (AI/AN). The IHP programs also directly support the IHS Strategic Plan Goal 1, Objective 1.2 through critical support in continuing to strengthen collaborations between the IHS, Tribes/Tribal organizations, Urban Indian organizations (I/T/U) and the Health Resources and Services Administration (HRSA)* to increase the number of sites eligible to participate as National Health Service Corps (NHSC) approved sites for the NHSC Scholarship program and LRP.

PROGRAM ACCOMPLISHMENTS

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

- Enabling AI/ANs to enter health care professions through a carefully designed system of preparatory, professional, and continuing educational assistance programs.

[1] Reflects Services account adjustments related to formal reprogramming notifications submitted to Congress in FY 2019. Amounts by "Sub IHS Activity" will continue to be adjusted during the period of availability, which conclude on September 30, 2020, for impacted funds.

- Serving as a catalyst in developing AI/AN communities by providing educational opportunities for AI/ANs to become health care professionals and return to their local communities to provide health care.
- Developing and maintaining American Indian psychology career recruitment programs as a means of encouraging AI/ANs to enter the mental health field.
- Assisting AI/AN health programs to recruit and retain qualified health professionals.
- Collaborating with the National Health Service Corps Loan Repayment Program that received an additional $15 million for loan repayment awards to clinicians working at IHS facilities, Tribally-operated 638 health programs, and Urban Indian programs to combat the nation's opioid crisis.
- Consulting annually with IHS Area Directors, Tribal health directors, and Urban Indian health directors regarding their health professions priorities eligible for Scholarship and Loan Repayment Program funding.

While the IHP programs have seen successes, IHP continues to strive to improve performance and identify areas of risk. Placement of new scholars within 90 days of completing their training continues to be a challenge. The use of online manuals, e-Newsletters, emails, and referral of graduates to recruiters have all been used to facilitate the 90 day scholar placement. In FY 2019, 42 percent of scholars had a hire letter within 90 days (target was 78 percent). Failure to meet this goal was primarily due to scholars not completing their licensing boards and finding positions within the 90 day period. The Scholarship program continues to seek new ways to assist IHS scholars to meet this requirement. Assuring scholars and loan repayment recipients meet their service obligation is another critical component of the IHP programs. Annual employment verification through personnel rosters and certification by Tribal employers assist in this process. Scholarship program and LRP databases allow staff to identify when health professionals are expected to complete their service obligation and allow for timely follow-up.

Loan Repayment Program (Section 108): The LRP is an invaluable tool for recruiting and retaining healthcare professionals by offering them the opportunity to reduce their student loan debts through service to Indian health programs with critical staffing needs. Applicants agree to serve two years at an Indian health program in exchange for up to $20,000 per year in loan repayment funding and up to an additional $5,000 per year to offset tax liability. Loan repayment recipients can extend their initial two-year contract on an annual basis until their original approved educational loan debt is paid.

In FY 2019, a total of 1,524 health professionals were receiving IHS loan repayment. This included 565 new two-year contracts, 481 one-year extension contracts and 478 health professionals starting the second year of their FY 2018 two-year contract.

Applicants who apply for but do not receive funding, are identified as either "matched unfunded" or "unmatched unfunded". The "matched unfunded" applicants are health professionals employed in an Indian health program. The "unmatched unfunded" applicants are health professionals that either decline a job offer because they did not receive loan repayment funding or those unable to find a suitable assignment meeting their personal or professional needs. In FY 2019, there were 532 "matched unfunded" applicants (including 193 nurses, 61 behavioral health providers, 14 dentists, 48 mid-level providers and 52 pharmacists, among others) and 153 "unmatched unfunded" health professionals (including 3 physicians, 14 behavioral health providers, 11 dentists, 31 mid-level providers and 64 nurses among others). The inability to fund these 685 health professional applicants is a significant challenge for the recruitment efforts of the agency. A more detailed breakout of loan repayment awards in FY 2019 by discipline is included in a table at the end of the narrative.

Scholarship Program (Sections 103 and 104) – Section 103 scholarships include the preparatory and pre-graduate scholarship programs that prepare students for health professions training programs. Graduate students and junior- and senior-level undergraduate students are given priority for funding for programs under Section 103, unless the section specifies otherwise. Section 104 includes the Health Professions Scholarship program, which provides financial support consisting of tuition, fees and a monthly stipend for AI/AN students from federally recognized Tribes enrolled in health profession or allied health profession programs. Students accepting funding for programs under Section 104 incur a service obligation and payback requirement. In FY 2019, there were 675 new online scholarship applications submitted to the IHS Scholarship program. After evaluating the application for completeness and eligibility, a total of 334 of these new scholarship applications were considered eligible for funding. The IHS Scholarship program was able to fund 146 new awards. The IHS Scholarship program also reviewed applications from previously awarded scholars that were continuing their education. A total of 142 continuation awards were funded in FY 2019. A detailed breakout of scholarships awarded by discipline in FY 2019 is included in a table at the end of the narrative.

Extern Program (Section 105) - Section 105 of the IHCIA, is designed to give IHS scholars and other health professions students the opportunity to gain clinical experience with IHS and Tribal health professionals in their chosen discipline. This program is open to IHS scholars and non-scholars. Students are employed up to 120 days annually, with most students working during the summer months. In FY 2019, the Extern Program funded a total of 34 student externs. A breakout of extern awards in FY 2019 by Area Offices is included in a table at the end of the narrative. In FY 2019, IHS implemented a new standard operating procedure that will actively recruit IHS Scholarship recipients into the Extern Program as well as offering Extern Program positions to non-Scholar health professional students.

FUNDING HISTORY/REQUEST

Fiscal Year	Amount
2017	$49,345,000
2018	$49,363,000
2019	$56,363,000
2020 Enacted	$65,314,000
2021 President's Budget	$51,683,000

TRIBAL SHARES

Program funds are subject to tribal shares and are transferred to Tribes when they assume the responsibility for operating the associated programs, functions, services, and activities. A portion of the overall program budget line is reserved for inherently federal functions and is therefore retained by the IHS to perform the basic operational services of the Agency.

BUDGET REQUEST

The FY 2021 budget submission for Indian Health Professions is $51.7 million, which is -$13.6 million below the FY 2020 Enacted Level.

FY 2020 Base Funding of $65.3 million – The base funding enables AI/ANs to enter the health care professions through a carefully designed system of preparatory, professional, and continuing educational assistance programs; serve as a catalyst in developing AI/AN communities by

providing educational opportunities and enabling AI/AN health care professionals to further Indian self-determination in the delivery of health care; and assist Indian health programs to recruit and retain qualified health professionals.

FY 2021 Funding Decrease of $13.6 million includes:

- Recruitment & Retention +$8.0 million to increase funding for scholarships and loan repayment recipients.

- Program Adjustment -$21.6 million - to maximize funding for direct patient care services.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2020 Target	FY 2021 Target	FY 2021 Target +/-FY 2020 Target
42 Scholarships: Proportion of Health Scholarship recipients placed in Indian health settings within 90 days of graduation. (Outcome)	FY 2019: 42 % Target: 78 % (Target Not Met)	78 %	50 %	-28 Awards
IHP-1 Number of scholarship awards under section 103 (Output)	FY 2019: 64 Awards Target: 89 Awards (Target Not Met)	89 Awards	65 Awards	-24 Awards
IHP-2 Number of scholarship awards under section 104 (Output)	FY 2019: 224 Awards Target: 223 Awards (Target Exceeded)	223 Awards	250 Awards	+27 Awards
IHP-3 Number of externs under section 105 (Output)	FY 2019: 34 Externs Target: 135 Externs (Target Not Met)	135 Externs	100 Externs	-35 Externs
IHP-4 Number of new 2 year contract awarded loan repayments under section 108 (Output)	FY 2019: 565 contracts Target: 465 contracts (Target Exceeded)	465 contracts	492 contracts	+27 Contracts
IHP-5 Number of continuing 1 year loan repayment contract extensions under section 108 (Output)	FY 2019: 481 Awards Target: 360 Awards (Target Exceeded)	360 Awards	500 Awards	+140 Awards
IHP-6 Total number of new awards funded in previous fiscal year under	FY 2019: 478 awards Target: 360 awards (Target Exceeded)	360 awards	465 awards	+105 Awards

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2020 Target	FY 2021 Target	FY 2021 Target +/-FY 2020 Target
section 108 (Outcome)				

* FY 2020 "Targets" include estimates based on complete FY 2019 funding cycle data.
** The "Number of Loan Repayments – Total" includes New Awards, Contract Extensions and Continuation Awards.

GRANTS AWARDS

The IHP administers three grant programs which fund colleges and universities to train students for health professions: (1) Quentin N. Burdick American Indians into Nursing Program (Section 112), (2) Indians into Medicine Program (Section 114), and (3) American Indians into Psychology Program (Section 217). These programs provide support to students during their health career professional pathway and encourage students to practice in the Indian health system.

(whole dollars)	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Quentin N. Burdick American Indians Into Nursing Program (Section 112) – CFDA No. 93.970			
Number of Awards	5	5	5
Average Award	$336,341	$336,341	$336,341
Range of Awards	$336,341	$336,341	$336,341
Indians Into Medicine Program (Section 114) – CFDA No. 93.970			
Number of Awards	4	4	4
Average Award	$321,250	$321,250	$321,250
Range of Awards	$195,000 - $700,000	$195,000 - $700,000	$195,000 - $700,000
American Indians Into Psychology Program (Section 217) – CFDA No. 93.970			
Number of Awards	3	3	3
Average Award	$240,785	$240,785	$240,785
Range of Awards	$240,785	$240,785	$240,785

Scholarship Program Awards – In FY 2019, students in the following disciplines received IHS Scholarship Program funding:

Section 103 Pre-professional - 17 students				
Pre-Clinical Psychology	3		Pre-Pharmacy	6
Pre-Nursing	3		Pre-Social Work	5
Section 103 Pre-graduate – 48 students				
Pre-Dentistry	10		Pre-Optometry	4
Pre-Medicine	32		Pre-Podiatry	2

Section 103 Pre-professional - 17 students				
Section 104 Health Professions - 223 students				
Counseling Psychology	5		Pharmacy	19
Dentistry	18		Physical Therapy	6
Chemical Dependency	2		Physician Assistant	17
Clinical Psychology	8		Optometry	13
Nurse Practitioner	20		Physician, Allopathic	44
Nurse, Baccalaureate Degree	25		Physician, Osteopathic	28
Nurse, Psychiatric	1		Podiatry	2
Nurse Midwife	1		Social Work	11
Nurse Anesthetist	2		Ultrasonography	1

Loan Repayment Program Awards – In FY 2019, the IHS LRP made awards to the following disciplines:

Awards by Profession	Total Awards	New Awards	Contract Extensions	Matched Not Awarded
Behavioral Health	76	41	35	61
Dental*	100	35	65	14
Nurse	260	206	54	193
Optometrists	60	12	48	2
Pharmacists	170	73	97	140
Physician Assistants/ Advanced Practice Nurses	126	69	57	48
Physicians	119	51	68	25
Podiatrists	20	7	13	1
Rehabilitative Services	77	43	34	21
Other Professions	38	28	10	27
TOTAL	**1046**	**565**	**481**	**532**

* Includes Dentists and Dental Hygienists.

Other Professions	Total Awards	Matched Not Awarded	By Pay System	Awards
Acupuncturist	1	0	Tribal Employees	645
Chiropractors	5	0	Civil Service	295
Dietetics/Nutrition	7	11	Commissioned Corps	97
Engineering	10	5	Urban Health Employees	9
Medical Laboratory Scientist	6	10		
Medical Technology	1	1		
Radiology Technicians	1	0		
Sanitarian	7	0		
TOTAL	**38**	**27**	**Total**	**1046**

Extern Program Awards – In FY 2019, the IHS Extern Program funded summer or winter externships for the following Area Offices for a total of 34:

AREA OFFICES	NUMBER OF EXTERNS
ALASKA	0
BEMIDJI	0
BILLINGS	6
CALIFORNIA	0

GREAT PLAINS	2
NASHVILLE	0
NAVAJO	4
OKLAHOMA	18
PHOENIX	0
PORTLAND	1
ALBUQUERQUE	3

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

TRIBAL MANAGEMENT GRANT PROGRAM

(Dollars in Thousands)

	FY 2019[1]	FY 2020	FY 2021	
	Final	Enacted	President's Budget	FY 2021 +/- FY 2020
BA	$2,165	$2,465	$0	-$2,465
FTE*	0	0	0	0

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

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

FY 2021 Authorization.....Permanent

Allocation Method ..... Discretionary competitive grants to Tribes and Tribal organizations

PROGRAM DESCRIPTION

The Tribal Management Grant (TMG) program was authorized in 1975 under Sections 103(b)(2) and 103(e) of Public Law (P.L.) 93-638, Indian Self-Determination and Education Assistance Act (ISDEAA), as amended. Under the authority of the ISDEAA, the program was established to assist all federally recognized Indian Tribes and tribally-sanctioned tribal organizations (T/TO) to plan, prepare, or decide to assume all or part of existing Indian Health Service (IHS) programs, functions, services, and activities (PFSA) and to further develop and enhance their health program management capability and capacity. (IHS Strategic Goal 1, Objective 1.1: Recruit, develop, and retain a dedicated, competent, and caring workforce and Objective 1.2: Build, strengthen, and sustain collaborative relationships.) The TMG program has provided discretionary competitive grants to T/TO, to establish goals and performance measures for current health programs, assess current management capacity to determine if new components are appropriate, analyze programs to determine if T/TO management is practicable, and develop and enhance infrastructure systems to manage or organize PFSA. The nature of the TMG program allowed T/TO the option to enter or not enter into ISDEAA contracts/compact agreements which are equal expressions of self-determination. (IHS Strategic Goal 3, Objective 3.1: Improve communication within the organization with Tribes, Urban Indian Organizations, and other stakeholders, and with the general public.)

The IHS established four funding priorities for the TMG program:

- Tribes that receive federal recognition or restoration within the last five years with implementing or developing management and infrastructure systems for their organization
- T/TO that need to improve financial management systems to address audit material weaknesses

[1] Reflects Services account adjustments related to formal reprogramming notifications submitted to Congress in FY 2019. Amounts by "Sub IHS Activity" will continue to be adjusted during the period of availability, which conclude on September 30, 2020, for impacted funds.

- Eligible Direct Service and Title I Federally recognized Indian Tribes or Tribal organizations submitting a competing continuation application or new application
- Eligible Title V Self Governance Federally recognized Indian Tribes or Tribal organizations submitting a competing continuation or new application.

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

(1) Planning - fund up to $50,000 with project periods not to exceed 12 months. A Planning Project allows establishment of goals and performance measures for current health programs or to design their health programs and management systems.
(2) Evaluation - fund up to $50,000 with project periods not to exceed 12 months. An Evaluation Study Project determines the effectiveness and efficiency of a program or if new components are needed to assist the T/TO to improve its health care delivery system.
(3) Feasibility - fund up to $70,000 with project periods not to exceed 12 months. A Feasibility study analyzes programs to determine if T/TO management is practicable.
(4) Health Management Structure (HMS) grants are funded up to $300,000 with project periods not to exceed 36 months. HMS projects include the design and implementation of systems to manage PFSA, such as Electronic Health Records (EHR) systems or billing and accounting systems, management systems, health accreditation, as well as correction of audit material weaknesses.

The IHS Tribal Management Grants program supports the IHS Strategic Plan Goal 1 to ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to AI/AN by directly providing Tribes and Tribal organizations grant opportunities to develop systems, support financial management systems, and expand programs to increase access to preventive care services and quality health care.

PROGRAM ACCOMPLISHMENTS

Fiscal Year	New Funded Awards	*Cont: 2/3 Year	Total Award
FY 2016	7	7	$1,164,442
FY 2017	16	3	$1,786,683
FY 2018	16	8	$2,235,271
FY 2019	11	15	$2,391,223

* Grants which originally had two or three year project periods and were in their second or third year of funding.

- Since 2015, increased the number of awards for new and continued with available funds. *Goal 1, Objective 1.1 – Recruit, develop, and retain a dedicated, competent, and caring workforce*.
- Provided technical assistance to potential applicants – *Goal 3, Objective 3.1 – Improve communication within the organization with Tribes, Urban Indian Organizations, and other stakeholders, and with the general public.*
- Approximately one percent of TMG funding has been used for overall administration of the program; these funds provide TMG program requirements, training, and general technical assistance. – *Goal 1, Objective 1.2 – Build, strengthen, and sustain collaborative relationships.*

FUNDING HISTORY/REQUEST

Fiscal Year	Amount
2017	$2,465,000
2018	$2,465,000
2019	$2,165,000
2020 Enacted	$2,465,000
2021 President's Budget	$0

TRIBAL SHARES

Program funds are not subject to tribal shares since they are transferred through a federally-administered grant program.

BUDGET REQUEST

The FY 2021 budget submission for Tribal Management Grants is $0, which is $2.5 million below the FY 2020 Enacted Level and the program is proposed for elimination

OUTPUTS / OUTCOMES

Measure	**Year and Most Recent Result / Target for Recent Result / (Summary of Result)**	**FY 2020 Target**	**FY 2021 Target**	**FY 2021 Target +/-FY 2020 Target**
TMG-1 Planning Grants (Output)	FY 2019: 0 planning grants Target: 1 planning grants (Target Not Met)	0 planning grants	0 planning grants	N/A
TMG-2 Health Management Structure (HMS) grants (Output)	FY 2019: 14 HMS grants Target: 2 HMS grants (Target not met)	0 HMS grants	0 HMS grants	N/A

GRANTS AWARDS

(whole dollars)	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Number of Awards	20 Total Awards: 11 Noncompeting Continuations and 9 New	18 Total Awards: 6 Noncompeting Continuations and 12 New	N/A
Average Award	$105,135	$130,000	N/A
Range of Awards	$50,000 - $150,000	$50,000 - $150,000	N/A

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

(Dollars in Thousands)

	FY 2019[1]	FY 2020	FY 2021	
	Final	Enacted	President's Budget	FY 2021 +/- FY 2020
BA	$70,788	$71,538	$81,480	+$9,942
FTE*	275	275	287	+12

*FTE numbers reflect only Federal staff and do not include increases for 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 2021 Authorization.....Permanent

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

PROGRAM DESCRIPTION

The Direct Operations budget supports the Indian Health Service (IHS) provision of Agency-wide leadership, oversight, and executive direction for the comprehensive public and personal health care provided to American Indians and Alaska Natives (AI/AN). Funds are used to promote the efficient and effective administration and oversight of national functions such as: human resources (HR), financial management, acquisitions, internal control and risk management, health care and facilities planning, health information technology, Contract Disputes Act claims analysis, and other administrative support and systems accountability. These types of direct operations performed at the Headquarters and Area Office levels provide the foundation necessary to carry out the Agency mission.

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

By delegation from the IHS Director, the 12 Area Offices distribute resources, carry out policies and internal controls, monitor and evaluate the full range of comprehensive healthcare and community-oriented public health programs, and provide technical support to local Service Units

[1] Reflects Services account adjustments related to formal reprogramming notifications submitted to Congress in FY 2019. Amounts by "Sub IHS Activity" will continue to be adjusted during the period of availability, which conclude on September 30, 2020, for impacted funds.

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

Direct Operations funding supports all three goals of the IHS Strategic Plan. Recruitment, development, and retention of a dedicated, competent, and caring workforce (Goal 1, Access, Objective 1.1) is the foundation for improving quality (Goal 2) and strengthening management and operations (Goal 3). These funds are essential for sustaining a human resources program that can enhance and retain a workforce to carry out the agency's mission. The funds also support quality improvement capabilities (Goal 2, Quality, Objective 2.1) to ensure a quality healthcare program that promotes accountability, integrity, and stewardship. Woven through all of these components are the concerted efforts to continually strengthen IHS program management and operations through improved communication (Goal 3, Objective 3.1), secure and effective management of IHS's assets and resources (Goal 3, Objective 3.2), and modernization of information technology and systems to support data driven decisions (Goal 3, Objective 3.3).

PROGRAM ACCOMPLISHMENTS

The Direct Operations budget is critical for continued progress in assuring an accountable, quality, and high-performing Indian health system. Examples of significant agency activities made possible by Direct Operations funds are provided below.

To establish long term goals for quality implementation and outcomes, the IHS developed a five-year (2019-2023) Strategic Plan. The Strategic Plan was published in February 2019 after extensive gathering of stakeholder input. The IHS initiated Tribal Consultation and Urban Confer on the IHS Strategic Plan initial framework and formed an IHS Federal-Tribal Strategic Planning Workgroup to review all comments and recommend a list of final goals and objectives for IHS leadership review and approval. The plan promotes a culture of accountability, quality, and patient safety across the agency, and serves as a roadmap for continual quality improvement.

In December 2018, the Office of Quality (OQ) was formally established within the IHS Headquarters to continue elevation of and national coordination and oversight for quality across the IHS health care system. The focus of the OQ is to provide a structure to promote accountability and oversight through quality assurance to promote and sustain compliance with Centers for Medicare and Medicaid Services and accreditation organizations; quality improvement through innovation and implementation of quality improvement science; improve patient safety and reduce all cause harm; and enterprise risk management to ensure that high risk agency systems and processes are identified, monitored, and mitigated. Through the national leadership of the OQ in FY 2019, the IHS has made significant strides in addressing priority areas for quality improvement including implementing credentialing and privileging software agency-wide; hiring an IHS credentialing program manager at headquarters; and awarding a new contract for an adverse events reporting and tracking system.

The IHS is committed to making improvements and ultimately to being removed from the Government Accountability Office (GAO) High Risk list. Although the IHS is still on the list, significant progress has been made. The GAO cited 14 open recommendations in the High Risk Reports. Of those 14 recommendations cited in the High Risk Reports, GAO closed 11 recommendations.

Like other rural healthcare providers, the IHS historically has difficulties recruiting and retaining healthcare providers. To address these challenges, IHS continues to maximize the use of available recruitment and retention tools such as recruitment, retention, and relocation incentives; and use of Title 38 pay authorities. Most recently, the IHS worked to convert podiatrist salaries to Title 38 to aid in the recruitment and retention of these critical healthcare providers. The IHS has also increased its competitive stance in the healthcare labor market through Title 38 Special Salary Rate (SSR) pay tables and developed a new table for licensed practical nurses and dental hygienists who serve in our hospitals and health centers. Additionally, pay rates have been increased in Title 38 SSRs for physician assistants and optometrists to ensure we are able to offer competitive salaries.

To strengthen human resource management, the IHS implemented the Security Manager System. This system supports the entire life cycle of IHS's personnel security and suitability processes, to include capturing and managing background investigations. Security Manager has a customized workflow that ensures proper case management with a complete audit trail into the personnel security process. Use of this electronic system provides a simplified, streamlined, and standardized personnel security management process across the IHS.

In FY 2019, the IHS continued to expand the use of data analysis and visualization tools to enhance reporting and data-driven decisions. Building on the successful completion of the IHS 3rd Party Revenue Dashboard—a Qliksense based application developed to enhance reporting, trend analysis, and monitoring of third-party resources (e.g. Medicare and Medicaid) collected by federally-operated facilities—the IHS completed the "Follow the Money" Dashboard. This dashboard allows non-technical users to review funding status and spending data related to Purchased/Referred Care (PRC) instantly. Both applications democratize data previously held only in the proprietary accounting and reporting systems, Unified Financial Management System and Financial Business Intelligence System. Users are able to access data in a non-technical format that can be quickly sorted and compared by parameters such as type, Area, Service Unit, month, and fiscal year. This capability eliminates delays in accessing data through production financial systems, provides more financial information more widely, and reduces the requirement for a skilled financial analyst to produce labor intensive reports on demand, thereby freeing valuable time for value added analysis.

The IHS is committed to ensuring quality care for all patients and is actively working on deploying innovative strategies with a focus on achieving and sustaining improvements in quality of care, accountability and data-driven decision making, and recruiting and retaining a high performing workforce.

FUNDING HISTORY

Fiscal Year	Amount
2017	$70,420,000
2018	$72,338,000
2019	$70,788,000
2020 Enacted	$71,538,000
2021 President's Budget	$81,480,000

TRIBAL SHARES

Direct Operations funds are subject to Tribal shares and are transferred to Tribes when they assume the responsibility for operating the associated programs, functions, services, and

activities. A portion of the overall Direct Operations budget line is reserved for inherently federal functions and is therefore retained by the IHS.

BUDGET REQUEST

The FY 2021 budget submission for Direct Operations is $81.5 million, which is $9.9 million above the FY 2020 Enacted Level.

FY 2020 Base Funding of $71.5 million – Funding provides for the direct operations of IHS's system-wide administrative, management, and oversight priorities at the discretion of the IHS Director that include:

- Continuing vital investments to enhance the IHS's capacity for providing comprehensive oversight and accountability in key administrative areas such as: human resources, property, acquisition, financial management, information technology, and program and personnel performance management.
- Improving responsiveness to external authorities such as Congress, the GAO, and the Office of Inspector General (OIG); and addressing Congressional oversight and reports issued by the GAO and the OIG to make improvements in management of IHS programs, such as the PRC program, quality oversight, and workforce.
- Addressing requirements for national initiatives associated with privacy requirements, facilities, and personnel security.
- Continuing analysis and settlement of tribal contracting and compacting Contract Support Costs (CSC) claims and maintaining policies and procedures to accurately determine CSC needs in the future.

FY 2021 Funding Increase of $9.9 million includes:

Current Services: +$44,000 for current services including:

- Inflation +$44,000 – to fund inflationary costs.

Quality & Oversight: +$4.9 million to provide expanded administrative oversight of national functions such as: human resources, financial management and health care facilities planning, as well as advancing the overall Agency-wide mission, priorities, and strategic plan.

Program Adjustment: +$4.9 million - to continue improvements in management and operations of the IHS, in alignment with the IHS Strategic Plan. Funds will enable continued and meaningful progress in addressing concerns raised by the GAO related to quality of care (GAO-17-181: Actions Needed to Improve Oversight of Quality of Care, published Jan 9, 2017) and recruitment of clinical providers (GAO-18-580: Agency Faces Ongoing Challenges Filling Provider Vacancies, published Aug 15, 2018). In addition, funding will provide resources for negotiating and administering lease cost agreements with Tribes and Tribal organizations authorized by the Indian Self-Determination and Education and Assistance Act, commonly referred to as 105(*l*) leases.

The increased funding level will enable continued implementation of the OQ for leading all quality and patient safety work including oversight of national policy, quality improvement strategies, and monitoring accountability of federally-operated facilities. Funds will be used for recruitment of additional staff and to provide the administrative and operational support necessary for carrying out the functions of the new Headquarters office.

Funds will also be used to strengthen the IHS's capacity for oversight in key areas such as workforce management and development, finance, acquisitions, and other evolving areas identified by agency leadership. The increase in administrative and operational funds will allow IHS to establish and sustain the level of national oversight required for a highly-functioning agency. Additional staff and operational funds will increase the efficiency and effectiveness of Headquarters programs focused on policy management and compliance, competency training, evaluation, data analysis and reporting, and accountability. Investments will also be made in enhanced automation tools to increase capacity for: data analysis and reporting that facilitates more informed data-driven decisions, more efficient responses to internal and external stakeholders on topics such as the budget, and managing workforce and personnel security. The OQ would provide for quality systems integration and address quality assurance, patient safety, business intelligence, risk management, and quality improvement.

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

	FY 2019 Enacted	**FY 2020 Enacted**	**FY 2021 President's Budget**
Headquarters (59.2%)	$41,906,496	$42,350,496	$48,236,160
Area Offices (12) (40.8%)	$28,881,504	$29,875,504	$33,243,840
BA	**$70,788,000**	**$71,538,000**	**$81,480,000**

AREA ALLOCATION

Direct Operations
(dollars in thousands)

DISCRETIONARY SERVICES	FY 2019 Final 1/			FY 2020 Estimated			FY 2021 Estimated			FY'21 +/- FY'20
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$35	$10,151	$10,186	$36	$10,259	$10,294	$41	$11,684	$11,725	$1,431
Albuquerque	855	669	1,524	864	676	1,540	984	770	1,754	214
Bemidji	1,197	0	1,197	1,210	0	1,210	1,378	0	1,378	168
Billings	1,889	71	1,960	1,909	72	1,981	2,175	82	2,256	275
California	1,271	0	1,271	1,285	0	1,285	1,463	0	1,463	179
Great Plains	2,091	0	2,091	2,113	0	2,113	2,407	0	2,407	294
Nashville	880	1,698	2,578	889	1,716	2,606	1,013	1,955	2,968	362
Navajo	2,627	0	2,627	2,655	0	2,655	3,024	0	3,024	369
Oklahoma	1,558	3,839	5,397	1,574	3,880	5,454	1,793	4,419	6,212	758
Phoenix	2,280	877	3,156	2,304	886	3,190	2,624	1,009	3,633	443
Portland	1,641	1,453	3,094	1,658	1,468	3,126	1,889	1,672	3,561	434
Tucson	585	0	585	591	0	591	673	0	673	82
Headquarters	35,120	0	35,120	35,492	0	35,492	40,425	0	40,425	4,933
Total, Direct Ops	**$52,029**	**$18,758**	**$70,788**	**$52,580**	**$18,957**	**$71,538**	**$59,888**	**$21,592**	**$81,480**	**$9,942**

1/ Reflects Services account adjustments related to formal reprogramming notifications submitted to Congress in FY 2019. Amounts by "Sub IHS Activity" will continue to be adjusted during the period of availability, which conclude on September 30, 2020, for impacted funds.
Note: FY 2020 through 2021 are estimates.

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

(Dollars in Thousands)

	FY 2019[1]	FY 2020	FY 2021	
	Final	Enacted	President's Budget	FY 2021 +/- FY 2020
BA	$4,806	$5,806	$4,887	-$919
FTE*	12	12	12	0

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

Authorizing Legislation ..... Title V of the Indian Self-Determination and Education Assistance Act (ISDEAA), as amended 25 U.S.C. § 5381 et seq., 42 C.F.R. Part 137

FY 2021 Authorization.....Permanent

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

PROGRAM DESCRIPTION

The Office of Tribal Self-Governance (OTSG) is responsible for a wide range of agency functions that are critical to the IHS's *efforts to build, strengthen, and sustain collaborative relationships (IHS Strategic Plan FY 2019-2023, Goal 1, Objective 1.2)* with American Indian and Alaska Native (AI/AN) nations, Tribal organizations, and other AI/AN groups. Since 1993, the Indian Health Service (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] Today, Indian Tribes and Tribal organizations administer over one-half of IHS resources through ISDEAA self-determination contracts and self-governance compacts.

The Self-Governance budget supports several activities:

- Develops and oversees the implementation of Tribal self-governance legislation and authorities in the IHS that build, strengthen, and sustain collaborative relationships *(IHS Strategic Plan FY 2019-2023, Goal 1, Objective 1.2) that increase access to quality health care services (Strategic Goal 1, Objective 1.3) and provides care to better meet the health care needs of American Indian and Alaska Native communities (Strategic Goal 2, Objective 2.2).*
- Reviews eligibility requirements for Tribes to participate in the Tribal Self-Governance Program and receives Self-Governance Planning and Negotiation Cooperative Agreements that will help to *promote excellence and quality through innovation of the Indian health system into an optimally performing organization (Strategic Goal 2, Objective 2.1) and to provide care to better meet the health care*

[1] Reflects Services account adjustments related to formal reprogramming notifications submitted to Congress in FY 2019. Amounts by "Sub IHS Activity" will continue to be adjusted during the period of availability, which conclude on September 30, 2020, for impacted funds.

needs of American Indian and Alaska Natives communities (Strategic Goal 2, Objective 2.2).

- Provides resources and technical assistance to Tribes and Tribal organizations *to build, strengthen, and sustain collaborative relationships (IHS Strategic Plan FY 2019-2023, Goal 1, Objective 1.2)* for the implementation of Tribal self-governance.
- Provides Tribal Self-Governance Program training to Tribes, Tribal organizations, and Tribal groups *to build, strengthen, and sustain collaborative relationships (IHS Strategic Plan FY 2019-2023, Goal 1, Objective 1.2) that increase access to quality health care services (Strategic Plan, Goal 1, Objective 1.3*).
- Coordinates national Tribal self-governance meetings, including an annual consultation conference in partnership with the Department of the Interior, to promote the participation by all AI/AN Tribes in the IHS Tribal Self-Governance program *and improve communication within the organization with Tribes, Urban Indian Organizations, and other stakeholders, and with the general public (Strategic Goal 3, Objective 3.1).*
- Develops, publishes, and presents information related to the IHS Tribal Self-Governance Program activities that will *build, strengthen, and sustain collaborative relationships (IHS Strategic Plan FY 2019-2023, Goal 1, Objective 1.2) with Tribes, Tribal organizations, state and local governmental agencies, and other interested parties to improve communication within the organization with Tribes, Urban Indian Organizations, and other stakeholders, and with the general public (Strategic Goal 3, Objective 3.1).*
- Coordinates self-governance Tribal Delegation Meetings for IHS Headquarters, and Area Senior officials to *build, strengthen, and sustain collaborative relationships (IHS Strategic Plan FY 2019-2023, Goal 1, Objective 1.2) that will provide care to better meet the health care needs of American Indian and Alaska Native communities (Strategic Goal 2, Objective 2.2) and improve communication within the organization with Tribes, Urban Indian Organizations, and other stakeholders, and with the general public (Strategic Goal 3, Objective 3.1).*

PROGRAM ACCOMPLISHMENTS

The IHS Tribal Self-Governance Program has grown dramatically since the execution of the initial 14 compacts and funding agreements in 1994. In Fiscal Year 2019, IHS transferred approximately $2.4 billion of the total IHS budget appropriation to Tribes and Tribal organizations to support 104 ISDEAA self-governance compacts and 130 funding agreements.[2]

The Self-Governance budget brings health care quality expertise to the IHS, and Tribes, by:

- Providing support for projects that assist Tribally operated health programs *that build, strengthen, and sustain collaborative relationships (IHS Strategic Plan FY 2019-2023, Goal 1, Objective 1.2)* to enhance information technology infrastructure *that create quality improvement capability at all levels of the*

[2] For FY 2020, the IHS estimates an additional five to ten Tribes will be entering into Title V ISDEAA compacts and funding agreements. This estimate corresponds to the number of Self-Governance Negotiation Cooperative Agreements available each fiscal year. Eligibility requirements for these agreements mirror the statutory requirements that Tribes must meet to participate in the IHS Tribal Self-Governance Program (25 U.S.C. §5383; 42 C.F.R. Part 137, Subpart C). For this pool, an average estimate of $5 million per Tribe is used to project estimates for Tribes entering into a Title V ISDEAA compacts and funding agreements, inclusive of both tribal shares and Contract Support Costs.

organization (Strategic Goal 2, Objective 2.1) and prepare for meaningful use and other federal reporting *standards that modernize information technology and information systems to support data driven decisions (Strategic Goal 3, Objective 3.3)*

- Collaborating on crosscutting issues and processes including, but not limited to: program management issues; self-determination issues; Tribal shares methodologies; and emergency preparedness, response and security *to secure and effectively manage the assets and resources (IHS Strategic Plan FY 2019-2023, Goal 3, Objective 3.2) and modernize information technology and information systems to support data driven decisions (Strategic Goal 3, Objective 3.3).*

These services are deployed in accordance with strategic planning, are data driven, and support program integrity *that create quality improvement capability at all levels of the organization (IHS Strategic Plan FY 2019-2023, Goal 2, Objective 2.1)* through adherence to reporting requirements. The Office of Tribal Self-Governance Funds Management Database supports the delivery of services by improved access to data *through secure and effective management of assets and resources (Strategic Goal 3, Objective 3.2)* to evaluate performance and identify areas of process improvement *and modernize information technology and information systems to support data driven decisions (Strategic Goal 3, Objective 3.3).*

FUNDING HISTORY

Fiscal Year	Amount
2017	$5,786,000
2018	$5,806,000
2019	$4,806,000
2020 Enacted	$5,806,000
2021 President's	$4,887,000

BUDGET REQUEST

The FY 2021 budget submission for Self-Governance is $4.9 million, which is $919,000 below the FY 2020 Enacted Level.

FY 2020 Base Funding of $5.8 million: The base funding supports further implementation of the IHS Tribal Self-Governance program, continues funding for Planning and Negotiation Cooperative Agreements to assist Indian Tribes to prepare and enter into the IHS Tribal Self-Governance program, and continues to fund performance projects and Tribal share needs in IHS Areas and Headquarters for any AI/AN Tribes that have decided to participate in the IHS Tribal Self-Governance program**.**

- Program Adjustment --$919,000 - to maximize funding through Services and Facilities to protect direct patient care services.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2020 Target	FY 2021 Target	FY 2021 Target +/-FY 2020 Target
TOHP-SP Implement recommendations from Tribes annually to improve the Tribal Consultation process and IHS operations. (Output)	FY 2019: 6 recommendations Target: 3 recommendations (Target Exceeded)	3 recommendations	4 recommendations	+1

GRANT AWARDS

(whole dollars)	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Planning Cooperative Agreements			
Number of Awards	6	5	5
Award Amount	$113,100-120,000	$120,000	$120,000
Negotiation Cooperative Agreements			
Number of Awards	2	5	5
Award Amount	$48,000	$48,000	$48,000

AREA ALLOCATION

Self-Governance

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2019 Final 1/			FY 2020 Estimated			FY 2021 Estimated			FY'21 +/- FY'20
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Albuquerque	0	0	0	0	0	0	0	0	0	$0
Bemidji	0	0	0	0	0	0	0	0	0	$0
Billings	0	0	0	0	0	0	0	0	0	$0
California	0	0	0	0	0	0	0	0	0	$0
Great Plains	0	0	0	0	0	0	0	0	0	$0
Nashville	0	0	0	0	0	0	0	0	0	$0
Navajo	0	0	0	0	0	0	0	0	0	$0
Oklahoma	0	0	0	0	0	0	0	0	0	$0
Phoenix	0	0	0	0	0	0	0	0	0	$0
Portland	0	0	0	0	0	0	0	0	0	$0
Tucson	0	0	0	0	0	0	0	0	0	$0
Headquarters	4,806	0	4,806	5,806	0	5,806	4,887	0	4,887	-$919
Total, Self-Gov	**$4,806**	**0**	**$4,806**	**$5,806**	**0**	**$5,806**	**$4,887**	**0**	**$4,887**	**-$919**

1/ Reflects Services account adjustments related to formal reprogramming notifications submitted to Congress in FY 2019. Amounts by "Sub IHS Activity" will continue to be adjusted during the period of availability, which conclude on September 30, 2020, for impacted funds.

Note: FY 2020 through 2021 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 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
Medicare	$248,638	$248,638	$260,253	$11,615
Medicaid	$807,605	$807,605	$845,751	$38,146
M/M Total:	**$1,056,243**	**$1,056,243**	**$1,106,004**	**$49,761**
Private Insurance	$109,272	$109,272	$154,333	$45,061
VA Reimbursements	$28,062	$28,062	$8,769	-$19,293
TOTAL :	**$1,193,577**	**$1,193,577**	**$1,269,106**	**$30,468**
FTE 1/	6,187	6,187	6,187	0

1/ FTE numbers reflect only federal staff and do not include increases in tribal staff.

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

PROGRAM DESCRIPTION

In 1976, the Indian Health Care Improvement Act (IHCIA) authorized the Indian Health Service (IHS) to collect Medicare and Medicaid (M&M) reimbursements for services provided in IHS facilities to patients with M&M eligibility. The IHCIA was later amended to allow IHS to collet Private Insurance (PI) reimbursements for services provided in IHS facilities for patients with PI. In 2010, the IHCIA was amended to authorize the IHS to be reimbursed by the Department of Veterans Affairs (VA) and the Department of Defense for services provided through the IHS to beneficiaries eligible for services from either such Department. In 2012, the IHS and the VA signed an agreement under which VA to reimburses IHS for direct care services provided through the IHS to eligible American Indian and Alaska Native (AI/AN) veterans.

In fiscal year (FY) 2019, $1.140 billion was collected from third party insurers, of which $995 million was Federal M&M collections and $138,349 million was collected from private insurers. The FY 2021 estimates above are based on the FY 2019 actual collections.

Public and private collections represent a significant portion of the IHS and Tribal health care delivery budgets. Some IHS health care facilities report that 60 percent or more of their yearly budget relies on revenue collected from third party payers. In order to fulfill the IHS Mission, IHS continues its efforts to improve the revenue generation process by including the IHS Strategic Plan FY 2019-2023 Goals and Objectives. Collection efforts from all payers by IHS facilities supports *Goal 1: To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people as well as Objective 1.3, Increase access to*

quality health care services.

Accreditation - In accordance with IHCIA authorization for collections, the IHS places the highest priority on meeting accreditation and certification standards for its healthcare facilities. Third party revenue is essential to maintaining facility accreditation, certification and standard of health care through organizations such as The Joint Commission or the Accreditation Association for Ambulatory Health Care. Collection funds are ultimately used to improve the delivery and access to healthcare for American Indian and Alaska Native (AI/AN) people. This activity supports the IHS Strategic Plan Goal 2: To promote excellence and quality through innovation of the Indian health system into an optimally performing organization. Feedback obtained from accreditation organizations during the review process is used by IHS facilities to support *Objective 2.1, Create quality improvement capability at all levels of the organization.*

Monitoring – The IHS employs an online system to monitor the third party reimbursement process for IHS operated facilities. The Third Party Internal Controls Self-Assessment Tool provides necessary information for local managers and Headquarters staff to monitor compliance with applicable policies and procedures during the third party revenue collections process so they can take necessary actions and improve overall program activity. The IHS has also implemented Third Party Revenue Collections and Third Party Alternate Resource (health insurance coverage) Dashboards to monitor collections and insurance coverage at the National, Area, State and local level. Training of revenue cycle staff to use the dashboards effectively to identify areas for improvement began in FY 2018 and will continue in FY 2020. In FY 2020, IHS will focus on development and implementation of a standard site review/site assessment/site internal auditing template.

In FY 2020, IHS will continue to strengthen its revenue generation policies and management practices, including internal controls, patient registration, patient benefits coordination, provider documentation training, certified procedural coding training, third party billing, electronic claims processing, accounts receivable, and debt management. Priority activities will include enhancement of third party billing and accounts receivable software to improve effectiveness and to ensure system integration with its business processes, compliance with M&M regulations, and industry standards and changes in operational processes. Improvements for IHS operated facilities are coordinated with concurrent enhancements in Purchased Referred Care business practices related to alternate resources. IHS has developed and implemented various tools including reports to analyze a facility's service population and identify opportunities to increase revenue. These efforts support the *IHS Strategic Plan Goal 3: To strengthen IHS program management and operations, and specifically, Objective 3.2, Secure and effectively manage the assets and resources, as well as Objective 3.3, Modernize information technology and information systems to support data driven decisions.*

In addition, IHS continues to ensure compliance with statutory rules and regulations that impact third party collections directly and indirectly. Rules pertaining to the Medicare and Medicaid programs continue to have a direct impact on revenue generation. IHS has formed workgroups to maximize the positive impact for all IHS, Tribal, and Urban Indian health program facilities, such as the National Business Office Committee, which serves as a subcommittee to the National Council of Executive Officers. These efforts support the IHS Strategic Plan *Goal 3: To strengthen IHS program management and operations, and Goal 3, Objective 1.2 Build, strengthen and sustain collaborative relationships.*

Partnerships – IHS is working to develop and enhance partnerships with federal and state agencies in support of IHS Strategic Plan *Goal 1, Objective 1.2: Build, strengthen, and sustain collaborative relationships.* IHS continues to work with CMS and the state Medicaid agencies to identify patients who are eligible to enroll in M&M and the state Children's Health Insurance Programs. IHS also continues these partnerships in the implementation of provisions in the IHCIA, and the Children's Health

Insurance Program Reauthorization Act. Enrollment and collections depend, in large part, on IHS's successful partnerships/relationships, state participation in Medicaid expansion, and awareness and willingness of IHS users to enroll in Medicaid and other programs.

IHS Areas have begun implementing care coordination agreements between IHS facilities and non-IHS providers, including urban Indian health care organizations for the purpose of facilitating 100 percent reimbursement to the states by Medicaid for payments they make to IHS and tribal health care providers when they treat IHS-eligible and Medicaid enrolled American Indian and Alaska Natives. Some states have committed to dedicate any cost savings to increasing services and access to care for Indians. IHS anticipates that in-network contracting with health plans may work for many facilities and is working with CMS to identify ways to provide informational resources for implementation. IHS is continuing to implement, train, and participate in the Medicare Payment Reform/Quality Initiative efforts by CMS. This includes increasing awareness, training and implementation of the Quality Payment Program under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). IHS is working on implementation of the Merit-Based Incentive Payment System and Advanced Alternative Payment Models with the end goal of improving quality and access to care.

IHS collaborates with CMS and the Tribes on a number of matters, including implementation of and training regarding recent changes in legislation, eligibility policies, covered services policies, reimbursement policies and payment methodologies, claims processing, denials, training and use of information technology resources at IHS and Tribal sites to increase the enrollment of M&M eligible AI/AN patients. IHS continues to coordinate outreach, education, and training efforts in collaboration with other federal, state and Tribal partners. IHS has partnered with CMS to provide a number of training sessions nationwide for Tribal and IHS employees, focusing on outreach and improving access to M&M programs. These training activities support the *IHS Strategic Plan Goal 1, Objective 1.1, Recruit, develop, and retain a dedicated, competent, and caring workforce and Goal 3, Objective 3.2: Secure and effectively manage the assets and resources*

In December 2012, IHS and the Department of Veterans Affairs (VA) signed the VA/IHS National Reimbursement Agreement that facilitates reimbursement by the VA to the IHS and Tribal facilities for direct health care services provided to eligible AI/AN veterans. In January 2017, IHS renewed its interagency agreement with the VA to facilitate the use of the Veteran's Health Administration (VHA) Consolidated Mail Outpatient Pharmacy (CMOP) System by the IHS. The intent of this agreement is to cost-effectively expand clinical and support capabilities of participating facilities through use of VHA CMOP resources and by combining participating facilities' prescription needs with VHA's. Improved efficiencies are gained through more efficient and effective use of staff, reduction in medication error costs, and reduction in medication error litigation. In June 2018, the IHS and VA signed an amendment to the agreement that extends the period of the reimbursement agreement through June 30, 2022. This was a significant step in continuing to ensure implementation of Section 405 of the IHCIA. The agreement represents a positive partnership to support improved coordination of care and non-duplication of resources between IHS federal facilities and the VA and it paved the way for agreements negotiated between VA and tribal health programs. IHS will continue to work directly with the VA to implement billing practices to ensure IHS receives proper payment for care provided at IHS and Tribal facilities to AI/AN veterans. Monitoring, auditing, and compliance with the agreement will continue to be a focus for FY 2019 through FY 2022. These efforts focus on the IHS Strategic Plan *Objective 1.2: Build, strengthen, and sustain collaborative relationships.*

Training - IHS provides continuous training to health care facility staff in areas related to various functions within the revenue cycle, including patient registration, benefits coordination, coding, third party billing, accounts receivable and other aspects of the revenue cycle. Programs are expected to

ensure sufficient resources and training for staff to capture insurance in the Resource and Patient Management System (RPMS) system and bill accordingly. Area I/T/U staff are highly encouraged to participate in annual CMS trainings. IHS hosts an annual Partnership Conference to provide the most current information related to finance, information technology, health information management, Purchased/Referred Care, and business office functions; special emphasis is also provided for the specific management needs of Tribes and urban programs. These training activities support the IHS Strategic Plan *Goal 1, Objective 1.1, Recruit, develop, and retain a dedicated, competent, and caring workforce and Goal 3, Objective 3.2: Secure and effectively manage the assets and resources.*

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

PROGRAM ACCOMPLISHMENTS

- With the Memorandum of Understanding and amended Reimbursement Agreement between the VA and IHS in place, IHS developed and executed an implementation plan to collect at all IHS federal sites serving eligible Veterans. The VA has approximately 114 agreements with Tribal Health Programs in addition to the agreements at federal sites. This partnership with the VA and implementation of VA reimbursement at IHS sites serve to support the IHS Strategic Plan Objective 1.2: Build, strengthen, and sustain collaborative relationships, *Goal 3, Objective 3.2, Secure and effectively manage the assets and resources and enables IHS to provide further services to local communities funded with these collections.*

- The IHS HQ has also entered into cooperative agreements since 2010 with organizations such as the National Indian Health Board and the National Congress of American Indians to coordinate and conduct consumer centered outreach and education, training and technical assistance on a national scale for the 573 Federally-recognized AI/AN Tribes and Tribal organizations on the changes and authorities of the new legislation for the ACA and the IHCIA. The national organization partners have provided well over 100 training sessions and webinars for Tribes and tribal members, helped coordinate numerous enrollment events, created toolkits for youth and elders and offered technical assistance to AI/AN and non-AI/AN enrollment assisters. Through the IHS National Indian Health Outreach and Education (NIHOE) Initiative, the IHS continues to partner with national and regional Tribal/Indian organizations to educate consumers and tribal governments on the health care insurance options available, the process for enrollment, financial assistance, the exemption options for American Indians and Alaska Natives, eligibility determinations, the tribal employer mandate, and maximizing revenue. This activity supports IHS Strategic *Plan Goal 3, Objective 1.2 Build, strengthen and sustain collaborative relationships.*

- In June 2019, the IHS Office of Resource Access and Partnerships hosted a joint Partnership Conference with nearly 1000 I/T/U attendees from the Business Office, OIT, Health Information Management, Purchased/Referred Care, Finance, and other components of the Revenue Cycle.

- The IHS HQ provided Area Revenue Cycle training in FY 2017, FY 2018, and FY 2019 to most facilities within the Agency. This included Tribal partners as well as Federal sites. Over 500 attendees participated in the training, which covered aspects of the entire revenue cycle. This training focused on Third Party Billing and Accounts Management, and Resource Patient Management

System (RPMS) Process Training. In addition, IHS hosted an Accounts Reconciliation Workshop in FY 2019, which included finance and business office staff from every IHS Area. In FY 2020, similar trainings will be offered to all Areas on the Revenue Cycle.

- In FY 2019, the IHS revised and updated the Revenue Operations Manual (ROM). The ROM provides a system-wide reference resource available to all I/T/U facilities across the United States, to assist staff with functions related to business operation procedures and processes. IHS is now in this process of developing training materials consistent with the IHS Third Party Internal Controls Policy and a training plan to be implemented in FY 2020.

- In FY 2019, IHS began working with Treasury Fiscal Services to further protect, control, and monitor all third party collections. Treasury mandates require that all Federal Agencies move towards an electronic environment for funds transfers and accountability of funds. IHS, in Partnership with Treasury Fiscal Services, PNC Bank (Fiscal Agent) and other Financial Institution began laying the groundwork for converting all paper checks received by the Agency to be settled in a more secure and timely manner. IHS continues to work towards a complete electronic patient account environment, and actually is surpassing industry standards in this arena.

- In FY 2019 IHS drafted a Pharmacy Benefits Manager Contract Review Process in order to more efficiently review, respond, negotiate, and track contract offers, modifications, and amendments. In FY 2020, the process will be fully implemented.

- Finally, in FY 2020 IHS will update the Third Party Internal Controls Self-Assessment Tool questions and collaborate internally on the update of the IHS Debt Management Policy.

FY 2019 - 2021 Collections Estimates

The FY 2019 estimate of collections is based on collections by month through June 30th, 2019; with the remaining 3 months estimated by straight line average. The FY 2020 and FY 2021 amounts are estimated based on the FY 2019 estimate, inflated by the average rate of annual increase from FY 2011 to FY 2018, by collection program. VA Reimbursements were based on a shorter period of average increases, based on it the limited period of time since the establishment of the agreement between IHS and VA to collect these funds.

***Medicare and Medicaid (M&M)* -- The FY 2021 Budget estimate assumes collections of $1.269 billion, $49.8 million over estimated FY 2019 collections:**

- ***Medicaid* – The FY 2021 budget estimate assumes collections of $845.7 million, $38.1 million over estimated FY 2019 collections.** IHS continues to educate its users on the benefits of Medicaid enrollment. IHS continues to monitor its user population and insurance coverage and is making all possible efforts to maximize Medicaid enrollment in all States and to maintain current collection levels.

- ***Medicare*** – **The FY 2021 budget estimate assumes collections of $260.3 million, $11.6 million over estimated FY 2019 collections.** IHS hospitals and clinics have taken strong steps to increase enrollment of its population in Medicare. In addition, IHS has expanded efforts to improve the quality of care and maintain current collections.

Private Insurance – **The FY 2021 budget estimate assumes collections of $154.3 million, $45.1 million over estimated FY 2019 collections.** IHS will continue to monitor its user population and increase direct assistance to stabilize and expand insurance coverage whenever possible to maintain

and maximize private insurance collections.

***VA/IHS National Reimbursement Agreement* – The FY 2021 budget estimate assumes collections of $8.8 million, -$19.3 million below estimated FY 2019 collections.**

The FY 2020 estimate is based on the FY 2019 estimated collections. The estimate includes actual collections received by IHS for Federal. IHS and VA have agreed to continue to monitor FY 2019 actual reimbursements and work together to improve the quality of care for all veterans and maximize payments whenever possible. IHS continues to work with the VA in identifying the actual number of AI/ANs with VA benefits eligibility and, of those, how many receive direct care from IHS. IHS and the VA continue to work in partnership to identify and resolve billing and reimbursement issues and provide sites with on-going support and training. All IHS sites have signed implementation plans and have the ability to bill the VA for Veterans Services.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2021 Performance Budget Submission to Congress

TABLE OF CONTENTS

Facilities

THIS PAGE INTENTIONALLY LEFT BLANK

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

FACILITIES

(Dollars in Thousands)

	FY 2019	FY 2020	FY 2021	
	Final	Enacted	President's Budget	FY 2021 +/- FY 2020
BA	$878,806	$911,889	$769,455	-$142,434
FTE*	1,232	1,232	1,232	--

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

SUMMARY OF THE FACILITIES BUDGET

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

The Facilities Appropriation continues funding for health facility support, public health and preventive services where staff are funded through the Facilities Appropriation to work in healthcare facilities and in the AI/AN communities across Indian country.

BUDGET AUTHORITY

The FY 2021 budget submission for Facilities is $769.455 million and is $142.434 million below the FY 2020 Enacted Level.

Maintenance & Improvement –The FY 2021 budget submission for Maintenance and Improvement is $167.948 million, which is $1 million below the FY 2020 Enacted Level. These funds are the primary source for providing 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 access and care through larger M&I projects to reduce the Backlog of Essential Maintenance, Alteration and Repair (BEMAR), which is estimated at over $648.9 million for all IHS and reporting Tribal facilities;
- Ensuring that health care facilities meet building codes and standards;
- Ensuring compliance with executive orders and public laws relative to building requirements, e.g., sustainability, energy conservation, seismic, environmental, handicapped accessibility, and security; and
- Demolishing facilities when excess to the needs of the Service and/or a liability to health and safety.

Sanitation Facilities Construction –The FY 2021 budget submission for Sanitation Facilities Construction is $192.931 million, which is $646,000 below the FY 2020 Enacted Level.

These funds provide for water supply, sewage disposal, and solid waste disposal facilities, including:

- Projects to serve new or like-new housing, such as Indian homes being constructed or rehabilitated by the BIA-Home Improvement Program, Tribes, individual homeowners, or other nonprofit organizations;
- Projects to serve existing AI/AN housing; and
- Special projects (e.g., studies, training, or other needs related to sanitation facilities construction) and emergency projects.

Health Care Facilities Construction – The FY 2021 budget submission for Health Care Facilities Construction is $124.918 million, which is $134.372 million below the FY 2020 Enacted Level.

This funding level for the construction of new and replacement healthcare facilities will allow IHS to continue/complete the following projects:

- Whiteriver Hospital, Whiteriver, AZ
- Bodaway Gap Health Center, The Gap, AZ
- Albuquerque Central Health Center, Albuquerque, NM
- New and Replacement Staff Quarters

Facilities and Environmental Health Support (FEHS) – The FY 2021 budget submission for Facilities and Environmental Health Support is $259.763 million, which is $2.2 million below the FY 2020 Enacted Level.

This total includes funding for leadership and staffing to manage and implement all aspects of the Facilities Appropriation and shared operating costs at existing, new and replacement health care facilities.

FEHS funds provide for:

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

Equipment –The FY 2021 budget submission for Equipment is $23.895 million, which is $4.2 million below the FY 2020 Enacted Level.

These funds provide for:

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

COLLECTIONS

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

Quarters – The FY 2021 Quarters Return budget submission for Rent Collections is $9.6 million, which is $500,000 above the FY 2020 Enacted Level for anticipated rental collections. FY 2019 rent collections were approximately $8.5 million and are projected to increase to approximately $9.6 million in FY 2021.

Collected funds are to be used for:

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

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

(Dollars in Thousands)

	FY 2019	FY 2020	FY 2021	
	Final	Enacted	President's Budget	FY 2021 +/- FY 2020
BA	$167,527	$168,952	$167,948	-$1,004
FTE*	--	--	--	--

*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 2021 Authorization.....Permanent

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

PROGRAM DESCRIPTION

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

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

IHS hospital administrators have reported that old or inadequate physical environments challenged their ability to provide quality care and maintain compliance with the Medicare Hospital Conditions of Participation. Further, the administrators reported that maintaining aging buildings and equipment is a major challenge. Over one third of all IHS hospital deficiencies have

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

been found to be related to facilities with some failing on infection control criteria and others having malfunctioning exit doors.

The physical condition of IHS-owned and many tribally-owned healthcare facilities is evaluated through routine observations by facilities personnel and by in-depth condition surveys. These observations and surveys identify facility, fire-life-safety, and program deficiencies, and are used to develop IHS' estimate of the Backlog of Essential Maintenance, Alteration, and Repair (BEMAR). The BEMAR is a measure of the condition of health care facilities in the Indian health system and establishes priorities for larger M&I projects. The BEMAR for all IHS and reporting Tribal health care facilities as of October 1, 2019, is $767.3 million. When IHS replaces an older, obsolete hospital or clinic with a new facility, all deficiencies associated with the old facility are removed from the backlog.

The Facilities Management Program addresses the IHS Strategic Plan FY 2019-2023, Goal 1: To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people; Objective 1.1: Recruit, develop, and retain a dedicated, competent, and caring workforce, and Objective 1.3: Increase access to quality health care services. Additionally, Facilities Program addresses the IHS Strategic Plan FY 2019-2023, Goal 3: To strengthen IHS program management and operations; Objective 3.2: Secure and effectively manage the assets and resources.

M&I Funds Allocation Method

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

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

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

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

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

[2] *Committing to the Cost of Ownership - Maintenance and Repair of Public Buildings,* The National Academies Press (1990), *available at* http://www.nap.edu/catalog.

Provision related to Demolition of hazardous, obsolete federal buildings, the inventory of this federal inventory continues to grow as does the potential liability.

IHS Strategic Plan and how the Facilities programs are implementing: In consultation with Tribes and the Federal healthcare sites, IHS is allocating funding to the IHS Area Offices to complete BEMAR projects to make renovations and improvements necessary to support health care delivery in the health care facilities and to modernize the health care facilities and staff quarters to expand access to quality health care services.

FUNDING HISTORY/REQUEST

Fiscal Year	Amount
2017	$75,745,000
2018	$167,527,000
2019	$167,527,000
2020 Enacted	$168,952,000
2021 President's Budget	$167,948,000

TRIBAL SHARES

Maintenance & Improvement funds are subject to Tribal shares and are transferred to Tribes when they assume the responsibility for operating the associated programs, functions, services, and activities at a Federal or Tribal healthcare site. Tribes may also contract or compact to perform individual Maintenance & Improvement projects that are awarded to federally owned sites

BUDGET REQUEST

The FY 2021 budget submission for Maintenance and Improvement is $167.9 million, which is $1.0 million below the FY 2020 Enacted Level.

FY 2021 Funding of $167.9 million includes:

Current Services of +$1.8 million, including:

- Inflation: +$1.8 million to fund inflationary costs of providing health care services.

Program Adjustment -$2.8 million - The budget proposes to prioritize other direct services while redirecting/reducing funding for other activities, such as Maintenance and Improvement.

- Approximately $91.0 million is the projected amount for routine maintenance and repair to sustain the condition of federal and Tribal healthcare facilities buildings. These funds will support facilities activities that are generally classified as those needed for 'sustainment' of existing facilities and provided to the IHS Area Offices and to Tribes for daily maintenance activities and local projects to maintain the current state of health care facilities. These *Routine Maintenance Funds* may be used for Area and Tribal M&I projects to fund smaller elements of the backlog of work to address the old and antiquated facilities plant infrastructure (e.g., mechanical and electrical BEMAR) and program enhancements.

- Approximately $73.9 million would be available for major Area and Tribal M&I projects to reduce the BEMAR deficiencies and to improve healthcare facilities to meet changing healthcare delivery needs. The FY 2020 Budget Request continues funding critical projects to address the old and antiquated facilities plant infrastructure (e.g., mechanical and electrical BEMAR), accreditation standards, and program enhancements, all of which is essential to support health delivery.

- Approximately $3 million would be available for environmental compliance projects. The IHS places a high priority on meeting Federal, State, and local legal/regulatory environmental requirements, including allocating funding to address findings and recommendations from environmental audits. The IHS has currently identified approximately $6.6 million in environmental compliance tasks and included them in the BEMAR database.

- M&I funds, a portion from above categories retained by Headquarters, also provide resources for the demolition of IHS facilities that are no longer needed. The IHS has approximately 120 Federally-owned buildings that are vacant, excess, or obsolete. Many of these buildings are safety and security hazards. IHS plans for orderly demolition of some of these buildings, in concert with transferring others, reducing hazards and liability. Demolition Funds may be used in concert with environmental compliance funds as available for demolition of the Federal buildings to the extent that the proposed action reduces hazards, environmental concerns, or liability to the Indian Health Service. Since FY 2000 when funds were first set aside for the demolition of Federal buildings, associated demolition costs have risen significantly due to inflation, environmental regulations, recycling and landfill diversion requirements, abatement of hazardous material, etc. For example, many IHS locations are very remote which significantly increases the cost to haul the demolition waste off the reservation to approved landfills and recycling facilities.

OUTPUTS / OUTCOMES

The Outcomes for this program are measured through BEMAR, i.e., progress in addressing maintenance needs and facility deficiencies. Maintaining effective and efficient healthcare buildings improve the ease and access to care, facilitate successful behavioral health services, and enable the hiring and retention of healthcare professionals by giving them modern space and equipment to deliver services.

IHS targets the M&I funding, and supplements these funds with collections where available, towards major projects to reduce the BEMAR and improve the condition of existing Federal and Tribal healthcare sites. A few examples of these projects include: renovating/expanding pharmacy space, improvements to dental clinics to serve more users, remodeling reception/waiting areas, construction of CT suite and new digital radiology rooms, repaving parking lots, emergency department renovations, new heating-ventilation-air conditions systems, sustainability projects to reduce utility costs, etc. Continued investment in the BEMAR which is currently at $767.3 million, will enable IHS and the Tribes to maintain accreditation standards and delivery quality health care services.

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 2019	FY 2020	FY 2021	
	Final	Enacted	President's Budget	FY 2021 +/- FY 2020
BA	$192,033	$193,577	$192,931	-$646
FTE*	119	119	119	--

*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 2021 Authorization.....Permanent

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

PROGRAM DESCRIPTION

The Indian Health Care Improvement Act (IHCIA) requires the Indian Health Service (IHS) to identify the universe of sanitation facilities needs for existing American Indian and Alaska Native (AI/AN) homes by documenting deficiencies and proposing projects to address their needs. These projects prevent communicable diseases by providing new and existing homes with services such as water wells, onsite wastewater disposal systems, or connections to community water supply and wastewater disposal systems. These projects can also include provision of new or upgraded water supply or waste disposal systems. These outcomes support both the HHS and IHS Strategic Plans. (HHS Strategic Plan FY 2018 – 2022, Objective 2.2: "*Prevent, treat, and control communicable diseases and chronic conditions*" and IHS Strategic Plan FY 2019-2023, Objective 1.3: *Increase access to quality health care services.* Strategy 14, "*Develop and coordinate environmental engineering, environmental health, and health facilities engineering services to provide effective and efficient public health services…*").

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

Projects that provide sanitation facilities to existing homes are selected for funding in priority order each year from the Sanitation Deficiency System (SDS). The SDS is an inventory of the sanitation deficiencies of federally recognized AI/AN eligible homes and communities; the sanitation deficiencies include needed water, sewer, and solid waste facilities for existing AI/AN homes. These actions support Strategy 1, "*Improve the transparency and quality of data collected regarding health care service and program outcomes*" (IHS Strategic Plan FY 2019-2023, Objective 2.1: *Create quality improvement capability at all levels of the organization*). Project selection is driven by

objective evaluation criteria including health impact, existing deficiency level, adequacy of previous service, capital cost, local Tribal priority, operations and maintenance capacity of the receiving entity, availability of contributions from non-IHS sources, and other conditions that are locally determined. The SDS priority position of each unfunded project is reevaluated with the Tribes in each Area annually.

Sanitation Facilities Construction (SFC) projects can be managed by IHS directly or by Tribes that elect to use the Title I or Title V authorization under P.L. 93-638, the Indian Self-Determination and Education Assistance Act. Sanitation facilities projects are carried out cooperatively with the Tribes that will be served, and construction is performed by either the IHS or the Tribes (IHS Strategic Plan FY 2019 – 2023, Objective 1.2: *Build, strengthen, and sustain collaborative relationships*). Projects start with a Tribal project proposal and are funded and implemented through execution of an agreement between a Tribe and IHS. In these agreements, the Tribes also assume ownership responsibilities, including operation and maintenance. The overall SFC goals, reporting requirements, eligibility criteria, project planning, and funding priorities remain the same, regardless of the delivery methods chosen by a Tribe.

The SFC Program leverages its capabilities in partnering with Tribes by also partnering with other Federal agencies in constructing or financing construction of water supply, wastewater and solid waste disposal projects addressing sanitation deficiencies faced by Tribes. One way in which the SFC Program engages in such partnerships is through the Infrastructure Task Force (ITF), a partnership of Federal agencies focused on finding ways to better serve Tribes through cooperative efforts (IHS Strategic Plan FY 2019 – 2023, Objective 1.2: *Build, strengthen, and sustain collaborative relationships*).

PROGRAM ACCOMPLISHMENTS

The SFC Program is an integral component of IHS disease prevention activities. IHS has carried out the program since 1959 using funds appropriated to provide water and waste disposal facilities for eligible AI/AN homes and communities. As a result, infant mortality rates and mortality rates for gastroenteritis and other environmentally-related diseases have declined. Research supported by the Centers for Disease Control and Prevention states populations in regions with a lower proportion of homes with water service, reflect significantly higher hospitalization rates for pneumonia, influenza, and respiratory syncytial virus.[1] Researchers associated the increasing illnesses with the restricted access to clean water for hand washing and hygiene. The SFC Program works collaboratively with Tribes to assure all AI/AN homes and communities are provided with safe and adequate water supply and waste disposal facilities as soon as possible.

In FY 2019, IHS provided service to 40,684 AI/AN homes and completed construction on 244 projects with an average project duration of 3.6 years. However, at the end of FY 2019 about 6,626, or 1.6 percent of all AI/AN homes tracked by IHS lacked water supply or wastewater disposal facilities; and, about 110,552 or approximately 27 percent of AI/AN homes tracked by IHS were in need of some form of sanitation facilities improvements. The individuals who live in homes without adequate sanitation facilities are at a higher risk for gastrointestinal disease, respiratory disease and

[1] Thomas W. Hennessy, Troy Ritter, Robert C. Holman, Dana L. Bruden, Krista L. Yorita, Lisa Bulkow, James E. Cheek, Rosalyn J. Singleton, and Jeff Smith. The Relationship Between In-Home Water Service and the Risk of Respiratory Tract, Skin, and Gastrointestinal Tract Infections Among Rural Alaska Natives. American Journal of Public Health: November 2008, Vol. 98, No. 11, pp. 2072-2078.

other chronic diseases.[2] Many of these homes without service are very remote and may have limited access to health care which increases the importance of improving environmental conditions. The total sanitation facility need reported through SDS has decreased approximately $0.10 billion or 3.5 percent from $2.67 billion to $2.57 billion from FY 2018 to FY 2019. In FY 2019, the Indian Health Service was appropriated $0.19 billion to address sanitation deficiencies and support provision of sanitation facilities to eligible AI/AN homes and communities. The magnitude of the sanitation facility needs decrease is not directly commensurate with the appropriated funds due to the underlying challenges of construction cost inflation, population growth, an increasing number of regulations, and failing infrastructure. Failing infrastructure is presumably the largest factor, a result of the infrastructure age and inadequate operation and maintenance. Under the IHCIA, the IHS is authorized to provide operation and maintenance assistance for, and emergency repairs to, Tribal sanitation facilities, when necessary to avoid a health hazard or to protect the Federal investment in sanitation facilities, however resources have not been appropriated specifically for this purpose.

During FY 2019 287 construction projects to address water supply and wastewater disposal needs were funded with a construction cost of $169 M. Once constructed, these sanitation facilities will benefit an estimated 140,000 AI/AN people and help avoid over 79,000 inpatient and outpatient visits related to respiratory, skin and soft tissue, and gastro enteric disease. The health care cost savings for these visits alone is estimated to be over $173M. These outcomes support Strategy 14, "Develop *and coordinate environmental engineering, environmental health, and health facilities engineering services to provide effective and efficient public health services…*" (IHS Strategic Plan FY 2019-2023, Objective 1.3: *Increase access to quality health care services*).

The SFC Program will continue in FY 2021 focusing on improving quality of data reported through the SDS on the sanitation facility needs supporting AI/AN homes and communities (IHS Strategic Plan FY 2019-2023, Objective 2.1: *Create quality improvement capability at all levels of the organization*). These efforts will ensure the sanitation facilities needs included in SDS are:

- Adequately documented;
- Reflect an update of current needs; and
- Include only sanitation facilities fundable by the SFC program for AI/AN eligible homes and communities and consistent with the prescribed Deficiency Levels referenced in the IHCIA.

Additionally, in FY 2021 the SFC Program will continue to focus on maintaining average construction project duration to 4.5 years. In order to achieve this outcome, funds will only be obligated to projects that have been certified by the SFC Program Areas as "ready to fund"; this means they have a well-defined scope, a detailed cost estimate, a completed preliminary design and that known potential risks to project construction, operation and maintenance have been considered and mitigated.

FUNDING HISTORY/REQUEST

Fiscal Year	Amount
2017	$101,772,000
2018	$192,033,000
2019	$192,033,000
2020 Enacted	$193,577,000
2021 President's Budget	$192,931,000

[2]Thomas W. Hennessy, Troy Ritter, Robert C. Holman, Dana L. Bruden, Krista L. Yorita, Lisa Bulkow, James E. Cheek, Rosalyn J. Singleton, and Jeff Smith. The Relationship Between In-Home Water Service and the Risk of Respiratory Tract, Skin, and Gastrointestinal Tract Infections Among Rural Alaska Natives. American Journal of Public Health: November 2008, Vol. 98, No. 11, pp. 2072-2078.

BUDGET REQUEST

The FY 2021 budget submission for Sanitation and Facilities Construction is $192.9 million, which is -$646,000 below the FY 2020 Enacted Level.

FY 2021 Funding amount of $192.9 million includes:

Program Adjustment -$2.5 million - The budget proposes to prioritize other direct services while redirecting/reducing funding for other activities, such as Sanitation and Facilities Construction.

Current Services of +$1.9 million, including:

- Inflation +$1.9 million to fund inflationary costs of providing health care services.

The FY 2021 Budget request of $192.9 million– provides funding in the following allocation categories:

- Approximately $130.0 million may 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 sanitation facilities that are in need of some form of improvement. Another element of the distribution formula is a weight factor that favors Areas with larger numbers of AI/AN homes without water supply or sewer facilities, or without both.

- Up to $2.9 million will be reserved at IHS Headquarters:

  Of this amount, $1.0 million will be used for emergency projects as requested by Areas to address water supply and waste disposal emergencies caused by natural disasters or other unanticipated situation that require immediate attention to avoid a health hazard or to protect the Federal investment in sanitation facilities. Remaining emergency unused funds at the end of the fiscal year may be distributed to address the SDS projects in the Areas.

  The remaining $1.9 million is for funding special projects. Starting in FY 2019 and ending in FY 2021 up to $1.0 million annually (total anticipated funding $3.0 million) may be utilized for the purpose of updating the inventory of open dumps currently identified in the IHS data system to ensure compliance with the requirements of the Indian Lands Open Dump Cleanup Act (PL103-399). An amount up to $500,000 will be used to incorporate a geographical information system (GIS) functionality into the SFC Program data system. The primary benefit of incorporating a GIS into the SFC Program's data system is to improve the Program's ability to access, store and update sanitation facilities composite as-built drawings. The graphical interface will allow for the collection, uploading and editing of field-collected data on installed sanitation facilities. It will allow users to update sanitation facilities as-built drawings for the purpose of aiding in needs identification, planning, design, construction, and technical assistance. An amount up to $400,000 will be used for redesign of the SFC Program data system to facilitate development of an improved user interface, reporting, and program oversight. The remaining special project funds will be used to pay for research studies, training, or other needs related to sanitation facilities construction, but which are not eligible for construction funds.

- Approximately $60 million will be used to serve new and like-new homes, which are non-Department of Housing and Urban Development (HUD) homes (HUD homes are served under HUD authorities and appropriations). Some of these funds may also be used for sanitation

facilities for individual homes of the disabled or sick, with a physician referral, indicating an immediate medical need for adequate sanitation facilities in their home.[3] As needed, amounts to serve new and like-new homes will be established by Headquarters after reviewing Area proposals. Priority will be given to projects under the BIA Housing Improvement Program (HIP) to serve new and like-new homes with the exception of "Category A" BIA HIP homes which are considered existing homes and will be served with the funds described in the first bullet of this section.

The IHS appropriated funds for sanitation facilities construction are prohibited by law from being used to provide sanitation facilities for new homes funded with grants by the housing programs of HUD. These HUD housing grant programs for new homes should continue to incorporate funding for the sanitation facilities necessary for those homes.

From this distribution, up to $5.0 million may be used for projects to clean up open dump sites and upgrade solid waste sites that present a health hazard on Indian lands and Alaska Native lands pursuant to the Indian Lands Open Dump Cleanup Act of 1994,[4] pending coordination with the EPA on oversight and evaluation of Tribal solid waste management programs.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2020 Target	FY 2021 Target	FY 2021 Target +/-FY 2020 Target
35 Number of new or like-new and existing AI/AN homes provided with sanitation facilities. (Outcome)	FY 2019: 40,684 Target: 19,478 (Target Exceeded)	37,045	40,400	+3,355
SFC-E Track average project duration from the Project Memorandum of Agreement (MOA) execution to construction completion. (Outcome)	FY 2019: 3.6 yrs Target: 4.0 yrs (Target Exceeded)	4.0 yrs	4.0 yrs	+0.0 yrs

GRANT AWARDS – This Program has no grant awards.

[3] Indian Health Service. Chapter 5 Eligibility for IHS SFC Program Services and IHS-Funded Projects. Criteria for the Sanitation Facility Construction Program June 1999 ver. 1.02, 3/13/03.

[4] Indian Lands Open Dump Cleanup Act of 1994 Pub. L.103-399, Oct. 22, 1994, 108 Stat. 4164 (25 U.S.C. 3091et seq.)

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

(Dollars in Thousands)

	FY 2019	FY 2020	FY 2021	
	Final	Enacted	President's Budget	FY 2021 +/- FY 2020
BA	$243,480	$259,290	$124,918	-$134,372
FTE*	--	--	--	--

*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 2021 Authorization.....Permanent

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

PROGRAM DESCRIPTION

The Indian Health Service (IHS) Health Care Facilities Construction (HCFC) funds provide optimum availability of functional, modern IHS and tribally operated health care facilities and where required staff quarters. The IHS is authorized to construct health care facilities and staff quarters, support Tribal construction of facilities under the Joint Venture Construction Program (JVCP), provide construction funding for Tribal projects Under the Small Ambulatory Program (SAP), and provide funding to construct new and replacement dental units.

The construction and modernization of IHS infrastructure through the health care facilities construction program helps ensure the IHS commitment to the Department of Health and Human Services Strategic Objectives 1.2: Expand safe, high-quality healthcare options, and encourage innovation and competition; and 1.3: Improve Americans' access to healthcare and expand choice of care and service options. The health care facilities constructed by the IHS ensure access to quality, culturally competent health care for one of the lowest income populations in the United States, American Indians and Alaska Natives (AI/AN). The focus of the IHS health care service programs provided in these facilities is on prevention and delivery of comprehensive primary care in a community setting.

The HCFC program is funded based on an IHS-wide list of priorities for construction projects. During FY 1990, at the direction of Congress, the IHS established the Health Facilities Construction Priority System (HFCPS) methodology. The HFCPS ranks proposals using factors reflecting the total amount of space needed, age and condition of the existing health care facility, if any, degree of isolation of the population to be served in the proposed health care facility, and availability of alternate health care resources. The remaining health care facilities projects on the HFCPS list, including those partially funded, total approximately $2.02 billion as of March 2019. The reauthorization of the Indian Health Care Improvement Act (IHCIA) includes a provision, "any project established under the construction priority system in effect on the date of enactment of the Act of 2009 shall not be affected by any change in the construction priority system taking place after that date…" Total need for the HCFC Program is approximately $14.5 billion for

expanded and active authority facility types according to *The 2016 Indian Health Service and Tribal Health Care Facilities' Needs Assessment Report to Congress*.

The Joint Venture Construction Program (JVCP) authorizes IHS to enter into agreements with Tribes that construct their own health care facilities. The Tribe provides the resources, whether from its own funds, through financing, grants, contributions, or a combination thereof, for the construction of its health care facility. IHS health care facility construction appropriations are not used for construction of facilities in the JVCP but may be used to equip the health care facility. Tribes apply for the JVCP during a competitive process and the approved projects are entered into agreements with IHS. Based on the date of projected completion of construction by the respective Tribe, the IHS agrees to request a funding increase from Congress for additional staffing and operations consistent with a fully executed beneficial occupancy of the health care facility.

The Small Ambulatory Program (SAP) provides funding for small Tribal health care facilities. The SAP is authorized by Section 306 of the Indian Health Care Improvement Act, Public Law 94-437, and projects are competitively selected for funding as funds are appropriated. The SAP program is available for AI/AN Tribes or Tribal organizations to competitively obtain funding for the construction, expansion or modernization of tribally owned small ambulatory health care facilities. The selected projects will not be a part of the IHS HFCPS.

These three programs implement the IHS Strategic Plan Goal 1 by increasing access to culturally appropriate health care services for American Indian and Alaska Native people. IHS Strategic Plan Goal 2 is supported when a new facility is completed. A new facility is designed to meet the demand for health services from a growing population by providing more healthcare providers and exam rooms, dentists and dental chairs, improved imaging systems, and expanded services such as eye care and audiology. Each new facility includes a component to address behavioral health issues. Administration staff is increased to strengthen management, collections and bring health care quality expertise to the replacement facility. Each facility also incorporates additional space for Tribal health programs which complements IHS programs and how the HCFC programs are implementing.

PROGRAM ACCOMPLISHMENTS

Each healthcare facility project that is completed increases access to much needed health care services. Each completed replacement facility is typically larger to meet the increased demand for health services from a growing population. Tribes typically provide land, at no cost to the Federal Government, for the new or replacement health care facility.

In FY 2019 one facility was completed: The Northern California Youth Regional Treatment Center in Davis, CA.

The FY 2019 appropriation completed funding for the Dilkon Alternative Rural Health Center, Dilkon, AZ; Pueblo Pintado Health Center Pueblo Pintado, AZ projects; and contributed to the Whiteriver Hospital, Whiteriver, AZ; Bodaway Gap Health Center, The Gap, AZ; and Albuquerque West Health Center, Albuquerque, NM projects.

The FY 2019 appropriation funded planning activities for and the Phoenix Indian Medical Center, Phoenix, AZ and the Gallup Indian Medical Center, Gallup, NM.

The FY 2019 appropriation also contributed $15.0 million to the IHS SAP and $10 million to the Staff Quarters Program. The projects have been selected and agreements are being reached to award the funds.

The JVCP has saved the Federal Government over $1.15 billion dollars in capital expenses since its inception. The outcome of the JVCP provides the same accomplishments as described above.

The federal construction and the Joint Venture programs bring new and increased health care capacity to AI/AN communities where there is a great need. These activities increase the access to quality healthcare in these underserved communities.

FUNDING HISTORY/REQUEST

Fiscal Year	Amount
2017	$117,991,000
2018	$243,480,000
2019	$243,480,000
2020 Enacted	$259,290,000
2021 President's Budget	$124,918,000

BUDGET REQUEST

The FY 2021 budget submission for Health Care Facilities Construction is $124.9 million, which is -$134.4 million below the FY 2020 Enacted Level.

FY 2021 Funding of $124.9 million includes:

Current Services of +$3.1 million, including:

- Inflation +$3.1 million to fund inflationary costs of providing health care services.

Health Care Facilities Construction +$106 million - This initiative will provide a continuation of the Health Care Facilities Priority Program. This facility will improve the access to medical care and the collaboration and partnership between tribes and the IHS.

Staff Quarters + $20 million - Funding for Staffing Quarters would fund the replacement and the addition of new housing quarters in isolated and remote locations for healthcare professionals to enhance and improve the recruitment and retention of quality healthcare professionals.

Program Adjustment -$263.5 million - The budget proposes to prioritize other direct services while redirecting/reducing funding for other activities, such as Health Care Facilities Construction.

Whiteriver Hospital, Whiteriver, AZ $60.0 million

These funds will be used to provide infrastructure and begin construction of the proposed replacement hospital. It will serve a projected user population of 36,113 providing 67,000 primary care provider visits and 101,200 outpatient visits annually. It is estimated 144 staff quarters will be required for health staff.

Bodaway Gap Health Center, The Gap, AZ $26.0 million

These funds will be used to complete construction of the 82 staff quarters located in The Gap, AZ. The Health Center will serve a projected user population of 4,646 generating 18,458 primary care provider visits annually. The facility will provide an expanded outpatient and community health department, and a full array of ancillary and support services.

Albuquerque Central Health Center, Albuquerque, NM $20.0 million

These funds will be used for construction the health center located in central Albuquerque, NM. The Health Center will serve a projected user population of 15,500 generating 59,300 primary care provider visits annually. The facility will provide an expanded outpatient and community health department, and a full array of ancillary and support services.

New and Replacement Staff Quarters $20.0 million

Many of the 2,700 quarters across the IHS health delivery system are more than 40 years old and in need of major renovation or total replacement. Additionally, in a number of locations the amount of housing units is insufficient. The identified unmet need, of housing units in isolated, remote locations is a significant barrier to the recruitment and retention of quality healthcare professionals across Indian Country. The amount distributed to each Area will be based on each Area's internal priority list.

OUTPUTS / OUTCOMES

Measure	**Year and Most Recent Result / Target for Recent Result / (Summary of Result)**	**FY 2020 Target**	**FY 2021 Target**	**FY 2021 Target +/- FY 2020 Target**
36 Health Care Facility Construction: Number of health care facilities construction projects completed. (Outcome)	FY 2019: 1 projects Target: 1 projects[1] (Target Met)	0 projects	0 projects	Maintain
HCFC-E Energy consumption in Leadership in Energy and Environmental Design (LEED) certified IHS health care facilities compared to the industry energy consumption standard for comparable facilities. (Outcome)	FY 2019: 1 Target: 1 (Target Met)	0	0	Maintain

GRANT AWARDS – Program has no grant awards.

[1]The health care facility completed in FY 2019 is Northern California Youth Regional Treatment Center, Davis, CA

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

FACILITIES AND ENVIRONMENTAL HEALTH SUPPORT

(Dollars in Thousands)

	FY 2019	FY 2020	FY 2021	
	Final	Enacted	President's Budget	FY 2021 +/- FY 2020
BA	$252,060	$261,983	$259,763	-$2,220
FTE*	1,073	1,073	1,073	--

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

(Dollars in Thousands)

	FY 2019	FY 2020	FY 2021	
Detail Breakout of FEHS Activity	Final	Enacted	President's Budget	FY 2021 (+/-) FY 2020
BA	$252,060	$261,983	$259,763	-$2,220
Facilities Support	*$152,722*	*$160,371*	*$159,892*	*-$479*
Environmental Health Support	*$82,230*	*$84,220*	*$82,871*	*-$1,349*
Office of Environmental Health and Engineering Support	*$17,108*	*$17,392*	*$17,000*	*-$392*
FTE	1,073	1,073	1,073	--
Facilities Support	*606*	*606*	*606*	--
Environmental Health Support	*392*	*392*	*392*	--
Office of Environmental Health and Engineering Support	*75*	*75*	*75*	--

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 2021 Authorization.....Permanent

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

SUMMARY OF PROGRAMS

Facilities and Environmental Health Support Account (FEHS) programs provide and support an extensive array of real property, health care facilities and staff quarters construction, maintenance and operation services, as well as community and institutional environmental health, injury prevention, and sanitation facilities construction services. The programs directly and indirectly support all of the IHS facilities performance measures and improved access to quality health services. The programs and staff at the IHS Headquarters, Area Office, and Service Unit levels work collaboratively with Tribes and other agencies to promote and provide access to improvements in public health through surveillance, education, intervention activities, construction of sanitation facilities and health care facilities. These activities are aligned in sub-

activities: Facilities Support, Environmental Health Support, and Office of Environmental Health and Engineering Support. In addition to personnel salary and benefits costs, funding under this activity is used for utilities, certain non-medical supplies and personal property, and biomedical equipment repair.

The IHS may use a limited amount of these FEHS funds for centrally charged assessments that benefit the staff and activities funded through the Indian Health Facilities appropriations. To date, the majority of IHS's assessments have been paid through the Indian Health Services appropriation; however, the amount of assessment costs have exceeded the amount of funds available within Services. In order to continue the emphasis on direct patient care, these FEHS funds that provide other types of administrative support for the Facilities appropriation may share in appropriate assessment charges proportionate to the underlying activities. For example, a centrally managed assessment for payroll services that is charged by the number of employees may be proportionately paid under both the Services and Facilities appropriations according to the number of staff supported by each appropriation.

FUNDING HISTORY/REQUEST

Fiscal Year	Amount
2017	$226,950,000
2018	$240,758,000
2019	$252,060,000
2020 Enacted	$261,983,000
2021 President's Budget	$259,763,000

BUDGET REQUEST

The FY 2021 budget submission for Facilities & Environmental Health Support is $259.8 million, which is -$2.2 million below the FY 2020 Enacted Level.

FY 2021 Funding Increase of $259.8 million includes:

Current Services of +$1.5 million, including:

- Inflation +$1.5 million to fund inflationary costs of providing health care services.

Staffing for New Facilities +$3.7 million to fund staffing and operating costs for new and replacement projects. These funds will support staffing and operating costs for new and replacement projects listed below. Funding for new/renovated facilities allows IHS to expand provision of health care in those areas where capacity has been expanded to address health care needs. The following tables display this request:

Staffing and Operating Costs for New/Replacement Facility	Amount	FTE/Pos
Yukon-Kuskokwim Primary Care Center (JV), Bethel, AK	$2,171,000	9
Naytahwaush Health Center (JV), Naytahwaush, MN	$853,000	3
Yakutat Tlingit Health Center (JV), Yakutat, AK	$175,000	0
Ysleta Del Sur Health Center (JV), El Paso, TX	$480,000	2
Grand Total:	**$3,679,000**	**14**

Program Adjustment -$7.4 million - The budget proposes to prioritize other direct services while redirecting/reducing funding for other activities, such as Facilities and Environmental Health Support.

This level of funding provides for the following allocation categories:

FACILITIES SUPPORT

PROGRAM DESCRIPTION

Facilities Support Account (FS) provides funding for Area and Service Unit staff for facilities-related management activities, operation and maintenance of real property and building systems, medical equipment technical support, and planning and construction management support for new and replacement health facilities projects. The sub-activity directly supports the IHS Strategic Plan FY 2019-2023 priorities: (1) People - Recruit, develop, and retain a dedicated, competent, caring workforce collaborating to achieve the IHS mission; (2) Partnerships- Build, strengthen, and sustain collaborative relationships that advance the IHS mission; (3) Quality- Excellence in everything we do to assure a high-performing Indian health system; and (4) Resources- Secure and effectively manage the assets needed to promote the IHS mission.

The IHS owns approximately 10,220,000 square feet of facilities (totaling 2,119 buildings) and 1,758 acres of federal and trust land. The nature of space varies from sophisticated medical centers to residential units and utility plants. Facilities range in age from less than one year to more than 167 years, with an average age greater than 39 years. A professional and fully-functional workforce is essential to ensure effective and efficient operations. An estimated 600 Federal positions (fulltime equivalents) are funded under this sub-activity. Typical staff functions funded may include:

- Facilities engineers and maintenance staff responsible for ensuring that building systems are operated properly, facilities and grounds are maintained adequately, utilities are managed appropriately, environmental compliance requirements are met, and buildings are safe;
- Specialized clinical engineers and technicians who maintain and service medical equipment;
- Realty staff that manages the real property requirements and quarters; and
- Facilities planning and construction-monitoring that assist in the planning and construction of projects.

In addition, FS provides partial 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. Accomplishments include supporting health delivery through the attainment of accreditation and the maintenance of the environment of care of buildings, utility systems, life safety systems, and medical equipment.

Adequate facilities/maintenance staffing both at the Area Offices and service units are paramount to maintain accreditation, for the continuity of health services, and ensuring that major building systems function correctly. Workload for the facilities and biomedical staff has continued to increase to meet the Agency's emphasis on accreditation standards and supporting program enhancements/expansion, which is predominately funded with collections.

The Facilities Management Program addresses the IHS Strategic Plan FY 2019-2023, Goal 1: To ensure that comprehensive, culturally appropriate personal and public health services are

available and accessible to American Indian and Alaska Native people; Objective 1.1: Recruit, develop, and retain a dedicated, competent, and caring workforce, and Objective 1.3: Increase access to quality health care services. Additionally, Facilities Program addresses the IHS Strategic Plan FY 2019-2023, Goal 3: To strengthen IHS program management and operations; Objective 3.2: Secure and effectively manage the assets and resources.

In consultation with Tribes and the Federal healthcare sites, IHS is coordinating with and allocating funding to the IHS Area Offices to complete BEMAR projects to make renovations and improvements necessary to support health care delivery in the health care facilities and to modernize the health care facilities and staff quarters to expand access to quality health care services including modern medical equipment.

PROGRAM ACCOMPLISHMENTS

In FY 2019, total utility costs were $13.5 million and total utility costs per Gross Square Feet (GSF) were $2.70/GSF. In FY 2021, the total utility cost is expected to be $14.6 million reflecting a 4.0 percent annual increase. The cost per GSF is expected to rise to approximately $2.92/GSF. IHS makes conscious efforts to help stem the growth in utility costs to ensure appropriations are sufficient to fund these needs. For example, IHS constructs new space that is at least 30 percent more energy efficient than building code requires and expects LEED Silver certification at those facilities. In June 2018, IHS placed into service a new Fort Yuma Health Care Center in Winterhaven, CA, that consumed 114,300 BTU/SF in fiscal year 2019 compared to the average IHS building that consumed 135,000 BTU/SF in fiscal year 2019.

Maintaining effective and efficient healthcare buildings and equipment improve the ease and access to care, facilitate successful behavioral health services, and enable the hiring and retention of healthcare professionals by giving them modern space and equipment to deliver services. This is all integral to quality health care for AI/ANs.

ENVIRONMENTAL HEALTH SUPPORT

PROGRAM DESCRIPTION

The Environmental Health Support Account (EHSA) provides funding for IHS Area, District, and Service Unit management activities and environmental health staff which include engineers, environmental health officers, engineering aides, injury prevention specialists, and institutional environmental health officers. More than 70 percent of these IHS and Tribal staff live and work in Tribal communities; another 20 percent provide regional services to Tribes or IHS facilities; and less than 10 percent of our staff are administrative managers. AI/ANs face hazards in their environments that affect their health status, including communities in remote and isolated locations, severe climatic conditions, limited availability of safe housing, lack of safe water supply, and lack of public health and safety legislation (e.g., lack of local solid waste ordinances, vehicle safety laws, or food safety laws). In accordance with congressional direction, these funds are distributed to the Areas based upon the workload and need associated with the two programs noted below.

- Sanitation Facilities Construction Program (SFC) – This program is an integral component of IHS disease prevention activities. IHS has carried out the program since 1959 using funds appropriated for SFC to provide safe water supply and waste disposal facilities for AI/AN people and communities. As a result, infant mortality rates and mortality rates for gastroenteritis and other environmentally-related diseases have been reduced. Research

supported by the Centers for Disease Control and Prevention states populations in regions with a lower proportion of homes with water service, reflect significantly higher hospitalization rates for pneumonia, influenza, and respiratory syncytial virus.[1] Researchers associate the increasing illnesses with the restricted access to clean water for hand washing and hygiene. The absence of clean water to sanitation facilities for tribal households exacerbate concern for the Indian Health Service Clinical Health Care program; further decreasing the quality of life for AI/ANs. Efforts by other public health specialists such as nutritionists and public health nurses are much more effective when safe water and adequate wastewater disposal systems are available in the home. In addition, the availability of such facilities is of fundamental importance to social and economic development, which leads to an improved quality of life and an improved sense of well-being.

The SFC Program works collaboratively with tribes to assure all AI/AN homes and communities are provided with safe and adequate water supply and waste disposal systems as soon as possible (IHS Strategic Plan FY 2019 – 2023, Objective 1.2: Build, strengthen, and sustain collaborative relationships) . Under this program in FY 2019, staff managed and/or provided professional engineering services to construct 436 sanitation projects with a total cost of over $275 million. The program manages annual project funding that includes contributions from Tribes, states, and other federal agencies. The SFC Program is the environmental engineering component of the IHS health delivery system. 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 professional engineering design and/or construction services for water supply and waste disposal facilities, 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," $1.0 million of these support funds are used for technical assistance, training, and guidance to Indian families and communities regarding the operation and maintenance of water supply and sewage disposal facilities.

In accordance with the Indian Health Care Improvement Act, the staff annually updates its inventory of sanitation facilities deficiencies for existing Indian occupied homes.[2] 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.[3] Both of these inventories are widely used by other governmental agencies in their evaluation and funding of sanitation facilities construction projects.

- Environmental Health Services (EHS) – National priority areas include: food safety, children's environments, healthy homes, vector borne and communicable disease, and safe drinking water. The EHS Program identifies environmental hazards and risk factors in Tribal communities and proposes control measures to prevent adverse health effects. The EHS

[1] Thomas W. Hennessy, Troy Ritter, Robert C. Holman, Dana L. Bruden, Krista L. Yorita, Lisa Bulkow, James E. Cheek, Rosalyn J. Singleton, and Jeff Smith. The Relationship Between In-Home Water Service and the Risk of Respiratory Tract, Skin, and Gastrointestinal Tract Infections Among Rural Alaska Natives. American Journal of Public Health: November 2008, Vol. 98, No. 11, pp. 2072-2078.
[2] Title III, Section 302(g) 1 and 2 of P.L. 94-437.
[3] P.L. 103-399.

Program monitors and investigates disease and injury. The program provides inspections to identify environmental hazards in homes, healthcare facilities, food service establishments, Head Start centers, and many other types of Tribal establishments. In addition, EHS provides training, technical assistance, and project funding (including cooperative agreements) to enhance the capacity of Tribal communities to address environmental health issues. *HHS Strategic Plan Goal 2, 3 and 5 (see goal descriptions below)*

EHS provides access to public health services to AI/ANs. Examples include referrals for home investigations to reduce environmental triggers for asthma patients; home investigations to reduce exposure to lead-based paint or other lead hazards (including drinking water sources) for patients with elevated blood-lead levels; animal bite investigations in Tribal communities and potential patient exposure to rabies virus; home investigations to address fall risk for elderly and other patients at risk for falls; and referrals for investigation of community disease outbreaks from multiple patient exposures to contaminated food or water. *HHS Strategic Plan Goal 2 and 3 (see goal descriptions below)*

The IHS Injury Prevention Program (IPP) leads IHS efforts to address injury disparities in AI/AN communities. AI/AN experience injury mortality rates that are 2.5 to 8.7 times higher than the U. S. all races rates. The IPP works with AI/AN, other agencies, and IHS programs to prevent unintentional injuries (motor vehicle-related, falls, burns, drowning, poisoning) and intentional injuries (suicide and violence-related) through technical assistance, training, and the Tribal Injury Prevention Cooperative Agreement Program (TIPCAP). Technical assistance is provided in the areas of data collection for project evaluation, building partnerships, implementing evidence-based strategies or innovative interventions, and developing tribal injury prevention programs. *HHS Strategic Plan Goal 2 and 3 (see goal descriptions below)*

The IHS Institutional Environmental Health (IEH) Program identifies environmental hazards and risk factors in the built environment and proposes control measures to prevent adverse health effects to patients, staff, and visitors in health care and other community facilities. The IEH program supports development and management of safe, functional health care facilities which contribute to the quality of care and workforce retention. The IEH program collaborates with entities such as the National Institutes of Health, Administration for Children and Families, and Uniformed Services University to improve IEH practices in IHS facilities and in our tribal communities. *HHS Strategic Plan Goal 2 and 3 (see goal descriptions below)*

- *HHS Strategic Plan Goal 2: Protect the Health of Americans Where They Live, Learn, Work, and Play by: Preventing and Controlling communicable and environmental diseases; and Preparing for and responding to public health emergencies.*
- *HHS Strategic Plan Goal 3: Strengthen the Economic and Social Well-Being of Americans across the Lifespan by Safeguarding the public against preventable injuries and violence or their results.*
- *HHS Strategic Goal 5: Promoting Effective and Efficient Management and Stewardship.*

PROGRAM ACCOMPLISHMENTS

EHS staff accomplishments reduce the need for direct healthcare services when environmentally related diseases and injuries are reduced. For example, the IHS Injury Prevention Program has been instrumental in reducing the injury mortality rate of AI/ANs by implementing a public health approach based upon effective strategies and initiatives to reduce the devastating burden of

injuries. Preventing severe, debilitating injuries reduces the cost and need for healthcare service; however, the challenge remains that unintentional injuries are still the leading cause of death for AI/ANs ages 1-44.[4]

From 1997-2019 the TIPCAP funded 106 fulltime tribal injury prevention positions and provided over $31 million in funding. Through these efforts the IHS IPP has contributed to the 58 percent decrease in injury mortality rates since 1973 and continues to invest in preventing injuries in the first place, instead of treating the impacts of injury and violence through our health care delivery system.

President's Management Agenda Goal 3 *Cross Agency Priority Goal – Developing a Workforce for the 21st Century.*

The IEH Program provides extensive technical assistance and training to safety and facility management staff as well as the many inter-related medical program and leadership staff. These efforts have led to a reduction in the IHS total occupational injury case rate which has decreased from 4.35 injuries/100 employees in 2004 to 1.84 injuries/100 employees in 2018.

The IEH program supports healthcare management by providing local accreditation support including mock environment of care surveys in which regulatory requirements and conditions for general safety, environmental infection control, fire safety, and chemical safety are assessed and recommendations for corrective action are provided. The IEH Program works to foster multi-disciplinary engagement amongst all levels of the organization to improve transparency and efficiency.

Staff engage Tribal, county, and state public health and public safety officials in Tribal communities. For example, staff engage local Bureau of Indian Affairs law enforcement or Tribal police to enhance motor vehicle related injury prevention efforts through child safety seat interventions and enhanced police enforcement activities such as seat belt usage or driving under the influence checkpoints. Staff work extensively with Tribal, county, and state health departments on a variety of public health issues including response to food-borne (i.e., salmonellosis), vector-borne (i.e., bubonic plague, Rocky Mountain spotted fever, hantavirus), and water-borne (i.e. legionellosis) disease outbreaks. Other examples of collaboration include surveillance activities related to emerging diseases and public health emergency preparedness.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2020 Target	FY 2021 Target	FY 2021 Target +/-FY 2020 Target
EHS-3 Injury Intervention: Occupant protection restraint use (Outcome)	FY 2019: 69.5%[5] Target: Greater than 64% (Target Exceeded)	100%[6]	Retired	N/A

4 Indian Health Focus: Injuries, 2017 Edition

5 Final observed driver seat belt use rate

6 Percent of all participating Areas distribute model practices and highlight challenges.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2020 Target	FY 2021 Target	FY 2021 Target +/-FY 2020 Target
EHS-4 Environmental Surveillance (Outcome)	FY 2019: 3.5%[7] Target: Less than 5% (Target Exceeded)	100%[8]	Retired	N/A
EHS-5 Number of persons who received injury prevention training (Output)			Baseline	N/A
EHS-6 Percent of food establishments with Certified Food Protection Manager (CFPM) (Output)			Baseline	N/A

In FY 2016, a national baseline was established for EHS-3 and EHS-4 at 64 percent and 5.1 percent, respectively. In FY 2018, 64 percent of drivers wore seat belts (EHS-3) and 3.4 percent of food borne illness risk factors were out of compliance (EHS-4). In FY 2019, 69.5 percent of drivers wore seat belts (EHS-3) and 3.5 percent of food borne illness risk factors were out of compliance (EHS-4). The FY 2020 target is based on 100 percent of all participating Areas distributing model practices and highlighting challenges to Tribes. *The FY 2020 targets are not comparable to FY 2019.

Performance Discussion

Injury Intervention: During the 2016-2020 performance cycle, in FY 2016, Area EHS Programs identified targeted communities from which a national baseline measure of seatbelt use was developed (64 percent). For the FY 2017 target, 8 of 10 (80 percent) of the Area programs implemented comprehensive interventions using at least three effective strategies to increase seatbelt usage rate in targeted Tribal communities. Examples include: developing or strengthening tribal seat belt laws, increasing partnerships with Tribal police, providing classroom curriculum for motor vehicle crash prevention at reservation schools. For the FY 2018 target, measure interim seat belt use to determine effectiveness of interventions and propose adjustments to interventions based on interim driver seat belt use findings, 64 percent of drivers wore seat belts (no change from the FY 2016 baseline year) and Areas modified their strategies to address identified intervention barriers. In FY 2019, Area programs conducted their final driver seat belt use rates, 69.5 percent of drivers used their seat belt. The results show an 8 percent increase in observed seat belt use when compared to the 64 percent baseline. In FY 2020, Area programs will share success stories with Tribes highlighting interventions which had the greatest impact at improving driver seat belt usage. ***IHS Strategic Plan Goal 1: To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people.*** *Objective 1.3: Increase access to quality health care services.* HHS Strategic Plan FY 2019-2023, Goal 2.2.

Environmental Surveillance: During the 2016-2020 performance cycle, in FY 2016, Area EHS Programs identified targeted Tribal Head Start and non-residential day care establishments from which a national baseline of foodborne illness risk factors was calculated (5.1 percent). For the

[7] Final percent of food borne risk factors that are out of compliance.

[8] percent of all participating Areas distribute model practices and highlight challenges.

FY 2017 target, 10 of 10 (100 percent) of the Areas implemented and reported comprehensive interventions using at least three effective strategies to decrease food risk factor deficiencies at targeted Tribal Head Start and non-residential day care establishments. Examples include: developing and implementing active managerial control and corrective action plan processes with local operators, focusing food inspection surveys on targeted risk factors, and providing access to training through the IHS Online Food Handlers Training Course. For the FY 2018 target, conduct an interim assessment of poor employee health and hygiene foodborne illness risk factors to determine effectiveness of interventions and adjust interventions based on interim findings, 3.4 percent of food borne illness risk factors were out of compliance (a decrease from the FY 2016 baseline year) and Areas continued their comprehensive interventions. In FY 2019, Area programs conducted their final assessments and data collection, 3.5 percent of food borne illness risk factors were out of compliance. The results show a 31 percent reduction in food borne illness risk factors that were out of compliance when compared to the 5.1 percent baseline. In FY 2020, Area programs will share success stories with Tribes highlighting interventions which had the greatest impact at improving driver seat belt usage. ***IHS Strategic Plan Goal 1: To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people.*** *Objective 1.3: Increase access to quality health care services.* HHS Strategic Plan FY 2019-2023, Goal 2.2.

The FY 2016 – 2020 EHS performance measures focus on reducing the risk of foodborne illness in children's environments and reducing the risk of motor vehicle-related injuries and deaths through increased use of seatbelts. Barriers that may impact the program's ability to meet these targets include competing local, regional and national priorities, staff turn-over, lapsed vacant positions, and a decentralized approach to program management that can result in non-standardized processes across the country. To help mitigate these barriers, EHS provides ongoing competency development through specialized training programs; strategic planning efforts that support uniform program management; and data management tools to support local staff.

GRANT AWARDS

In FY 2018, the Injury Prevention Program awarded $1.3 million in cooperative agreements to fund 32 Tribal programs. In FY 2019, (year four of the five-year agreements) $1.3 million in continuation funds were awarded to the 31 Tribal programs.

OFFICE OF ENVIRONMENTAL HEALTH AND ENGINEERING SUPPORT

PROGRAM DESCRIPTION

The IHS Office of Environmental Health and Engineering Support activity (OEHE) provides funds for executive 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, perform management functions and have responsibility for all construction contracting in excess of $150,000.

Management activities include**:**

- national policy development and implementation
- budget formulation, project review and approval
- congressional report preparation

- quality assurance (e.g., internal control reviews, Federal Managers Financial Integrity Act activities and other oversight)
- technical assistance (e.g., consultation and training)
- construction contracting
- long range planning
- meetings (with HHS, Tribes, and other federal agencies)
- recruitment and retention efforts.

Typical direct support functions are**:**

- Project officers and contracting officer representatives for health care facilities construction projects: reviewing and/or writing technical justification documents, participating in design reviews and site surveys, conducting onsite inspections, and monitoring project funding status.
- Staff support real property asset management requirements. These actions are to ensure management accountability and the efficient and economic use of federal real property.
- Staff serving as contracting officer representatives and project officers in support of data systems, cooperative agreements, inter-agency agreements, and community-based projects.

In accordance with appropriation committee direction, OEHE staff develop, maintain, and utilize data systems to distribute Facilities Appropriation resources to Area offices for facilities and environmental health activities and construction administration and management, based upon workload and need. Also, technical guidance, information, and training are provided throughout the IHS system in support of the Facilities Appropriation.

Office of Environmental Health and Engineering (OEHE) Support advances the HHS Strategic Plan Goal 1: Reform, Strengthen, and Modernize the Nation's Healthcare System by increasing access to healthcare and strengthening the healthcare workforce to meet diverse needs. OEHE Support advances the HHS Strategic Plan Goal 2: Protect the Health of Americans Where They Live, Learn, Work, and Play by: Preventing and Controlling communicable and environmental diseases; and Preparing for and responding to public health emergencies. Additionally, OEHE Support furthers HHS Strategic Goal 5: Promoting Effective and Efficient Management and Stewardship.

PROGRAM ACCOMPLISHMENTS

The following are activities which focus on the IHS mission and priorities:

- review and approval of Program Justification Documents (PJDs) and Program Of Requirements (PORs)
- announcement and review of Joint Venture and Small Ambulatory projects
- awarding and monitoring contracts for all aspects of the Facilities Appropriation, including all types of construction contracts and 638 construction project agreements.
- OEHE coordinating construction, environmental health, and real property activities through the 12 Area Offices to ensure program consistency, to ensure the most effective use of resources across IHS, and to support field programs through budget preparation and required reporting, thus ensuring the most effective, accountable use of resources to improve access to quality healthcare services.

OEHE strengthens the overall management of IHS by reviewing and approving the planning documents for health care facilities construction projects called PJDs and PORs. OEHE also

reviews joint venture and small ambulatory projects which address assessing health care and improving health care delivery. These programs include behavioral health services. These programs include behavioral health services. The OEHE facilities programs integrate strategic planning, performance, and program integrity into the office's daily business practices. One example is the Sanitation Facilities Construction Strategic planning efforts and identification of needs (Strategy 1, "*Improve the transparency and quality of data collected regarding health care service and program outcomes*" from IHS Strategic Plan FY 2019-2023, Objective 2.1: *Create quality improvement capability at all levels of the organization*). Implementation of this plan has improved project management, reduced project durations and transformed the data system used by IHS and federal partners to manage sanitation programs in Indian country. Another example is the Environmental Health program strategic visioning and the Ten Essential Environmental Health Services as a framework. Implementation of both of these initiatives is ongoing.

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

(Dollars in Thousands)

	FY 2019	FY 2020	FY 2021	
	Final	Enacted	President's Budget	FY 2021 +/- FY 2020
BA	$23,706	$28,087	$23,895	-$4,192
FTE*	--	--	--	--

*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 2021 Authorization.....Permanent

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

PROGRAM DESCRIPTION

Equipment funds are used for maintenance, upgrades, replacement, and the purchase of new medical equipment systems at Indian Health Service (IHS) and Tribal healthcare facilities. It directly supports the Agency's priorities of Partnerships and Quality.

Accurate clinical diagnosis and effective therapeutic procedures depend in large part on health care providers using modern and effective medical equipment/systems to assure the best possible health diagnosis. The IHS and Tribal health programs manage approximately 90,000 devices consisting of laboratory, medical imaging, patient monitoring, pharmacy, and other biomedical, diagnostic, and patient equipment valued at approximately $500 million. With today's medical devices/systems having an average life expectancy of approximately six years and rapid technological advancements, medical equipment replacement is a continual process making it necessary to replace worn out equipment or provide equipment with newer technology to enhance the speed and accuracy of diagnosis and treatment. To replace the equipment at the end of its six-year life would require approximately $84.0 million per year.

Many of the IHS hospital administrators reported that old or inadequate physical environments challenged their ability to provide quality care and maintain compliance with the Medicare Hospital Conditions of Participation. Further, the administrators reported that maintaining aging buildings and equipment is a major challenge. Over one third of all IHS hospitals' deficiencies have been found to be related to facilities with some failing on infection control criteria and others having malfunctioning exit doors.

Equipment Funds Allocation Method

The IHS Equipment funds are allocated in three categories: Tribally-constructed health care facilities, TRANSAM program, and new and replacement equipment:

1. Tribally-Constructed Health Care Facilities – The IHS provides medical equipment funds to support the initial purchase of equipment for tribally-constructed health care facilities. The Budget Request supports approximately $5.0 million for competitive awards to Tribes and Tribal organizations that construct new or expand health care facilities space using non-IHS funding sources. Tribes and Tribal organizations will use these funds to serve approximately 500,000 patients with newly purchased medical equipment.

2. TRANSAM Program – Equipment funds may be 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.[1] The Budget includes $500,000 for the TRANSAM Program from the Equipment budget. Under the TRANSAM Program, excess equipment and supplies, at an annual estimated value of $5.0 million, are acquired for distribution to federal and Tribal sites.

3. New and Replacement Equipment –Approximately $19.7 million will be allocated to IHS and Tribal health care facilities to maintain existing and purchase new medical equipment, including the replacement of existing equipment used in diagnosing illnesses. The funding allocation is formula based.

The Facilities Management Program addresses the IHS Strategic Plan FY 2019-2023, Goal 1: To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people; Objective 1.1: Recruit, develop, and retain a dedicated, competent, and caring workforce, and Objective 1.3: Increase access to quality health care services. Additionally, Facilities Program addresses the IHS Strategic Plan FY 2019-2023, Goal 3: To strengthen IHS program management and operations; Objective 3.2: Secure and effectively manage the assets and resources.

IHS Strategic Plan and how the Facilities programs are implementing: In consultation with Tribes and the Federal healthcare sites, IHS is allocating funding to the IHS Area Offices to replace and modernize medical equipment to support health care delivery and expand access to quality health care services.

FUNDING HISTORY/REQUEST

Fiscal Year	Amount
2017	$22,966,000
2018	$23,706,000
2019	$23,706,000
2020 Enacted	$28,087,000
2021 President's Budget	$23,895,000

TRIBAL SHARES

Equipment funds are subject to tribal shares and are transferred to Tribes when they assume the responsibility for operating the associated programs, functions, services, and activities at a Federal or Tribe healthcare site.

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

BUDGET REQUEST

The FY 2021 budget submission for Equipment is $23.9 million, which is $4.2 million below the FY 2020 Enacted Level.

FY 2021 Funding of $23.9 million includes:

Current Services of +$257,000 including:

- Inflation: +$257,000 to fund inflationary costs of providing health care services.

This level of funding provides for the following allocation categories:

- Approximately $20.4 million for new and routine replacement medical equipment to over 1,500 federally and tribally-operated healthcare facilities;
- $3.0 million for new medical equipment in tribally-constructed health care facilities; and
- $500,000 for the TRANSAM program.

Program Adjustment -$4.4 million - The budget proposes to prioritize other direct services while redirecting/reducing funding for other activities, such as Equipment.

These funds will be used for maintenance, upgrades, replacement, and the purchase of new medical equipment systems at IHS and Tribal healthcare facilities.

OUTPUTS / OUTCOMES

This program measures outcomes through its inventory of medical equipment. Maintaining and fielding modern medical equipment improve the ease and access to care, enhance the diagnostic capabilities leading to better health outcomes, and enable the hiring and retention of healthcare professionals by giving them modern space and equipment with which to deliver services.

IHS targets Equipment funding and supplements these funds with collections where available, toward equipment purchases to reduce the backlog of over-age equipment and field new, state-of-the-art equipment and systems. A few examples of these purchases include: digital x-ray systems (dental, 3D panoramic x-ray, full radiology rooms, 3D mammography, computed tomography), optometry equipment (visual field analyzers, simultaneous fundus and optical coherence tomography), lab analyzers for in-house testing, sterilization equipment, specialized microscopes, patient lifting equipment, picture archiving & communications systems (PACS), central patient monitoring systems, and ultrasound systems. This equipment will improve diagnostic capabilities, provide faster analysis, and facilitate provision of services to American Indian and Alaska Native communities.

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 2019	FY 2020	FY 2021	
	Final	Enacted	President's Budget	FY 2021 +/- FY 2020
BA	$8,500	$9,100	$9,600	+$500
FTE*	40	40	40	--

Quarters funds are not BA but are rents collected for quarters which are returned to the service unit for maintenance and operation costs. They fall under the Program Level Authority.
*FTE numbers reflect only Federal staff and do not include increases in Tribal staff.

Authorizing Legislation .....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended 2010; Public Law 98-473, Sec. 320, as amended

FY 2021 Authorization.....Permanent

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

PROGRAM DESCRIPTION

When available housing is limited in the area of Indian Health Service (IHS) health care facilities, staff quarters are provided to assist with recruitment and retention of health care providers. The operation, maintenance, and improvement costs of the staff quarters are funded with this funding designated as Quarters Return (QR) funds, i.e., the rent collected from tenants residing in the quarters. The use of the funds includes maintenance personnel services, security guard services, repairs to housing units and associated grounds, purchase of materials, supplies, and household appliances/equipment (e.g., stoves, water heaters, furnaces, etc.). In certain situations, Maintenance and Improvement Program funds may be used, in conjunction with QR funds, to ensure adequate quarters' maintenance. For example, this may be necessary in locations with few quarters where QR funds are insufficient to pay for all required maintenance costs.

The Facilities Management Program addresses the IHS Strategic Plan FY 2019-2023, Goal 1: To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people; Objective 1.1: Recruit, develop, and retain a dedicated, competent, and caring workforce, and Objective 1.3: Increase access to quality health care services. Additionally, Facilities Program addresses the IHS Strategic Plan FY 2019-2023, Goal 3: To strengthen IHS program management and operations; Objective 3.2: Secure and effectively manage the assets and resources.

IHS Strategic Plan and how the Facilities programs are implementing: In consultation with Tribes and the Federal healthcare sites, IHS is allocating funding to the IHS Area Offices to complete BEMAR projects to make renovations and improvements necessary to support health care delivery in the health care facilities and to modernize the health care facilities and staff quarters to expand access to quality health care services.

FUNDING HISTORY/REQUEST

Fiscal Year	Amount
2017	$8,500,000
2018	$8,500,000
2019	$8,500,000
2020 Enacted	$9,100,000
2021 President's Budget	$9,600,000

BUDGET REQUEST

The FY 2021 Quarters Return budget submission for Rent Collections is $9.6 million, which is $500,000 above the FY 2020 Enacted Level for anticipated rental collections. FY 2019 rent collections were approximately $8.5 million and are projected to increase to approximately $9.6 million in FY 2021. Rental rates are established in accordance with OMB Circular A-45 and adjusted annually based on the national Consumer Price Index (CPI).

This level of funding for Anticipated Rent Collections provides for the following:

The operation, management, and general maintenance of quarters, including maintenance personnel services, repairs to housing units and associated grounds, purchase of materials, supplies, and household appliances/equipment (e.g., stoves, water heaters, furnaces, etc.).

OUTPUTS / OUTCOMES - This program measures outcomes through the inventory of staff quarters. Well-maintained and modern housing units are an essential element in recruiting and retaining healthcare professionals at IHS and Tribal healthcare sites. Rent collections, augmented with Maintenance & Improvement funding and collections where available, are used to maintain, repair, and modernize existing quarters. Typically work may include painting, carpeting, new appliances, roof replacement, etc.

GRANT AWARDS – This program has no grant awards.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2021 Performance Budget Submission to Congress

TABLE OF CONTENTS

Contract Support Costs

THIS PAGE INTENTIONALLY LEFT BLANK

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Contract Support Costs: 75-0344-0-1-551
CONTRACT SUPPORT COSTS

(Dollars in Thousands)

	FY 2019[1]	FY 2020	FY 2021	
	Final	Enacted[2]	President's Budget	FY 2021 +/- FY 2020
BA	$822,227	$855,000	$855,000	+$0
FTE*	0	0	0	0

*Contract Support Costs are not currently 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 2021 Authorization.....Permanent

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

PROGRAM DESCRIPTION

The Indian Self-Determination and Education Assistance Act (ISDEAA), Public Law 93-638, provides Tribes or Tribal Organizations (T/TO) the authority to contract with the Department of Health and Human Services, through the Indian Health Service (IHS), to operate Federal programs serving eligible persons and to receive not less than the amount of funding that the Secretary would have otherwise provided for the direct operation of the program for the period covered by the contract (otherwise known as the "Secretarial amount"). The 1988 amendments to the Act authorized Contract Support Costs (CSC) be paid in addition to the Secretarial amount.

CSC are defined as necessary and reasonable costs for activities that T/TO must carry out to ensure compliance with the contract and prudent management but that the Secretary either did not normally carry out in his or her direct operation of the program or provided from resources other than those transferred under contract. The IHS CSC policy was established in 1992 and most recently revised on August 6, 2019, which updates from the October 2016 policy revisions,[3] an update to reflect necessary changes. These changes include the method by which Congress has funded CSC, and moves from limited to uncapped awards, and the provision of CSC to an indefinite appropriation.

CSC is administered for IHS by the Office of Direct Services and Contracting Tribes (ODSCT), an office with responsibility for three primary functions that directly impact the relationship with each Indian T/TO. The ODSCT serves as the primary conduit between the IHS and the Direct Service Tribes, management of P.L. 93-638 Title I, ISDEAA contracts, and CSC in support of

[1] Reflects Services account adjustments related to formal reprogramming notifications submitted to Congress in FY 2019. Amounts by "Sub IHS Activity" will continue to be adjusted during the period of availability, which conclude on September 30, 2020, for impacted funds.

[2] The Congressional Budget Office score for FY 2020 is $820 million.

[3] *Indian Health Manual*, Part 6 – Services to Tribal Governments and Organizations, Chapter 3 – Contract Support Costs, *available at* http://www.ihs.gov/ihm/index.cfm?module=dsp_ihm_pc_p6c3.

both Title I contracts and Title V compacts.

- *IHS Strategic Plan (SP) Goal 1, Objective 1.2, Building, strengthen, and sustain collaborative relationships;*
- *Strategic Goal 3, Objective 3.1, Improve communication within the organization with Tribes; and 3.2, Secure and effectively manage the assets and resources*

PROGRAM ACCOMPLISHMENTS

- Following is a summary CSC funds for FY 2015 – FY 2020, as of December 2019:

	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Appropriations*	$662,970,000	$686,859,423	$714,642,272	$762,642,272	$762,642,272	$855,000,000
Paid to Tribes	($644,690,838)	($657,504,298)	($723,978,364)	($765,661,629)	($567,531,161)	($234,704,023)
Balance*	$18,279,162	$29,355,125	$(9,336,092)	$(3,019,357)	$195,111,111	$(234,704,023)

* Funds remain in process for payment to tribes and/or pending final reconciliation with tribes to determine the final amounts.

- IHS updated its CSC Policy on August 6, 2019 that incorporates the changes applicable to the section of the policy relating to an alternative method for calculating indirect costs (IDC) associated with recurring Service Unit shares – also referred to as the "97/3 method" or "97/3 split". In May of 2017, IHS initiated Tribal Consultation and used the comments received to reinstate the "97/3" provision that requires agreement by both IHS and the Tribes to determine the appropriate method to calculate IDC associated with recurring Service Unit shares. *IHS SP Goal 1, Objective 1.2.*

- IHS Headquarters reconciles CSC fund requests on a quarterly basis and allocates funds to each Area office to pay tribes. *IHS SP Goal 3, Objective 3.2*

- IHS uses the CSC automated data system to track and monitor all CSC activity. The CSC data set is used to track all CSC funds, including any new and expanded assumption, renegotiation of CSC amounts, and distribution and payment of funds. IHS also uses the system to project CSC need based on the most current data. *IHS SP Goal 3, Objective 3.3 – Modernize Information Technology and information systems to support data-driven decisions.*

- IHS continues to use the internal electronic database to monitor each Title I and V ISDEAA negotiation, including CSC negotiations. The database monitors each phase of a negotiation to ensure that IHS uses a consistent agency business approach, meet statutory deadlines, and accurately calculate required funding amounts. In addition, the database tracks new and expanded assumptions and is used to determine the status of funds, workload, planning of resources, and subsequent years' funding needs. *IHS SP Goal 3, Objective 3.3*

- IHS continues to make progress in resolving Contract Disputes Act claims from T/TO for additional CSC funding for prior years. As of August 25, 2019, the IHS has extended settlement offers on 1,564 of the 1,624 claims, with settlement payments of approximately $880 million that has been tentative or confirmed for payment from the Judgment Fund. *IHS SP Goal 3, Objective 3.1*

FUNDING HISTORY

Fiscal Year	Amount
2017	$800,000,000
2018	$762,642,000
2019	$822,227,000
2020 Enacted	$855,000,000
2021 President's Budget	$855,000,000

BUDGET REQUEST

The FY 2021 Budget submission for Contract Support Costs continues the indefinite discretionary appropriation established in FY 2016, with an estimated funding level of $855 million which is the same as the FY 2020 Enacted level.

The overall funding level varies with need that is adjusted to meet the actual need for each fiscal year, which means that the appropriated amount will continue to fluctuate until the CSC need is fully reconciled for each year. The requested funding level reflects IHS's best current estimate of the need.

AREA ALLOCATION

CONTRACT SUPPORT COSTS

(dollars in thousands)

DISCRETIONARY	FY 2019 Final 1/			FY 2020 Estimated			FY 2021 Estimated			FY '21 +/- FY '20
SERVICES	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$0	$243,944	$243,944	$0	$253,668	$253,668	$0	$253,668	$253,668	$
Albuquerque	0	20,343	20,343	0	21,154	21,154	0	21,154	21,154	$
Bemidji	0	43,547	43,547	0	45,282	45,282	0	45,282	45,282	$
Billings	0	15,287	15,287	0	15,897	15,897	0	15,897	15,897	$
California	0	68,475	68,475	0	71,204	71,204	0	71,204	71,204	$
Great Plains	0	7,821	7,821	0	8,132	8,132	0	8,132	8,132	$
Nashville	0	35,445	35,445	0	36,858	36,858	0	36,858	36,858	$
Navajo	0	64,916	64,916	0	67,503	67,503	0	67,503	67,503	$
Oklahoma	0	124,207	124,207	0	129,158	129,158	0	129,158	129,158	$
Phoenix	0	45,088	45,088	0	46,885	46,885	0	46,885	46,885	$
Portland	0	62,990	62,990	0	65,501	65,501	0	65,501	65,501	$
Tucson	0	26,111	26,111	0	27,152	27,152	0	27,152	27,152	$
Headquarters	0	64,053	64,053	0	66,606	66,606	0	66,606	66,606	$
Total, CSC	**$0**	**$822,227**	**$822,227**	**$0**	**$855,000**	**$855,000**	**$0**	**$855,000**	**$855,000**	**$**

1/ Reflects Services account adjustments related to formal reprogramming notifications submitted to Congress in FY 2019. Amounts by "Sub IHS Activity" will continue to be adjusted during the period of availability, which conclude on September 30, 2020, for impacted funds.

Note: FY 2020 through 2021 are estimates.

THIS PAGE INTENTIONALLY LEFT BLANK

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2021 Performance Budget Submission to Congress

TABLE OF CONTENTS

ISDEAA 105*(l)* Leases

THIS PAGE INTENTIONALLY LEFT BLANK

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Section 105(*l*) Leases: 75-0200-0-1-551
ISDEAA SECTION 105(*l*) LEASES

(Dollars in Thousands)

	FY 2019[1]	FY 2020	FY 2021	
	Final	Enacted	President's Budget	FY 2021 +/- FY 2020
BA	$0	$0	$101,000	+$101,000
FTE*	0	0	0	0

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

Authorizing Legislation ..... 25 U.S.C. § 5324(*l*)
Indian Self-Determination and Education Assistance Act, P.L. 93-638, as amended

FY 2021 Authorization.....Permanent

Allocation Method .....P.L. 93-638 Self-Determination Contract and Compacts, Lease Cost Agreements

PROGRAM DESCRIPTION

The Indian Self-Determination and Education Assistance Act (ISDEAA), at 25 U.S.C. § 5324(*l*), also referred to as Section 105(*l*), requires the Indian Health Service (IHS) to enter a "lease" upon the request of a Tribe or Tribal Organization furnishing a tribally owned or leased facility used in support of its tribally operated ISDEAA contract or compact. IHS does not directly use or occupy the tribal facility under the lease. Through regulations contained in 25 C.F.R. Part 900, Subpart H, IHS identified elements of compensation included in a Section 105(*l*) lease.

A 2016 Federal Court's decision (Maniilaq Association v. Burwell) prohibits IHS from capping funding under Section 105(l) at the level that IHS would have otherwise spent to operate a facility if it were to carrying out the Federal health programs. There is no statutory or regulatory limitation on when proposals may be submitted to the IHS, so IHS cannot reliably project annual costs or provide reliable estimates during a single fiscal year. Lease costs have grown exponentially, since the Maniilaq decision, and have quadrupled between FY 2018 and FY 2019. Because IHS does not have dedicated funding for leases, IHS has been forced to reprogram funds twice in FY 2019 totaling over $70 million and once in FY 2018 totaling $25 million. Absent a change, IHS will continue to divert increasing amounts of resources from direct services to pay for leases. IHS cannot legally reduce the amount of funds provided to self-determination Tribes and tribal organizations, so the only funds available for reprogramming come from Tribes that IHS serves directly.

The prevalence of Section 105(l) leases in FY 2017 was largely confined to the Alaska Area. However, by FY 2019, leases have proliferated throughout the IHS system and proposals have been received in 10 of 12 IHS Areas.

[1] Reflects Services account adjustments related to formal reprogramming notifications submitted to Congress in FY 2019. Amounts by "Sub IHS Activity" will continue to be adjusted during the period of availability, which conclude on September 30, 2020, for impacted funds.

The Budget provides full funding for Section 105(l) leases at an estimated $101 million through a new, separate indefinite discretionary appropriation, and also includes reforms to improve management of tribal lease payments. The Budget includes legislative proposals and appropriations language to support this new indefinite appropriation, which were developed in collaboration with the Department of the Interior's Bureau of Indian Affairs (BIA) and Bureau of Indian Education (BIE). IHS will continue to work with BIA and BIE to develop additional policies and guidance, in consultation with Tribes and tribal organizations, to clarify procedures and improve management of tribal lease payments.

This new, separate funding source supports IHS Strategic Plan goals and objectives for increasing access to care by establishing a dedicated funding source for these required costs and preventing the redirection of other IHS funds intended for health care services (*Goal 1, Access, Objective 1.3, Increase access to quality health care services*).

PROGRAM ACCOMPLISHMENTS

In FY 2019, the IHS received 205 proposals, totaling nearly $101 million, an amount four times higher than in FY 2018 and 17 times higher than in FY 2017. Based on the exponential growth of Section 105(*l*) leases from 37 proposals totaling $6 million in FY 2017, to 83 proposals totaling $25 million in FY 2018, and 205 proposals totaling $101 million in FY 2019, costs for future years are expected to continue growing as more Tribes and Tribal Organizations across the country submit additional proposals.

In FY 2019, the IHS received an increase of $25 million in the Services Hospitals and Health Clinics (H&HC) budget line for tribal clinic operational costs. This amount supplemented the $11 million included in the IHS's base funding level for a total of $36 million for tribal clinic operational costs, including Village Built Clinics (VBCs) in Alaska. Based on prior agency decisions made through consultation with Alaska Tribes, approximately $6 million of the base funds were transferred to the Alaska Area on a recurring basis primarily for VBCs. The remaining $30 million was allocated for Section 105(*l*) leases; however, additional resources were required to meet the full need. Under current appropriations, the IHS is legally required to fund Section 105(*l*) leases from the IHS's "Indian Health Services" lump sum appropriation account. Similar to FY 2018, the IHS provided formal notice to Congress and reprogrammed funding from within the IHS's Services appropriation account to meet FY 2019 funding requirements, shifting funds from direct patient care to lease costs.

The IHS conducted Tribal Consultation and Urban Confer in FY 2018 and again in FY 2019 on short-term and long-term options for meeting requirements of the ISDEAA related to Section 105(*l*). Tribal and Urban Indian Organization feedback strongly recommended seeking additional resources, such as through a separate indefinite appropriation, and remained critical of any redirection of existing funding, which diminishes the Indian health system's ability to provide direct health care services. At the recommendation of Tribes and Tribal Organizations, the IHS established a technical team to help collect and analyze information necessary for developing cost projections. The team includes representatives from the IHS Tribal Self-Governance Advisory Committee, the IHS Direct Services Tribes Advisory Committee, the IHS Facilities Appropriation Advisory Board, the IHS National Tribal Budget Formulation Workgroup (NTBFW), and subject matter experts from the IHS. This team serves as a technical resource to the NTBFW and their on-going work is included in the IHS's annual Tribal Consultation and Urban Confer on the budget.

FUNDING HISTORY

Fiscal Year	Amount
2017	$0
2018	$0
2019	$0
2020 Enacted	$0
2021 President's Budget	$101,000,000

BUDGET REQUEST

The FY 2021 budget submission for ISDEAA Section 105(*l*) leases is $101.0 million as an indefinite discretionary appropriation, which is $101.0 million above the FY 2020 Enacted Level. $6.0 million will remain in the H&HC budget line primarily for VBCs.

OUTPUTS / OUTCOMES

There are no outputs/outcomes for this funding at this time.

GRANTS AWARDS -- The program does not award grants.

AREA ALLOCATION – Funds are allocated to Areas as ISDEAA Section 105(*l*) lease proposals are received and executed each fiscal year.

THIS PAGE INTENTIONALLY LEFT BLANK

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2021 Performance Budget Submission to Congress

TABLE OF CONTENTS

Special Diabetes Program for Indians

THIS PAGE INTENTIONALLY LEFT BLANK

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
SPECIAL DIABETES PROGRAM FOR INDIANS

(dollars in thousands)

	FY 2019	FY 2020	FY 2021	
	Final	Enacted	President's Budget	FY 2021 +/- FY 2020
BA	$150,000	$96,575	$150,000	+$53,425
FTE*	129	129	129	0

Authorizing Legislation ..... 111 Stat. 574, 1997 Balanced Budget Act (P.L. 105-33), Consolidated Appropriation Act 2001 and amendment to Section 330C (c)(2)(c) Public Health Service Act through Senate Bill 2499 (passed the Senate 12/18/07) to extend funding through FY 2009, the Medicare Improvements for Patients and Providers Act of 2008 (P.L. 110-275) Title III Special Diabetes Program for Indians (SDPI) to extend funding through FY 2011, the H.R. 4994 Medicare and Medicaid Extenders Act of 2010 to extend SDPI funding through FY 2013, the American Taxpayer Relief Act of 2012 (P.L. 112-240) to extend funding through FY 2014, the Protecting Access to Medicare Act of 2014 (P.L. 113-93; H.R. 4302) to extend funding through FY 2015. P.L. 114-10 – The Medicare Access and CHIP Reauthorization Act of 2015 authorized SDPI for FY 2016 and FY 2017, P.L. 115-63 — Disaster Tax Relief and Airport and Airway Extension Act authorized SDPI for the first quarter of FY 2018, and P.L. 115-96— Department of Homeland Security Blue Campaign Authorization Act of 2017 authorized SDPI for the second quarter of FY 2018, P.L. 115-123 – Bipartisan Budget Act of 2018 authorized SDPI for the rest of FY 2018 and all of FY 2019, the Continuing Appropriations Act, 2020, and Health Extenders Act of 2019 (P.L. 116-59) authorized SDPI through November 21, 2019, the Further Continuing Appropriations Act, 2020, and Further Health Extenders Act of 2019 (P.L. 116-69) authorized SDPI through December 20, 2019. SDPI authorized through May 22, 2020 through the Further Consolidated Appropriations Act, 2020 (H1865PLT).

FY 2021 Authorization..... Expires May 22, 2020 (FY 2020)

Allocation Method ..... Grants and Contracts

PROGRAM DESCRIPTION

The Special Diabetes Program for Indians (SDPI) grant program provides funding for diabetes treatment and prevention to approximately 301 Indian Health Service (IHS), Tribal, and Urban (I/T/U) Indian health grant programs. Funds for SDPI were first authorized in FY 1998; as such, FY 2021 would be the 24th year of the SDPI. SDPI is currently authorized through May 22, 2020. The IHS Office of Clinical and Preventive Services (OCPS) Division of Diabetes Treatment and Prevention (DDTP) provides leadership, programmatic, administrative, and technical oversight to the SDPI grant program.

The mission of the DDTP is to develop, document, and sustain public health efforts to prevent and control diabetes in American Indians and Alaska Natives (AI/ANs) by promoting collaborative strategies through its extensive diabetes network. This mission aligns with *Goal 1 of the IHS Strategic Plan, To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people and Objective 2.2 of the HHS Strategic Plan, Provide care to better meet the health care needs of*

American Indian and Alaska Native communities. The diabetes network consists of a national program office, Area Diabetes Consultants in each of the 12 IHS Areas, and approximately 301 SDPI grants and sub-grants at I/T/U sites across the country.

Target Population: American Indians and Alaska Natives

Diabetes and its complications are major contributors to death and disability in nearly every Tribal community. AI/AN adults have the highest age-adjusted rate of diagnosed diabetes (15.1 percent) among all racial and ethnic groups in the United States, more than twice the rate of the non-Hispanic white population (7.4 percent).[1] In some AI/AN communities, more than half of adults 45 to 74 years of age have diagnosed diabetes, with prevalence rates reaching as high as 60 percent.[2]

Allocation Method

In the Balanced Budget Act of 1997, Congress instructed the IHS to use SDPI funds to "establish grants for the prevention and treatment of diabetes" to address the growing problem of diabetes among AI/ANs. The entities eligible to receive these grants were I/T/Us. The IHS distributes this funding to approximately 301 I/T/U sites annually through a process that includes Tribal consultation/Urban confer, development of a formula for distribution of funds, and a formal grant application and administrative process. *This process is consistent with IHS Strategic Plan Objective 1.2 to "build, strengthen, and sustain collaborative relationships*".

Strategy

The SDPI brings Tribes together to work toward a common purpose and share information and lessons learned. The Tribal Leaders Diabetes Committee, established in 1998, reviews information on the SDPI progress and provides recommendations on diabetes-related issues to the IHS Director. Through partnerships with federal agencies, private organizations, and an extensive I/T/U network, DDTP undertook one of the most strategic diabetes treatment and prevention efforts ever attempted in AI/AN communities and demonstrated the ability to design, manage, and measure a complex, long-term project to address this chronic condition. Because of the significant costs associated with treating diabetes, I/T/Us have used best and promising practices for their local SDPI funding to address the primary, secondary, and tertiary prevention of diabetes and its complications. *These efforts increase the availability and accessibility of comprehensive, culturally appropriate personal and public health services to AI/AN people, which supports Goal 1 of the IHS Strategic Plan and Objective 1.3 of the HHS Strategic Plan.*

This collaborative approach supports the strategic planning process necessary to identify the goals and objectives needed to achieve the intended SDPI outcomes. As in *Objectives 1.2, 1.3, and 3.1*

[1] Centers for Disease Control and Prevention (CDC). *National Diabetes Statistics Report: Estimates of Diabetes and Its Burden in the United States, 2017*. Atlanta, GA: U.S. Department of Health and Human Services; 2017. *Available at*: https://www.cdc.gov/diabetes/pdfs/data/statistics/national-diabetes-statistics-report.pdf

[2] Lee ET, Howard BV, Savage PJ, et al. Diabetes and impaired glucose tolerance in three American Indian populations aged 45-74 years: the Strong Heart Study. *Diabetes Care*. 1995;18:599-610.

of the IHS Strategic Plan, the SDPI promotes collaboration and communication with Tribes and Urban Indian Organizations in the development of quality community-based diabetes prevention and treatment programs.

PROGRAM ACCOMPLISHMENTS

SDPI: Two Major Components

As directed by Congress and Tribal consultation, the SDPI consists of two major components: (1) SDPI Grant Program; and (2) Diabetes data and program delivery infrastructure.

1. SDPI Grant Program

The SDPI grant program (formerly called the SDPI Community-Directed grant program) provides $138.7 million per year in grants and technical assistance for local diabetes treatment and prevention services at I/T/U health programs in 35 states. Each of the communities served by the SDPI grant program is unique in that its diabetes treatment and prevention needs and priorities are defined locally. Based on these local needs and priorities, the SDPI grant programs implement interventions to address the diabetes epidemic.

The Consolidated Appropriations Act of 2001 established statutory authority for SDPI to implement a best practices approach to diabetes treatment and prevention. As such, the SDPI has incorporated Indian Health Diabetes Best Practices into the SDPI grant application process used throughout AI/AN communities. This effort is used to promote excellence and quality within the SDPI programs, which aligns with the IHS Strategic Plan Goal 2. Grant programs are required to document the use of one SDPI Diabetes Best Practice,[3] corresponding evaluation measures, and progress in achieving program objectives in order to enhance accountability. Grantees receive training on how to collect, evaluate, and improve their data collection and use it to improve their outcome results.

Impact of the SDPI Grant Programs

SDPI funding has enabled staff and programs at the local and national levels to increase access to diabetes treatment and prevention services throughout the Indian health system. The following table demonstrates substantial increases in access to many activities and services:

Diabetes treatment and prevention services available to AI/AN individuals	Access in 1997	Access in 2018	Absolute Percentage increase
Diabetes clinics	31%	76%	+45%
Diabetes clinical teams	30%	97%	+67%
Diabetes patient registries	34%	98%	+64%
Nutrition services for adults	39%	94%	+55%

[3] *Available at* https://www.ihs.gov/sdpi/sdpi-community-directed/diabetes-best-practices/

Diabetes treatment and prevention services available to AI/AN individuals	Access in 1997	Access in 2018	Absolute Percentage increase
Access to registered dieticians	37%	86%	+49%
Culturally tailored diabetes education programs	36%	98%	+59%
Access to physical activity specialists	8%	86%	+78%
Adult weight management programs	19%	82%	+63%

Clinical Diabetes Outcomes during SDPI

At the same time that access to these diabetes services increased, key outcome measures for AI/ANs with diabetes showed improvement or maintenance at or near national targets. These results have been sustained throughout the inception of SDPI. Examples include:

- *Improving Blood Sugar Control*
  Blood sugar control among AI/ANs with diabetes served by the IHS has improved over time. The average blood sugar level (as measured by the A1C test) decreased from 9.0 percent in 1996 to 8.1 percent in 2019, nearing the A1C goal for most patients of less than 8 percent.
- *Improving Blood Lipid Levels*
  Average LDL cholesterol (i.e., "bad" cholesterol) declined from 118 mg/dL in 1998 to 90 mg/dL in 2019, surpassing the goal of less than 100 mg/dL.
- *Reducing Kidney Failure*
  The rate of new cases of kidney failure due to diabetes leading to dialysis declined by more than half (54 percent) in AI/AN people from 1996 to 2013. This is a much larger decline than in any other racial group in the US.[4]

2. Diabetes Data and Program Delivery Infrastructure

The IHS has used funding from the SDPI to strengthen the diabetes data infrastructure of the Indian health system by improving diabetes surveillance and evaluation capabilities. The SDPI supports the development and implementation of the IHS Electronic Health Record, and the IHS Diabetes Management System in all 12 IHS Areas, which supports Objective 3.3 of the IHS Strategic Plan.

Facilities associated with SDPI programs participate in the annual IHS Diabetes Care and Outcomes Audit. The Diabetes Audit is the cornerstone of the IHS DDTP diabetes care surveillance system, tracking annual performance on diabetes care and health outcome measures. Data collection for the Diabetes Audit follows a standardized protocol to ensure statistical integrity and comparability of measures over time. The 2019 Diabetes Audit included a review of 127,474 patient charts at 329 I/T/U health facilities. The Diabetes Audit enables IHS and the SDPI programs to monitor and evaluate yearly performance at the local, regional, and national levels, as well as enhance quality improvement capabilities across AI/AN communities. These innovative efforts align with Objective 2.1 of the IHS Strategic Plan. DDTP provides Diabetes Audit training through online and webinar formats. DDTP receives evaluations on all trainings provided to guide improvements for future sessions.

[4] Bullock A, Burrows NR, Narva AS, et al. Vital Signs: Decrease in Incidence of Diabetes-Related End-Stage Renal Disease among American Indians/Alaska Natives — United States, 1996–2013. MMWR Morb Mortal Wkly Rep 2017;66:26-32. DOI: http://dx.doi.org/10.15585/mmwr.mm6601e1.

Key Performance/Accomplishments

Annual SDPI assessments have shown significant improvements in the availability of diabetes clinical care and community services provided over time when compared to the baseline SDPI assessment in 1997 (see table above titled "Diabetes treatment and prevention services available to AI/AN individuals").

Ongoing efforts to improve blood glucose, blood pressure, and cholesterol values will continue to reduce the risk for microvascular, as well as macrovascular complications (see "Outputs/Outcomes" table below).

Reporting

In addition to internal monitoring of the SDPI Grant Program, the DDTP has completed five SDPI Reports to Congress to document the progress made since 1997. The SDPI Reports to Congress are as follows:

- January 2000 Interim Report to Congress on SDPI;
- December 2004 Interim Report to Congress on SDPI;
- 2007 SDPI Report to Congress: On the Path To A Healthier Future;
- 2011 SDPI Report to Congress: Making Progress Toward A Healthier Future; and
- 2014 SDPI Report to Congress: Changing the Course of Diabetes: Turning Hope into Reality.

Following Tribal consultation, beginning in FY 2016, SDPI funding has been distributed as follows:

Special Diabetes Program for Indians – Total Yearly Costs

CATEGORY	Percentage of the total	(Dollars in Millions)
SDPI Grant Programs (272 Tribal and IHS grants, sub-grants, and technical assistance in FY 2017).	**86.8%**	**$130.2**
Administration of SDPI grants (includes program support funds to IHS Areas, Tribal Leaders Diabetes Committee, DDTP, Grants Management, evaluation support contracts, etc.)	**4%**	**6.1**
Urban Indian Health Program SDPI Grant Programs ($8.5M allocated to 29 grants and technical assistance in FY 2017)	**5.7%**	**8.5**
Funds to strengthen the Data Infrastructure of IHS	**3.5%**	**5.2**
TOTAL:	**100%**	**$150.0**

BUDGET REQUEST

The SDPI is currently authorized through May 22, 2020, under the Further Continuing Appropriations Act, 2020. The FY 2021 budget proposes to extend funding through FY 2021, at $150 million each year. The distribution of funding is shown in the grant tables that follow. Please note that the numbers provided for FY 2021 are likely to change due to the start of the new SDPI grant cycle.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2020 Target	FY 2021 Target	FY 2021 Target +/-FY 2020 Target
53 Controlled BP <140/90 (Outcome)	FY 2019: 57.2% Target: 52.3 % (Target Exceeded)	60.5 %	59.1%	-1.4%
54 Statin Therapy to Reduce Cardiovascular Disease Risk in Patients with Diabetes (Intermediate Outcome)	FY 2019: 47.4 % Target: 37.5 % (Target Exceeded)	51.6 %	49.0%	-2.6%
86 Reduce the proportion of American Indians/Alaska Natives with diagnosed diabetes who have poor glycemic control (A1c >9%). (Outcome)	FY 2019: 17.4% Target: Set Baseline	17.4%	16.8%	-0.6%

GRANTS AWARDS

The SDPI provides grants for diabetes treatment and prevention services to I/T/U health programs in 35 states. The SDPI grant programs provide local diabetes treatment and prevention services based on community needs.

(whole dollars)	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Number of Awards	301 (includes sub-grants)	301 (includes sub-grants)	301 (includes sub-grants)
Average Award	$450,579	$450,579	$450,579
Range of Awards	$19,394 - $7,553,570	$19,394 - $7,553,570	$19,394 - $7,553,570

FY 2021 State/Formula Grants

CFDA No. 92.237 / Special Diabetes Program for Indians Grant Programs by State and FY 2021 Annual Financial Assistance Awards					
State	State Name	FY 18 Total # Grant Programs	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
AK	Alaska	19	10,191,326	$10,191,326	$10,191,326
AL	Alabama	1	279,211	279,211	279,211
AZ	Arizona	28	28,913,564	28,915,564	28,915,564
CA	California	39	9,740,219	9,740,219	9,740,219

CFDA No. 92.237 / Special Diabetes Program for Indians Grant Programs by State and FY 2021 Annual Financial Assistance Awards					
State	State Name	FY 18 Total # Grant Programs	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
CO	Colorado	3	903,625	903,625	903,625
CT	Connecticut	2	232,777	232,777	232,777
FL	Florida	2	486,980	486,980	486,980
IA	Iowa	1	304,592	304,592	304,592
ID	Idaho	4	935,841	935,841	935,841
IL	Illinois	1	281,832	281,832	281,832
KS	Kansas	5	937,919	937,919	937,919
LA	Louisiana	4	364,530	364,530	364,530
MA	Massachusetts	2	168,316	168,316	168,316
ME	Maine	5	543,580	543,580	543,580
MI	Michigan	12	2,363,824	2,363,824	2,363,824
MN	Minnesota	8	3,274,552	3,274,552	3,274,552
MS	Mississippi	1	1,256,112	1,256,112	1,256,112
MT	Montana	10	5,564,865	5,564,865	5,564,865
NE	Nebraska	5	1,931,172	1,931,172	1,931,172
NV	Nevada	14	5,203,730	5,203,730	5,203,730
NM	New Mexico	28	12,615,849	12,613,849	12,613,849
NY	New York	3	1,264,077	1,264,077	1,264,077
NC	North Carolina	1	1,351,228	1,351,228	1,351,228
ND	North Dakota	5	3,168,173	3,168,173	3,168,173
OK	Oklahoma	27	23,460,585	23,460,585	23,460,585
OR	Oregon	9	1,832,727	1,832,727	1,832,727
RI	Rhode Island	1	113,475	113,475	113,475
SC	South Carolina	1	163,399	163,399	163,399
SD	South Dakota	9	6,014,743	6,014,743	6,014,743
TN	Tennessee	1	130,001	130,001	130,001
TX	Texas	4	784,901	784,901	784,901
UT	Utah	5	2,051,292	2,051,292	2,051,292
WA	Washington	27	4,792,337	4,792,337	4,792,337
WI	Wisconsin	12	3,421,213	3,421,213	3,421,213
WY	Wyoming	2	1,032,196	1,032,196	1,032,196
	Total States	**301**	**$136,074,763**	**$136,074,763**	**$136,074,763**
	Indian Tribes*	**254**	**$114,124,998**	**$114,196,150**	**$114,196,150**

*This is the number of tribes that are primary grantees or sub-grantees.

THIS PAGE INTENTIONALLY LEFT BLANK

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2021 Performance Budget Submission to Congress

TABLE OF CONTENTS

Drug Budget

THIS PAGE INTENTIONALLY LEFT BLANK

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Drug Control Budget
FY 2021

	Budget Authority (in Millions)		
	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Drug Resources by Function			
Prevention	25.147	25.812	25.227
Treatment	92.300	92.721	92.780
Total Drug Resources by Function	$117.447	$118.533	$118.007
Drug Resources by Decision Unit			
Alcohol and Substance Abuse	113.806	114.892	114.366
Urban Indian Health Program	3.641	3.641	3.641
Total Drug Resources by Decision Unit	$117.447	$118.533	$118.007
Drug Resources Personnel Summary			
Total FTEs (direct only)	171	171	171
Drug Resources as a Percent of Budget			
Agency Budget	$ 7,103.444	$ 7,354.627	$ 7,660.674
Drug Resources Percentage	1.65%	1.61%	1.54%

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 that partially come from the National Institute on Alcohol Abuse and Alcoholism programs transferred to the IHS under the UIHP budget.

BUDGET SUMMARY

In FY 2021, IHS requests $118.0 million for its drug control activities. This is a decrease of $526,000 below the FY 2020 Enacted level.

Alcohol and Substance Abuse
FY 2021 Request: $114.4 million

In FY 2021, the IHS budget request for its drug control activities supports ONDCP funding priorities as well as the *Strategy*. The *Strategy* emphasizes the partnership between Federal agencies and their state, local, tribal, and international counterparts and reduce drug-induced mortality. IHS is also working with Federal partners to implement ONDCP's efforts to address the current opioid crisis and reduce the number of American's dying from dangerous drugs.

The Administration's Office of National Drug Control *Strategy* guides and expands Federal government efforts to reduce the size of the drug-using population through 1) prevention and education, 2) increasing access to treatment services for those suffering from substance use disorder and 3) reducing the availability of dangerous drugs. The Administration's *Strategy* offers a valuable opportunity for IHS to advance its mission by strengthening existing programs to control and reduce substance use and eliminate its deleterious effects on the health and safety of AI/AN patients and communities.

In FY 2021, IHS will continue to serve AI/ANs impacted by substance use disorders and dependence through IHS, Tribal, and Urban Indian operated substance use disorder treatment and prevention programs and Youth Regional Treatment Centers (YRTCs). In addition to direct services, the IHS Alcohol and Substance Abuse grant and federal award program supports the IHS Strategic Plan *Goal 2, Objective 2.2 to provide care to better meet the health care needs of AI/AN communities and Goal 1 to ensure comprehensive, culturally appropriate services in the prevention, treatment and recovery of alcohol and substance use disorders.*

The IHS Division of Behavioral administers community-based grants that promote the use and development of evidence-based and practice-based models that represent culturally-appropriate prevention and treatment approaches to substance use from a community-driven context. In particular, the IHS Opioid Grant Program and the Substance Abuse and Suicide Prevention program (SASP) will support the IHS Strategic Plan Goal 1, *Objective 1.2 to build, strengthen, and sustain collaborative relationships and Objective 1.3 to increase access to quality health care services*.

IHS Opioid Grant Program: In FY 2019, IHS received $10 Million in fiscal year (FY) 2019 funding under the Special Behavioral Health Pilot Program (SBHPP) for American Indians and Alaska Natives to be targeted at opioid specific activities. In FY 2019, IHS held Tribal Consultation and Urban Confer to support the development of a grant program that will promote the documentation, and sharing of locally-designed, culturally-appropriate prevention, treatment, recovery, and aftercare services for mental health and substance use disorders in American Indian

and Alaska Native communities. A funding opportunity for the SBHPP will be released in FY2020.

IHS Substance Abuse and Suicide Prevention (SASP): The SASP is a nationally-coordinated grant program, focuses on providing targeted substance abuse and suicide prevention and intervention resources to AI/AN communities with the greatest need for these programs. There is mutual development and implementation of the SASP, formerly known as the Methamphetamine and Suicide Prevention Initiative, with Tribes, Tribal programs, and other Federal agencies which now provides support to 175 IHS, Tribal, and Urban Indian health programs nationally. This initiative promotes the use and development of evidence-based programs (EBP) and practice-based models that represent culturally-appropriate prevention and treatment approaches to methamphetamine abuse and suicide prevention from a community-driven context. Data from FY 2017-2018 indicate that 93 percent of grantees reported use of an EBP, and 86 percent of grantees have integrated cultural services into project activities over 16,500 community members have been trained in suicide and substance use prevention.

IHS awarded 108 projects to Tribes, Tribal organizations, Urban Indian Organizations, and federal facilities under the MSPI (GenI Initiative) to promote early intervention strategies and implement positive youth programming aimed at reducing risk factors for suicidal behavior and substance abuse. Funded projects work with Native youth, up to and including age 24, on increasing access to prevention activities for youth to prevent methamphetamine use and other substance use disorders that contribute to suicidal behaviors, in culturally appropriate ways. All projects funded have a training objective to increase and expand the types of healthcare providers trained in SUD screening, assessment or treatment including Brief Intervention and Motivational Interviewing and to hire additional behavioral health staff (i.e., licensed behavioral health providers and paraprofessionals, including but not limited to peer specialists, mental health technicians, and community health aides) specializing in child, adolescent, and family services who will be responsible for implementing project activities that address all of the required objectives listed.

The IHS Youth Regional Treatment Centers (YRTCs) provide residential substance abuse and mental health treatment services to AI/AN youth. Congress authorized the establishment of these YRTCs in each of the 12 IHS Areas, with two (northern and southern) specifically authorized for the California Area. The YRTC in Northern California is expected to be operational in early 2020. The 12 currently funded YRTCs provide quality holistic behavioral health care for AI/AN adolescents that integrate traditional healing, spiritual values and cultural identification. In FY 2019 all federal YRTCs in operation 18 months or longer increased have achieved accreditation status.

Two YRTC facilities, Desert Sage and the Healing Lodge of the 7 Nations are in the last year of an after pilot project that focuses continued support for youth upon completion of program. This Aftercare pilot had an emphasis on developing culture-based treatment and aftercare services pilot programs within that prevent alcohol and substance abuse relapse among youth discharged. While evaluations are in place, current data indicates that these programs have resulted in improved coordination around aftercare and case management, increased training of community supports for the adolescents, improved identification of transitional living, increased awareness of the use of social media, and improved follow-up with data collection after discharge. This pilot program will continue to support YRTC's ability to support the IHS Strategic Plan *Goal 1 to ensure comprehensive, culturally appropriate services in the prevention, treatment and recovery of alcohol and substance use disorders*.

The strategic goal is to support Tribal and Urban Indian programs in their continued substance use prevention, treatment, and infrastructure development. These efforts represent an innovative partnership with IHS to deliver services developed by the communities themselves, with a national support network for ongoing program development and evaluation.

Substance use disorders continue to rank high on the concern list of Tribal partners. IHS believes that a shift in emphasis to earlier intervention is required to be successful in reducing the consequences of substance use disorders. IHS proposes focusing on early intervention with adolescents and young adults and preventing further progression by recognizing and responding to the source 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 UIOs at annual conferences, meetings, and webinars. Continuing medical education and Continuing Education Units are offered in these training opportunities provided to primary care providers.

Patients treated for substance use disorder often present with a need to address co-occurring mental disorders. The IHS Division of Behavioral Health currently funds 12 grantees through the Behavioral Health Integration Initiative, a nationally-coordinated grant program that provides funding to Tribes, Tribal organizations, Urban Indian Organizations and federal facilities to plan, develop, implement and evaluate behavioral health integration with primary care. The grantees have focused on increased screening and early detection of mental health diagnoses, such as depression, anxiety and Post-Traumatic Stress Disorder. As a result of the funding, grantees are reporting an increase in access to care and increased coordination of care among providers.

IHS encourages all healthcare providers to screen patients both at the time of consideration of use of chronic opioid therapy and periodically during active treatment. Screening surveys may be helpful to a clinician in determining the risk of aberrant drug behaviors and guiding the frequency of monitoring. Screening surveys could be incorporated into the triage/nurse screening process prior to seeing the clinician. Indian Health Service developed a Pain Management website: https://www.ihs.gov/painmanagement/substancescreening/

IHS continues to support the integration of substance use disorder treatment into primary care and emergency services through its activities to implement the *Strategy*. Integrating treatment services into outpatient primary care offers opportunities for healthcare providers to identify patients with substance use disorders, provide them with medical advice, help them understand the health risks and consequences, and refer patients with more severe substance use-related problems to treatment.[1] One integration activity is Screening, Brief Intervention, and Referral to Treatment (SBIRT), which is an early intervention and treatment service for people with substance use disorders and those at risk of developing these disorders.

IHS has increased efforts to implement the Screening, Brief Intervention, and Referral to Treatment (SBIRT) across IHS facilities as an evidence-based practice to identify patients with alcohol and/or substance related problems. In FY 2019 percent of AI/AN ages 9-75 screened using SBIRT was 8.9 percent and this target was achieved with a final result of 14.9 percent screened. IHS promotes the use of this tool by training providers in clinical and community settings. SBIRT is intended to meet the public health goal of reducing the harms and societal costs associated with risky use by reducing diseases, accidents, and injuries. SBIRT screens for all levels of substance use, not just dependency. As an additional resource, Indian Health Service

[1] ONDCP. Integrating Treatment into Healthcare. *Available at* http://www.whitehouse.gov/ondcp/integrating-treatment-and-healthcare.

developed an Alcohol and Substance Abuse Program webpage:
https://www.ihs.gov/asap/providers/sbirt/

The IHS established a multi-disciplinary workgroup to form the IHS National Committee on Heroin, Opioids, and Pain Efforts (HOPE). The HOPE Committee is comprised of a multidisciplinary membership to include clinical representation from family medicine, pharmacy, behavioral health, nursing, pediatrics, physical therapy, and injury prevention. The HOPE Committee work plan supports the HHS 5-Point Strategy to Combat the Opioid Crisis with a specific focus on 1) better pain management; 2) improving access to culturally relevant prevention, treatment, and recovery support services; 3) increasing availability and distribution of opioid overdose reversing drugs; and 4) improved public health data reporting and surveillance.

Reducing the Number of Drug Overdose Deaths:

The IHS has expanded access to harm reduction interventions that include increased access to the opioid overdose reversal medication, naloxone. Since 2015, the IHS has maintained an ongoing collaboration with the Bureau of Indian Affairs (BIA) to train and provide naloxone to BIA Law Enforcement Officers (LEO) for responding to opioid overdoses. These initial efforts have evolved into a robust harm reduction strategy that includes a combination of policy and workforce development efforts. In March 2018, the IHS implemented a policy in the Indian Health Manual (Chapter 35) entitled *Prescribing and Dispensing of Naloxone to First Responders* to require IHS Federal pharmacies to provide naloxone to Tribal law enforcement agencies and other trained first responders. The IHS has also created a naloxone toolkit for tribal communities that includes a culturally responsive training video and a digital story from two Law Enforcement Officers involved in a naloxone 'save'. This toolkit also contains a train the trainer curriculum and standardized forms to support first responder initiatives. In November 2019, the IHS developed and released a health education video that shared best and promising practices surrounding naloxone distribution and the way IHS and the Red Lake Nation are responding to the opioid crisis.

The IHS has further adapted the toolkit and strategy to equip community first responders and paraprofessionals with training on opioid overdose response and naloxone. These expanded collaborations with local law enforcement and community first responders resulted in an initial pilot community-health naloxone train-the-trainer program to include naloxone distribution. Ninety-six community-health workers completed training as naloxone trainers for their tribal communities in one week.

Increase Mandatory Prescriber Education and Continuing Training on Best Practices and Current Clinical Guidelines:

The IHS implemented the "Chronic Non-Cancer Pain Management Policy" to promote appropriate pain management as a primary prevention tool. In February 2018, IHS released a revised policy to include clinical practice guidelines contained in the 2016 *CDC Guideline for Prescribing Opioids for Chronic Pain*. This revised policy adopts the 2016 "CDC Guideline for Prescribing Opioids for Chronic Pain" and specifically requires IHS sites to establish and implement local chronic non-cancer pain protocols and procedures; requires prescribers to complete training on appropriate and effective use of controlled substance medications; and establishes the requirement to initiate opioid treatment as a shared decision between the prescriber and the patient to respect and support the patient's right to optimal pain assessment and management.

In August 2018, the IHS released its "Dental Acute Pain Management Guideline" for prescribing opioids for acute pain secondary to common general dentistry conditions and procedures. Guideline implementation, prescriber training, and evaluation are ongoing.

The IHS has also implemented IHM Chapter 32 "State Prescription Drug Monitoring Programs" that establishes policy requirement for Federal facilities to participate with state-based Prescription Drug Monitoring Programs (PDMP). Controlled substance prescribers working in IHS federal-government-operated facilities must query state Prescription Drug Monitoring Program databases prior to prescribing opioids for pain treatment longer than seven days and periodically throughout chronic pain treatment. To reduce barriers to nation-wide PDMP implementation and integration and data sharing efforts to improve interoperability of systems In FY 2019 IHS has developed and released software programming to automate controlled substance dispensing reports to state-based PDMPs to near real-time reporting to improve the fidelity of IHS dispensing data in state PDMP databases. The IHS has been in preliminary planning and design discussions to evaluate feasibility of PDMP interoperability into the IHS Electronic Health Record. These efforts supporting the IHS Strategic Plan *Goal 3, Objective 3.3 Modernize information technology and information systems to support data driven decisions.*

In March 2019, the IHS released the *Recommendations to the Indian Health Service on American Indian/Alaska Native Pregnant Women and Women of Childbearing Age with Opioid Use Disorder* developed in collaboration with the American College of Obstetricians and Gynecologists' (ACOG) Committee on American Indian and Alaska Native Women's Health. This resource will help providers improve maternal participation in early prenatal care, improve screening for substance use disorder, and increase access to MAT for pregnant women and women of child-bearing age. The goal of these clinical recommendations is to foster relationships and improve awareness surrounding trauma-informed approaches to maternal opioid use that may lead to recovery, hope, and healing. Additionally, the IHS and the American Academy of Pediatrics Committee on Native American Child Health (CONACH) recently released the *Recommendations to the Indian Health Service on Neonatal Opioid Withdrawal Syndrome* that includes clinical recommendations on the prevention and management of neonatal opioid withdrawal syndrome. These recommendations provide standards of care for screening, diagnosing, support, and treatment of pregnant mothers and infants affected by prenatal opioid exposure

Proper Pain Management and Opioid Stewardship and Training:

The IHS has created and released a comprehensive Opioid Stewardship workbook to assist sites with creating best practices surrounding safe opioid prescribing and increasing access to integrative pain treatments. The workbook emphasizes utilizing opioid surveillance strategies to evaluate population health outcomes, target opioid interventions, enhance clinical decision support, and create professional practice evaluation strategies. The IHS opioid stewardship program evaluation considers metrics that evaluate trends in Morphine Milligram Equivalents versus a restricted focus on total opioid prescription fills.

The IHS has also created a robust workforce development strategy to include didactic training. In September 2019, the IHS launched its Pain Management and Opioid Use Disorder Continuing Medical Education webinar series. The IHS has hosted learning sessions in this series that include buprenorphine prescribing in pregnancy as well as an auricular acupuncture-training program. Additional sessions are scheduled in FY 2020. The IHS has also recently facilitated dedicated access to tele-consultation services for IHS clinicians to receive on-demand substance use expert recommendations and tailored clinical guidance for IHS healthcare providers of all

experience levels. This service is also available to assist IHS health systems with creating clinic policies and procedures to support creation of integrated MAT services in IHS facilities.

In May 2016, the IHS implemented a policy on mandatory opioid training requiring all federally controlled substance prescribers to complete the "IHS Essential Training on Pain and Addiction" with required refresher training every 3 years. This training is now available on demand with continuing medical education credits. The IHS released its Refresher training course in January 2018, including four sessions of its mandatory five-hour training course for providers on proper opioid prescribing. In FY 2019, 302 new clinicians completed this course. The mandate also includes an additional refresher training after three years. In FY 2019, 7251 clinicians completed the Essential Training on Pain and Addiction Refresher course.

In FY 2019, IHS provided three webinars that addressed pain management, opioids, and opioid misuse with a total of 108 attendees.

- Opioid Use and the Adolescent Brain
- Initiating Buprenorphine as Medication Assisted Treatment for Pregnant Women with Opioid Use Disorder
- Medication Assisted Treatment -MAT

In FY 2019 the IHS delivered live, instructor-lead, intensive pain management training course to include myofascial pain management techniques that includes half-and-half Drug Addiction Treatment Act (DATA) waiver training. This course were offered in multiple IHS Areas and a total of 35 clinicians attended these trainings. The IHS is committed to increasing general health system employee knowledge surrounding opioids and plans to create additional training modules in FY 2019 with content focused on non-prescribing clinicians on the fundamentals of pain management and safe opioid prescribing as well as training for community members on opioid safety initiatives.

The IHS has also created a robust workforce development strategy to include didactic training. In September 2019, the IHS launched its Pain Management and Opioid Use Disorder Continuing Medical Education webinar series. The IHS has hosted learning sessions in this series that include buprenorphine prescribing in pregnancy as well as an auricular acupuncture-training program. Additional sessions are scheduled in FY 2020. The IHS has also recently facilitated dedicated access to tele-consultation services for IHS clinicians to receive on-demand substance use expert recommendations and tailored clinical guidance for IHS healthcare providers of all experience levels. This service is also available to assist IHS health systems with creating clinic policies and procedures to support creation of integrated MAT services in IHS facilities.

To provide ongoing clinical support for providers, IHS, in partnership with the University of New Mexico Pain Center, provides a weekly Chronic Pain and Opioid Management ECHO (Extension for Community Healthcare Outcomes). ECHO is a case-based learning model in which consultation is offered through virtual clinics to primary care clinicians by an expert team to share knowledge and elevate the level of specialty care available to patients. In FY 2019, 178 IHS, tribal, and urban clinicians participated in ECHO. The ECHO continues in FY 2020.

In 2019, IHS hosted a webinar series for healthcare providers titled, Substance Use and the Adolescent Brain. The series provided educational lectures specifically related to understanding the impact of substances (Cannabis, Stimulants, Synthetic drugs, Inhalants, etc.) on the adolescent brain development and functioning. This series provided participants with psychosocial and evidence-based medication intervention strategies. The series included an overview of treatment

services and how to refer youth to the IHS and Tribal Youth Regional Treatment Centers, which address the ongoing issues of substance abuse and co-occurring disorders among American Indian and Alaska Native youth.

The IHS collaborated in FY 2018 with the CDC to participate in the CDC Opioid Quality Improvement Collaborative to implement five opioid quality improvement measures at four IHS sites. Communication to employees and stakeholders involving best and promising practices and resources addressing pain management and addiction is achieved through our expanded internet presence. The IHS released a combined website for opioids in FY 2018 located at www.ihs.gov/opioids.

Increasing Access to Medication Assisted Treatment (MAT) Services:

In June 2019, IHS released the Special General Memorandum *Assuring Access to MAT* that requires Federal Indian Health Service Facilities to create an action plan to identify or create local medication assisted treatment resources and coordinate patient access to these services when indicated. Key components of these approaches include enhanced screening and early identification of Opioid Use Disorders; improved care coordination and patient referral for treatment; and workforce development strategies to increase education and resources surrounding using medications in the support of recovery.

In FY 2018, buprenorphine and suboxone became part of the IHS Core Formulary. Buprenorphine and suboxone are common medications used to treat opioid use disorder. With these added to the Core Formulary, all IHS facilities with pharmacies have these medications readily available for their patients. Data related to buprenorphine and suboxone will be captured in reporting tools that will support regional-level efforts to better monitor MAT and SUD treatment across IHS.

The Indian Health Service does face challenges in providing MAT in certain sectors within Indian Country. The rural and frontier nature of where American Indians/Alaska Natives live creates barriers to accessing health facilities. This is especially evident in Alaska where patients often only have access to a community health aide serving within a village-based clinic, hours away by plane from a larger health center. Additionally, IHS has felt the impact of a declining supply of specific health professionals who could support the IHS workforce and address behavioral health needs. The IHS recognizes that telemedicine is one tool for increasing access to specialized medical services, such as MAT. The IHS has published a policy in the Indian Health Manual (Chapter 38) entitled Internet Eligible Controlled Substance Prescriber Designation to assure access to MAT using telemedicine models for remotely located Tribal members.

In May 2019, IHS hosted a webinar for healthcare providers on Medication Assisted Treatment, which provided participants with training on how to recognize the signs/symptoms of different types of substance use disorders, and pharmacotherapy options to treat substance use disorders.

IHS hosted the 2019 IHS National Combined Councils Meeting, an agency wide meeting which provides opportunities for multidisciplinary collaboration focusing on the clinical and administrative needs of the agency. This year continuing education trainings were provided for healthcare providers, and session topics included: 1) Addressing the Opioid Crisis in Indian Country, 2) Exploring Best Practices in Chronic Pain Management, and 3) Evaluating Options for Creating and Sustaining Integrated Primary Care Medication Assisted Treatment Models. IHS also provided a 4.25 hour training, titled “Prescriber Data Waiver Training.” This training session

assisted participants with meeting the SAMHSA and DEA requirements to apply for a DATA waiver to prescribe buprenorphine in the treatment of opioid use disorder.

Reducing Availability of Illicit and Dangerous Drugs:

The IHS supports the safe and effective disposal of unused pharmaceuticals at the enterprise level through the provision of reverse distributor services at Federal pharmacies for unopened expired controlled substances. The agency has participated in interagency efforts to support proper collection and disposal of pain medications.

I/T/U pharmacies have continued to enroll as DEA collectors and to participate in prescription drug disposal efforts. IHS collaborated with the State of North Dakota to achieve 100 percent of IHS sites in the state (both Federal and Tribal) to be registered as DEA collectors. In FY 2019, the IHS expanded patient level disposal through the addition of 29 Federal Pharmacy sites as registered DEA controlled substance collectors. This included funding for supplies and technical assistance with DEA requirements.

On the IHS pain management website, IHS provides resources for tribal and urban Indian communities on Take-Back Event, Permanent Collection Sites, Mail-Back Programs and Environmentally Safe Options from Home. The website also has two sessions focused on safe storage of medications and medication disposal for providers on proper opioid disposal. https://www.ihs.gov/painmanagement/disposal/patientdisposal/

Increase Prescription Drug Monitoring Program (PDMP) Interoperability and Usage:

The IHS is working to improve public health data surveillance and reporting and has developed a data reporting system that will provide prescribing and diagnosis data on national, regional, and local levels. This will enable IHS to track emerging trends, evaluate changes in prescribing practices, monitor overdose rates and emergency department utilization, and assess changes with access to MAT. The IHS will evaluate expanded partnerships and data-related resources with other Federal partners and Tribal Epidemiology Centers in FY 2019. These reporting and surveillance tools will strengthen IHS program management and operations by improving communication within the organization with Tribes, Urban Indian Organizations, and other stakeholders, and with the general public Strategic Plan Goal 3, Objective 1.1 *Improve communication within the organization, Tribes, Urban Indian Organizations, and other stakeholders, and with the general public*.

The availability of community health workers (specifically Behavioral Health Aides) serving in AI/AN can create a robust peer recovery training program to equip and support peer recovery services. The new Behavioral Health Aid positions under the Community Health Aid Program (CHAP) has the potential to fill this need. The program includes building capacity for both peer recovery specialists and community health workers.

Urban Indian Health Program – Alcohol and Substance Abuse Title V Grants
FY 2021 Request: $3.6 million

The 41 Urban Indian Organizations (UIOs) are an integral part of the Indian health care system and serve as resources to both tribal and urban communities. Urban Indians are often invisible in the urban setting and face unique challenges when accessing healthcare. A large proportion of Urban Indians live in or near poverty and face multiple barriers such as the lack of quality and culturally relevant health care services in cities. UIOs are an important support to Urban Indians

seeking to maintain their tribal values and cultures and serve as a safety net for our urban patients. UIOs that offer inpatient and outpatient substance use disorder treatment have become reliable referral sites for Tribes and Urban Indians. In FY 2021, IHS is proposing $3.6 million for the urban ONDCP budget.

AI/AN people who live in urban centers present a unique morbidity and mortality profile. Urban AI/AN populations suffer disproportionately higher mortality from certain causes in sharp contrast to mainstream society. These unique challenges require a targeted response. Existing UIOs see their efforts in health education, health promotion, and disease prevention as essential to impacting the behavioral contributors to poor health[2]:

- Alcohol-induced death rates are 2.8 times greater for urban AI/AN people than urban all races.
- Chronic liver disease death rates are 2.1 times greater for urban AI/AN people than urban all races.
- Accidents and external causes of death rates are 1.4 times greater for urban AI/AN people than urban all races.

Alcohol and drug-related deaths continue to plague urban AI/ANs. Alcohol-induced mortality rates for urban AI/ANs are markedly higher than for urban all races. All regions, with the exception of eastern seaboard cities in the Nashville Area, show dramatically higher rates for urban AI/ANs than for urban all races who live in the same communities: the Billings Area is 4 times greater, the Phoenix Area is 6 times greater, the Tucson Area is 6.7 times greater, and the Great Plains Area has a 13.4 times greater alcohol-induced rate of mortality.[3]

Urban AI/AN populations are more likely to engage in health risk behaviors. Urban AI/ANs are more likely to report heavy or binge drinking than all-race populations and urban AI/ANs are 1.7 times more likely to smoke cigarettes. Urban AI/ANs more often view themselves in poor or only fair health status, with 22.6 percent reporting fair/poor health as compared to 14.7 percent of all races reporting as fair/poor.

Fetal alcohol spectrum disorders is a term used to describe a range of effects that can occur in someone whose mother consumed alcohol during pregnancy. Fetal alcohol spectrum disorders include disorders such as fetal alcohol syndrome, alcohol-related neuro developmental disorder, and alcohol-related birth defects. Interventions are needed in urban centers to address prevention efforts for urban AI/ANs with fetal alcohol spectrum disorders. The IHS policy on conferring with UIOs identifies fetal alcohol spectrum disorders as a provision that requires the IHS to confer with UIOs “to develop and implement culturally sensitive assessment and diagnostic tools including dysmorphology clinics and multidisciplinary fetal alcohol spectrum disorders clinics for use in Indian communities and urban centers." Heavy drinking during pregnancy can cause significant birth defects, including fetal alcohol syndrome. Fetal alcohol syndrome is the leading and most preventable cause of intellectual disability. The rates of fetal alcohol syndrome 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 fetal alcohol syndrome.

[2] Indian Health Service, Report to Congress: New Needs Assessment of the Urban Indian Health Program and the Communities it Services at 10 (Mar. 31, 2016) (hereinafter New Needs Assessment), available at https://www.ihs.gov/urban/includes/themes/newihstheme/display_objects/documents/ReportToCongressUrbanNeedsAssessment.pdf.
[3] Ibid.

The UIOs emphasize integrating behavioral health, health education, health promotion and disease prevention into primary care offered within a culturally appropriate framework, which leads to positive outcomes for urban AI/ANs. Urban AI/ANs in need of substance use disorder treatment commonly exhibit co-occurring disorders. UIOs have recognized the need for more mental health and substance use disorder counselors to adequately address the needs presented by AI/ANs with co-occurring disorders. Stakeholders reported the need for more age and gender-appropriate resources for substance use disorder outpatient and residential treatment. While male AI/ANs can encounter wait times for treatment admission up to six months, treatment options for youth, women, and women with children can be greater than six months. Some of the most successful AI/AN treatment programs for youth, women, and women with children are administered by UIOs. Affecting lifestyle changes among urban AI/AN families requires a culturally sensitive approach. UIOs have operated culturally appropriate initiatives to reduce health risk factors. The continued efforts of UIOs to target behavioral or lifestyle changes offer the best hope for impacting the major health challenges of the urban AI/AN population.

The IHS has contracts and grants with 41 UIOs to provide health care and referral services for Urban Indians in 22 states. These IHS contracts and grants with UIOs address the *IHS Strategic Plan Goal 1 by ensuring that comprehensive, culturally appropriate personal and public health services are available and accessible to AI/AN people. Awarding of these contracts and grants to UIOs also addresses HHS Strategic Plan Goal 2, Objective 2.3, to reduce the impact of mental and substance use disorders through prevention, early intervention, treatment, and recovery support*. UIOs provide high quality, culturally relevant prevention, early intervention, outpatient and residential substance abuse treatment services, and recovery support to address the unmet needs of the Urban Indian communities they serve. Social determinants of health play a key role in health and wellness and UIOs are addressing a range of factors which contribute to improved health outcomes.

According to the most recent urban Indian data, more than 75,000 AI/AN patients access services through UIO programs. Also, UIOs perform more than 650,000 visits for AI/AN patients including medical, dental, behavioral health, other professional and enabling services directly or by paid referral. Data also indicates that members from 540 of the 574 (94 percent) federally recognized tribes accessed services from at least one of the 41 UIOs.

In FY 2019, the IHS Office of Urban Indian Health Programs awarded 4-in-1 grants to 33 UIOs. The grantees are awarded for a three-year funding cycle from April 1, 2019 - March 31, 2022. These grants provide funding to UIOs to make health care services more accessible for AI/ANs residing in urban areas. Funding is used to support four health program areas: health promotion and disease prevention services; immunization services; alcohol and substance abuse related services; and mental health services. Grantees are required to participate in a national evaluation of the 4-in-1 grant program, which addresses *IHS Strategic Plan Goal 2 to promote excellence and quality through innovation of the Indian health system into an optimally performing organization*. The national evaluation includes reporting on the cultural interventions integrated into the 4-in-1 program activities, and practice based and evidence based approaches that are implemented or modified to meet the needs of the Urban Indian service population. *These grants expand safe, high quality healthcare options, and encourage innovation and competition, which meets HHS Strategic Plan Goal 1, Objective 1.2.*

PERFORMANCE

Information regarding the performance of the drug control efforts of IHS are based on agency GPRA/GPRAMA documents and other information that measure the agency's contribution to the *Strategy*.

In FY 2021, the IHS will track the number of unique patients receiving office-based MAT (buprenorphine and naltrexone) within the Indian Healthcare System. The IHS will continue to track the number of naloxone prescriptions as part of efforts to increase access to naloxone.

The table and accompanying text below represent highlights of IHS achievements during FY 2018, the latest year for which data are available. The selected performance measures reported in the table provide targets and results from both Tribally Operated Health Programs and Federally Administered Health Programs.

Indian Health Service		
Selected Measures of Performance	**FY 2019 Target**	**FY 2019 Achieved**
» Universal alcohol screening	37%	40.7%
» Accreditation rate for Youth Regional Treatment Centers in operation 18 months or more	100%	100%
» Report on number of emergency department patients who receive SUD intervention	38,262	46,272
» Report on number of SUD services in primary care clinics	133,210	142,040

To provide more comprehensive routine screening, IHS retired the alcohol screening measure for female patients and expanded the new alcohol screening measure to include all patients 9 through 75 years of age. The FY 2019 universal alcohol screening target of 37 percent was met with final results achieving 40.7 percent screened.

The accreditation measure for YRTCs reflects an evaluation of the quality of care associated with accreditation status by either The Joint Commission, the Commission on Accreditation of Rehabilitation Facilities (CARF), state certification, or regional Tribal health authority certification. For youth with substance use disorders, the YRTCs provide invaluable treatment services. In FY 2019, all YRTCs in operation 18 months or longer achieved accreditation status.

The IHS monitors two program measures on the number of substance use disorder (SUD) encounters provided in emergency departments and primary care clinics. The final results for the FY 2019 number of SUD encounters provided in emergency department was 46,272 while SUD encounters provided in primary care clinics totaled 142,040. In addition, starting in FY 2017, IHS tracked overall substance use disorder encounters provided in all clinical settings across the health system to aid in promoting integrated substance use disorder services. The final results for FY 2019 SUD intervention services provided across all IHS clinics was 657,402 encounters.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2021 Performance Budget Submission to Congress

TABLE OF CONTENTS

Supplemental Tables

THIS PAGE INTENTIONALLY LEFT BLANK

FY 2021 BUDGET SUBMISSION
INDIAN HEALTH SERVICE
OBJECT CLASSIFICATION
(Dollars in Thousands)

Object Class	FY 2019 Final 1/	FY 2020 Enacted	FY 2021 Pres. Budget	FY 2021 +/- FY 2020
DIRECT OBLIGATIONS				
Personnel Compensation:				
Full-Time Permanent(11.0).....	459,706	477,346	494,655	17,309
Other than Full-Time Permanent(11.3).....	18,962	19,619	19,002	(617)
Other Personnel Comp.(11.5).....	67,866	68,668	70,006	1,338
Military Personnel Comp (11.7).....	75,850	77,497	79,007	1,510
Special Personal Services Payments (11.8).....	384	385	389	4
Subtotal, Personnel Compensation.....	622,768	643,515	663,059	19,544
Civilian Personnel Benefits(12.1).....	181,641	188,346	192,017	3,671
Military Personnel Benefits (12.2)	35,929	36,296	37,003	707
Benefits to Former Personnel(13.0).....	998	981	1,000	19
Subtotal, Pay Costs.....	**841,336**	**869,138**	**893,079**	**23,941**
Travel(21.0).....	28,943	29,429	35,003	5,574
Transportation of Things(22.0).....	6,986	6,867	7,001	134
Rental Payments to GSA(23.1).....	13,972	13,734	14,001	267
Rental Payments to Others(23.2).....	998	981	1,000	19
Communications, Utilities and				
Miscellaneous Charges(23.3.....	14,762	14,506	14,789	283
Printing and Reproduction(24.0).....	208	209	212	3
Other Contractual Services:				
Advisory and Assistance Services(25.1).....	5,988	5,886	6,001	115
Other Services(25.2).....	590,831	637,630	714,064	76,434
Purchases from Govt. Accts.(25.3).....	912,196	114,773	116,010	1,237
Operation and Maintenance of Facilities(25.4)....	4,990	4,905	5,000	95
Research and Development Contracts(25.5).....	0	0	0	0
Medical Care(25.6).....	389,230	393,368	406,036	12,668
Operation and Maintenance of Equipment(25.7)..	9,980	9,810	10,001	191
Subsistence and Support of Persons(25.8).....	6,986	6,867	7,001	134
Subtotal, Other Contractual Current.....	**1,920,201**	**1,173,239**	**1,264,113**	**90,874**
Supplies and Materials(26.0).....	111,779	112,811	134,012	21,201
Equipment (31.0).....	9,980	9,810	48,004	38,194
Land & Structures (32.0).....	109,783	125,564	60,005	(65,559)
Investments & Loans (33.0).....	0	2	2	0
Grants, Subsidies, & Contributions (41.0).....	2,872,229	3,853,151	3,888,253	35,102
Insurance Claims & Indemnities (42.0).....	22,955	22,562	23,002	440
Interest & Dividends (43.0).....	91	91	92	1
Subtotal Non-Pay Costs.....	**5,112,887**	**5,362,956**	**5,489,489**	**126,533**
Total, Direct Obligations.....	**5,954,223**	**6,232,094**	**6,382,568**	**150,474**

Salary and Expenses INDIAN HEALTH SERVICE (Budget Authority in Thousands)			
Object Class	FY 2019 Final 2/ Level	FY 2020 Enacted Level	FY 2021 President's Budget
Personnel compensation:			
Full-time permanent (11.1)	$459,706	$477,346	$494,655
Other than full-time permanent (11.3)	$18,962	$19,619	$19,002
Other personnel compensation (11.5)	$67,866	$68,668	$70,006
Military personnel (11.7)	$75,850	$77,497	$79,007
Special personnel services payments (11.8)	$384	$385	$389
Subtotal personnel compensation	$622,768	$643,515	$663,059
Civilian benefits (12.1)	$181,641	$188,346	$192,017
Military benefits (12.2)	$35,929	$36,296	$37,003
Benefits to former personnel (13.0)	$998	$981	$1,000
Subtotal Pay Costs	$841,336	$869,138	$893,079
Travel (21.0)	$28,943	$29,429	$35,003
Transportation of things (22.0)	$6,986	$6,867	$7,001
Communication, utilities, and misc. charges (23.3)	$14,762	$14,506	$14,789
Printing and reproduction (24.0)	$208	$209	$212
Other Contractual Services:			
Advisory and assistance services (25.1)	$5,988	$5,886	$6,001
Other services (25.2)	$590,831	$637,630	$714,064
Purchase of goods and services from government accounts (25.3)	$912,196	$114,773	$116,010
Operation and maintenance of facilities (25.4)	$4,990	$4,905	$5,000
Research and Development Contracts (25.5)	$0	$0	$0
Medical care (25.6)	$389,230	$393,368	$406,036
Operation and maintenance of equipment (25.7)	$9,980	$9,810	$10,001
Subsistence and support of persons (25.8)	$6,986	$6,867	$7,001
Subtotal Other Contractual Services	$1,920,201	$1,173,239	$1,264,113
Supplies and materials (26.0)	$111,779	$112,811	$134,012
Subtotal Non-Pay Costs	$2,082,879	$1,337,061	$1,455,130
Total Salary and Expenses			
Rental Payments to GSA(23.1)	$13,972	$13,734	$14,001
Rental Payments to Others(23.2)	$998	$981	$1,000
Grant Total, Salaries & Expenses and Rent	$2,939,185	$2,220,914	$2,363,210
Direct FTE 1/	8,925	8,925	8,968

1/ Reflects staff paid for only within Indian Health Services and Indian Health Facilities Accounts.

2/ Reflects Services account adjustments related to formal reprogramming notifications submitted to Congress in FY 2019. Amounts by "Sub IHS Activity" will continue to be adjusted during the period of availability, which concludes on Sept. 30, 2020, for impacted funds.

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

	FY 2019 Final	FY 2020 Enacted	FY 2021 PB
Headquarters 1/			
Sub-Total, Headquarters	447	447	484
Area Offices			
Alaska Area Office	360	360	360
Albuquerque Area Office	1,023	1,023	1,024
Bemidji Area Office	553	553	554
Billings Area Office	993	993	993
California Area Office	144	144	145
Great Plains Area Office	2,220	2,220	2,220
Nashville Area Office	201	201	201
Navajo Area Office	4,186	4,186	4,187
Oklahoma City Area Office	1,712	1,712	1,713
Phoenix Area Office	2,558	2,558	2,559
Portland Area Office	502	502	502
Tucson Area Office	319	319	319
Sub-Total, Area Offices	14,771	14,771	14,777
Direct and Reimburseable, including SDPI	15,218	15,218	15,260
Trust Funds (Gift)	21	21	21
TOTAL FTES	15,239	15,239	15,281

1/ 14 positions for Hepatitis C and for the Community Health Aide Program are initially scored as headquarters FTE, but this distribution will change as programs are developed and Area needs assessed.

INDIAN HEALTH SERVICE

DETAIL OF PERMANENT POSITIONS

(Dollars in Thousands)

	FY 2019 Final 1/	FY 2020 Enacted	FY 2021 Pres. Budget
Total - ES	14	14	14
Total - ES Salaries	$3,139	$3,139	$3,139
GS/GM-15	465	465	465
GS/GM-14	418	418	418
GS/GM-13	461	461	575
GS-12	1,129	1,129	1,129
GS-11	1,217	1,217	1,217
GS-10	649	649	649
GS-9	1,183	1,183	1,183
GS-8	502	502	502
GS-7	1,144	1,144	1,144
GS-6	1,518	1,518	1,518
GS-5	1,888	1,888	1,888
GS-4	910	910	910
GS-3	353	353	353
GS-2	311	311	311
GS-1	8	8	8
Subtotal	12,156	12,156	12,270
Total - GS Salaries	$666,249	$666,249	$679,400
Director Grade CO-06	385	385	385
Senior Grade CO-05	558	558	558
Full Grade CO-04	587	587	587
Senior Assistant Grade CO-03	290	290	290
Assistant Grade CO-02	29	29	29
Junior Grade CO-01	9	9	9
Subtotal	1,858	1,858	1,858
Total - CO Salaries	$119,536	$119,536	$125,723
Ungraded	1,271	1,271	1,271
Total - Ungraded Salaries	$50,148	$50,148	$52,667
Trust Funds (Gift)	23	23	23
Average ES level	ES-02	ES-02	ES-02
Average ES salary	$174	$174	$174
Average GS grade	5.1	5.1	5.1
Average GS salary	$55	$55	$55

FY 2021 Congressional Justification
Programs Proposed for Discontinuation

One program within the Indian Health Service budget has been proposed for elimination: Tribal Management Grants.

Tribal Management Grant Program: The FY 2020 Enacted amount for the Tribal Management Grant Program is $2,465,000, with the program discontinued in FY 2021. The Budget discontinues this program to prioritize funding for clinical services and staffing of new and replacement health care facilities to provide health care to AI/ANs. This program has played a role in IHS's approach to Native American health care.

Physicians' Comparability Allowance (PCA) Worksheet

1) Department and component:

HHS/Indian Health Service

2) Explain the recruitment and retention problem(s) justifying the need for the PCA pay authority.

(*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.)*

N/A – No PCA data to report

3-4) Please complete the table below with details of the PCA agreement for the following years:

	PY 2019 (Actual)	**CY 2020 (Estimates)**	**BY* 2021 (Estimates)**
3a) Number of Physicians Receiving PCAs	0	0	0
3b) Number of Physicians with One-Year PCA Agreements	0	0	0
3c) Number of Physicians with Multi-Year PCA Agreements	0	0	0
4a) Average Annual PCA Physician Pay (without PCA payment)	0	0	0
4b) Average Annual PCA Payment	0	0	0

*BY data will be approved during the BY Budget cycle. Please ensure each column is completed.

5) 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.)*

N/A

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

N/A

Modernization of the Public-Facing Digital Services
21st Century Integrated Digital Experience Act

On Dec. 20, 2018, President Trump signed the 21st Century Integrated Digital Experience Act (IDEA), which requires data-driven, user-centric website and digital services modernization, website consolidation, and website design consistency in all Executive Agencies. Departments across the federal landscape are beginning to implement innovative digital communications approaches to increase efficiency and create more effective relationships with their intended audiences. The American public expects instant and impactful communications – desired, trusted content available when they want it, where they want it, and in the format they want it. If the consumer is not satisfied they move on and our opportunity for impact is lost.

Modernization Efforts

In FY 2019 HHS engaged Department leadership and developed a Digital Communications Strategy that aligns with the requirements of IDEA. As the result of a comprehensive review of costs associated with website development, maintenance, and their measures of effectiveness, HHS will prioritize:

- modernization needs of websites, including providing unique digital communications services, and
- develop estimated costs for achieving performance metrics.

Over the next five years HHS will continue to implement IDEA by focusing extensively on a user-centric, Digital First approach to both external and internal communications and developing performance standards. HHS will focus on training, hiring, and tools that drive the communication culture change necessary to successfully implement IDEA.

Over the next year, HHS Agencies and Offices will work together to continue to implement IDEA and the HHS Digital Communications Strategy across all communications products and platforms.

INDIAN HEALTH SERVICE

Summary of Reimbursements, Assessments, and Purchases

FY 2020 Estimate

Agreement Type		FY 2018 Actuals	FY 2019 Actuals	FY 2020 Estimate
	Reimbursement for Services Purchased within HHS			
SSF-PSC	Service & Supply Fund (SSF) - Program Support Center (PSC)	10,268,860	10,572,000	10,686,000
SSF-NonPSC	Office Business Management Transformation (OBMT)	42,800	44,000	44,000
SSF-NonPSC	Offices of Human Resources (OHR) - e.g. Enterprise Services, Operations	6,111,514	6,795,000	6,933,000
SSF-NonPSC	Office of Chief Product Officer (OCPO) - OCIO	5,292,588	4,250,000	4,319,000
SSF-NonPSC	Office of Operations (OPS) - OCIO	3,695,716	2,600,000	2,640,000
SSF-NonPSC	Office of IT Strategy, Policy & Governance (OSPG) - OCIO	600,893	562,000	610,000
SSF-NonPSC	Office of Information Security (OIS) - OCIO	2,643,829	2,986,000	3,069,000
SSF-NonPSC	Equal Employment Opportunity Compliance & Operations (EEOCO)	613,623	421,000	421,000
SSF-NonPSC	Office Security & Strategic Information (OSSI)	4,109,435	0	0
	Subtotal SSF Non-PSC	23,110,398	17,658,000	18,036,000
SSF-NonASA	Acquisition Integration Modernization (AIM)	239,000	358,000	358,000
SSF-NonASA	Category Management	231,000	231,000	231,000
SSF-NonASA	Commissioned Corps Force Management (CCFM)	8,157,000	8,391,071	8,713,000
SSF-NonASA	Departmental Contract Information System (DCIS)	429,000	424,000	424,000
SSF-NonASA	Departmental Ethics Program - OGC (moved from Joint Funding Agreement)	431,000	447,000	456,000
SSF-NonASA	Web Media (Formerly Web Communications)	5,478,000	5,563,000	5,563,000
SSF-NonASA	Web Crawler	19,000	19,000	0
SSF-NonASA	Freedom of Information Act (Request and Appeal)	16,000	17,000	17,000
SSF-NonASA	Grants.gov System	48,000	37,000	37,000
SSF-NonASA	Grants Solutions Center of Excellence-Support & System Services	434,000	418,000	426,000
SSF-NonASA	HHS Broadcast Studio (moved from Joint Funding Agreement)	35,000	59,000	59,000
SSF-NonASA	Consolidated Acquisition System (HCAS) Operations & Maintenance (O&M)	2,610,000	3,243,000	2,797,000
SSF-NonASA	Media Monitoring & Analysis (moved from Joint Funding Agreement)	84,000	64,000	83,000
SSF-NonASA	Office of General Counsel (OGC) Claims	190,000	259,000	264,000
SSF-NonASA	Office of Program Audit Coordination (Formerly Audit Resolution)	602,000	667,000	662,000
SSF-NonASA	Small Business Center (Formerly Small Business Consolidation)	800,000	1,000,000	1,000,000
SSF-NonASA	Strategic Planning System	26,250	26,000	26,000
SSF-NonASA	Tracking Accountability Government Grants System (TAGGS)	304,000	262,000	271,000
SSF-NonASA	National Security Adjudications	175,000	37,000	45,000
SSF-NonASA	Unified Financial Management System (UFMS) O&M / Pass-Thru	8,269,000	8,910,000	9,198,000
SSF-NonASA	UFMS (Governance)	1,173,000	1,242,000	1,279,000
SSF-NonASA	UFMS (CFRS, FBIS/OBIEE)	2,135,000	2,467,000	2,295,000
	Subtotal SSF Non-Assistant Secretary Administration (ASA)	31,885,250	34,141,071	34,204,000
	Subtotal - Purchased within HHS through SSF	**65,264,508**	**62,371,071**	**62,926,000**
	Joint Funding Agreement (JFA) Assessments			
JFA	Chief Financial Officer (CFO) Financial Statement Audit	652,613	712,670	712,670
JFA	DATA Act	416,662	56,173	56,173
JFA	Interdepartmental Council on Native American Affairs	80,000	80,000	80,000
JFA	Office of Global Health Affairs	20,000	20,000	20,000
JFA	National Clinical Care Commission	22,800	90,000	90,000
JFA	Regional Health Administrators	308,010	308,000	308,000
	Subtotal - JFA Assessments	**1,500,085**	**1,266,843**	**1,266,843**
	Government-wide Administrative Functions (GAF)			
IAA	Federal Employment Services (USAJOBS)	101,792	103,249	103,249
IAA	Dept. of Homeland & Security (DHS) - HQ, Dallas & Seattle	156,927	158,827	158,827
IAA	General Services Administration (GSA) Fleet (Non-OPS)	10,039	9,075	9,075
IAA	GSA - HQ & Seattle FIT Loan	1,190,224	925,810	1,031,200
IAA	GSA - HQ, Dallas & Seattle Rent	4,878,539	4,904,563	4,904,563
IAA	HHS Federal Audit Clearinghouse (FAC)	2,936	2,956	2,956
IAA	National Archives & Records Admin (NARA)	12,000	10,000	10,000
IAA	National Institute of Health - Health Services Research Library	676,608	705,197	705,197
IAA	Office of General Counsel (OGC) - Legal Services	1,702,516	1,648,381	1,648,381
IAA	Office of Personnel Management (OPM) - Credit Monitoring	132,251	0	0
IAA	Office of Personnel Management (OPM) - Investigations	596,536	322,673	322,673
IAA	Radio Frequency Spectrum	152,940	169,111	169,111
IAA	Unified Communications (UC) Services	905,618	0	0
	Subtotal - GAF Interagency Agreements (IAA)	**10,518,926**	**8,959,842**	**9,065,232**
	Grand Total	77,283,519	72,597,756	73,258,075

FY 2021 Congressional Justification
"Good Accounting Obligation in Government Act (GAO-IG Act) Report."

The information below addresses the requirements of the Good Accounting Obligation in Government Act (GAO-IG Act; Public Law 115-414) to provide a report identifying each public recommendation issued by the Government Accountability Office (GAO) and federal Offices of Inspectors General (OIG) which remains unimplemented for one year or more from the annual budget justification submission date. The recommendations below apply specifically to this division of HHS. Please refer to the General Departmental Management budget justification for more information on the Department's overall progress in implementing GAO and OIG recommendations.

Appendix 1: OIG-GAO Open Recommendations							
Report Number	**Report Title**	**Report Date**	**Recommendation Text**	**Concur / Non-Concur**	**Implementation Timeline**	**Implementation Status**	**Implementation Updates and Constraints**
GAO-14-255	Native American Housing: Additional Actions Needed to Better Support Tribal Efforts	3/27/2014	To increase consistency and reduce time and predevelopment cost for NAHASDA grant recipients, an interagency effort similar to that of the federal infrastructure task force but specific to tribal housing should be initiated with participants from Indian Health Service, HUD, Department of the Interior, and the U.S. Department of Agriculture to develop and implement a coordinated environmental review process for all agencies overseeing tribal housing development. In addition, the agencies should determine if it would be appropriate to designate a lead agency in this effort.	Concur	NA	In Progress	In March 2018, GAO informed the Indian Health Service (IHS) that in order to close this recommendation the implementation plan must be finalized by the interagency workgroup. The implementation plan will require additional review by the full workgroup before the workgroup will be able to finalize the plan. The implementation plan is still in final draft, which is under review by the workgroup led by the Department of Housing and Urban Development (HUD). IHS provided additional feedback to HUD regarding the final draft implementation plan in July 2018. In June 2019, IHS contacted HUD the IHS Principal Deputy Director sent a letter to the HUD Deputy Assistant Secretary for Native American Programs requesting a status update on HUD actions to move the workgroup forward to finalize the plan. At this time, no additional meetings have been scheduled by the workgroup. IHS has raised the issue of Native American housing with the HHS Intradepartmental Council on Native American Affairs to make it a priority moving forward.
GAO-15-588	Buy Indian Act: Bureau of Indian Affairs and Indian Health Services Need Greater Insight into Implementation of Regional Offices	7/9/2015	To ensure consistent implementation of the Buy Indian Act procurement authority across the agencies and to enhance oversight of implementation of the Act at regional offices, the Secretaries of the Interior and Health and Human Services should direct the Bureau of Indian Affairs and Indian Health Service respectively, to clarify and codify their policies related to the priority for use of the Buy Indian Act, including whether the Buy Indian Act should be used before other set-aside programs.	Concur	NA	In Progress	The Indian Health Service is in the process of developing new policy guidance related to the Buy Indian Act. The draft rule is currently pending publication for comment in the Federal Register.

GAO-15-588	Buy Indian Act: Bureau of Indian Affairs and Indian Health Services Need Greater Insight into Implementation of Regional Offices	7/9/2015	To ensure consistent implementation of the Buy Indian Act procurement authority across the agencies and to enhance oversight of implementation of the Act at regional offices, the Secretaries of the Interior and Health and Human Services should direct the Bureau of Indian Affairs and Indian Health Service respectively, to collect data on regional offices' implementation of key requirements, such as challenges to self-certification.	Concur	NA	In Progress	Once the Indian Health Service (IHS) has promulgated its new Buy Indian policy, which is currently pending publication for comment in the Federal Register, the IHS will revisit how to collect data on regional/area offices' implementation of key policy requirements, including monitoring authentication of contractor credentials.
GAO-16-333	Indian Health Service: Actions Needed to Improve Oversight of Patient Wait Times	4/28/2016	The Secretary of HHS should direct the Director of IHS to monitor patient wait times in its federally operated facilities and ensure corrective actions are taken when standards are not met.	Concur	NA	In Progress	On June 12, 2019, the Indian Health Service (IHS) released a new wait time standard for Emergency Departments (ED) and updated the standard for primary care visits in IHS direct care facilities (IHS Circular No. 19-02 and No. 19-03). IHS is implementing systems to facilitate monitoring and oversight for both sets of standards. IHS anticipates requesting GAO close this recommendation as implemented by the end of 2019.
GAO-17-181	Indian Health Service: Actions Needed to Improve Oversight of Quality of Care	1/9/2017	To help ensure that quality care is provided to AI/AN people, as part of the implementation of its quality framework, the Secretary of HHS should direct the Director of IHS to ensure that agency-wide standards for the quality of care provided in its federally operated facilities are developed, that facility performance in meeting these standards is systematically monitored over time, and that enhancements are made to its adverse event reporting system.	Concur	NA	In Progress	In July 2019, the Indian Health Service (IHS) requested GAO close this recommendation as implemented. GAO provided feedback that once the new IHS adverse event reporting system is fully implemented across the agency they will be ready to close this recommendation. IHS anticipates full implementation by the end of March 2020.
GAO-18-309	Drinking Water and Wastewater Infrastructure: Opportunities Exist to Enhance Federal Agency Needs Assessment and Coordination on Tribal Projects	6/14/2018	The Director of IHS should implement a targeted, resource-efficient method to identify additional eligible Indian homes that may have existing deficiencies to include in IHS's Home Inventory Tracking System (HITS).	Concur	NA	In Progress	The Indian Health Service (IHS) Headquarters office of Sanitation Facilities Construction (SFC) Program issued a memo in August 2018 to IHS Area SFC Directors, directing them to leverage the annual sanitation needs data gathering and reporting period to work collaboratively with tribes to identify additional eligible Indian homes with deficiencies that can be included in HITS. IHS anticipates requesting GAO close this recommendation as implemented by the end of 2019.

GAO-18-309	Drinking Water and Wastewater Infrastructure: Opportunities Exist to Enhance Federal Agency Needs Assessment and Coordination on Tribal Projects	6/14/2018	The Director of IHS should implement a mechanism to indicate in HITS whether each home with a deficiency level of 0 has been assessed.	Concur	NA	In Progress	The Indian Health Service is implementing a new mechanism to indicate in HITS when a home currently classified with a deficiency level (DL) of 0 has been assessed. IHS anticipates requesting GAO close this recommendation as implemented by the end of 2019.
GAO-18-309	Drinking Water and Wastewater Infrastructure: Opportunities Exist to Enhance Federal Agency Needs Assessment and Coordination on Tribal Projects	6/14/2018	The Director of IHS should reassess the point distribution across the Sanitation Deficiency System scoring factors as part of its program guidelines update, in light of trade-offs between funding projects that address the most severe sanitation deficiencies and projects that meet other needs.	Concur	NA	In Progress	The Indian Health Service (IHS) invited tribes to provide comments on whether the priority ranking scoring system appropriately meets the needs of Tribal communities. IHS received comments from Tribes and Tribal organizations echoing GAO's recommendation to assess the scoring weights and consider revisions that provide more weight for projects that address high deficiency level needs. Based on these responses, the IHS Sanitations Facilities Construction Program implemented scoring changes in the updated Sanitation Deficiency System Guide released in September 2019. IHS anticipates requesting GAO close this recommendation as implemented by the end of 2019.
GAO-18-309	Drinking Water and Wastewater Infrastructure: Opportunities Exist to Enhance Federal Agency Needs Assessment and Coordination on Tribal Projects	6/14/2018	The Director of IHS, in cooperation with other members of the tribal infrastructure task force, should review the 2011 task force report and identify and implement additional actions to help increase the task force's collaboration at the national level.	Concur	NA	In Progress	In March 2019, the Indian Health Service shared with the Infrastructure Task Force (ITF), led by the Environmental Protection Agency (EPA), a table summarizing comments/actions taken in response to the 2011 task force report in addition to the remaining challenges associated with implementing the recommended actions. Further discussion and action with the ITF is needed.
GAO-18-309	Drinking Water and Wastewater Infrastructure: Opportunities Exist to Enhance Federal Agency Needs Assessment and Coordination on Tribal Projects	6/14/2018	The Director of IHS, in cooperation with other members of the tribal infrastructure task force, should direct IHS area offices to identify and pursue additional mechanisms to increase their collaboration.	Concur	NA	In Progress	The Indian Health Service (IHS) hosted on May 1, 2019, a joint face to face meeting with the Environmental Protection Agency (EPA) to discuss areas for increased collaboration. The meeting included representatives from the IHS Area Offices, EPA HQ and EPA Regions. During the meeting there was discussion on data sharing, best practices for identifying sanitation facilities projects for joint funding collaboration, and report outs on progress made with managing interagency agreement close outs. In May 2019, IHS requested GAO close this recommendation as implemented. GAO responded that IHS reported activities only satisfied a portion of the recommendation and that IHS needs to show increased collaboration with other ITF agencies

							as well.
GAO-18-580	Indian Health Service: Agency Faces Ongoing Challenges Filling Provider Vacancies	8/15/2018	The Director of IHS should obtain, on an agency-wide basis, information on temporary provider contractors, including their associated cost and number of full-time equivalents, and use this information to inform decisions about resource allocation and provider staffing.	Concur	NA	In Progress	Challenges in rolling-up contractor information on a national level stem from the fact that the Indian Health Service (IHS) often uses single contract vehicles, such as staffing companies, to hire multiple providers for temporary periods of time. IHS contract databases do not centrally track the numbers of individual providers through such staffing contracts. The ability to analyze and compare detailed actual costs of federal hires vs. contract hires is currently limited to local information sources and on a narrow area of focus, such as one provider category or one facility at a time. IHS is implementing a monthly reporting requirement to IHS Areas and plans to use this information to inform decisions about resource allocation and provider staffing.
A-07-15-04221	Expenses Incurred by the Rocky Boy Health Board Were Not Always Allowable or Adequately Supported	3/22/2016	We recommend that Rocky Boy refund to the Federal Government $37,259 in overpaid travel expenses for FYs 2011 and 2012.	Concur	2017	Awaiting Disposition	IHS believes this amount was paid back by the Health Board. IHS is confirming and will advise HHS.
A-07-16-05090	The Indian Health Service's Controls Were Not Effective in Ensuring That Its Purchase Card Program Complied With Federal Requirements and Its Own Policy	7/5/2018	We recommend that IHS strengthen controls to ensure that purchase cardholders comply with Federal requirements and IHS's own policy by ensuring that purchase card usage is adequately monitored for compliance with Federal requirements and IHS's own policy.	Concur	2020	In Progress	Progress report under development and will be provided to OIG by 12/31/2020.

A-07-16-05090	The Indian Health Service's Controls Were Not Effective in Ensuring That Its Purchase Card Program Complied With Federal Requirements and Its Own Policy	7/5/2018	We recommend that IHS strengthen controls to ensure that purchase cardholders comply with Federal requirements and IHS's own policy by ensuring that all IHS purchase cardholders complete the HHS-required training on the use of the purchase card to ensure compliance with Federal requirements and IHS's policy.	Concur	2020	In Progress	Progress report under development and will be provided to OIG by 12/31/2020.
A-07-16-05091	The Indian Health Service's Controls Were Not Effective in Ensuring That Its Travel Card Program Complied With Federal Requirements and Its Own Policy	4/12/2018	We recommend that IHS reemphasize the requirements for the use of the travel card to ensure that all travel cardholders are aware of the requirements	Concur	2020	In Progress	Progress report under development and will be provided to OIG by 12/31/2020.
A-07-16-05091	The Indian Health Service's Controls Were Not Effective in Ensuring That Its Travel Card Program Complied With Federal Requirements and Its Own Policy	4/12/2018	We recommend that IHS ensure that travel card usage is adequately monitored for compliance with the travel card requirements.	Concur	2020	In Progress	Progress report under development and will be provided to OIG by 12/31/2020.
A-07-17-03227	The Indian Health Service Did Not Always Resolve Audit Recommendations in Accordance With Federal Requirements	9/24/2018	We recommend that IHS promptly resolve the 513 outstanding audit recommendations that were past due as of September 30, 2016.	Concur	2020	In Progress	Progress report under development and will be provided to OIG by 12/31/2020.
A-07-17-03227	The Indian Health Service Did Not Always Resolve Audit Recommendations in Accordance With Federal Requirements	9/24/2018	We recommend that IHS update policies and procedures related to the Federal audit resolution process to include specifying the detailed steps to be taken to ensure that management decisions are issued within the required 6-month resolution period.	Concur	2020	In Progress	Progress report under development and will be provided to OIG by 12/31/2020.

A-07-17-03227	The Indian Health Service Did Not Always Resolve Audit Recommendations in Accordance With Federal Requirements	9/24/2018	We recommend that IHS follow its policies and procedures related to the non-Federal audit resolution process to ensure that management decisions are issued within the required 6-month resolution period.	Concur	2020	In Progress	Progress report under development and will be provided to OIG by 12/31/2020.
A-07-17-03227	The Indian Health Service Did Not Always Resolve Audit Recommendations in Accordance With Federal Requirements	9/24/2018	We recommend that IHS follow the quarterly reconciliation process that it implemented at the end of our audit period.	Concur	2020	In Progress	Progress report under development and will be provided to OIG by 12/31/2020.
A-07-17-03227	The Indian Health Service Did Not Always Resolve Audit Recommendations in Accordance With Federal Requirements	9/24/2018	We recommend that IHS give higher priority to audit resolution so that the audit resolution process is conducted in accordance with Federal requirements	Concur	2020	In Progress	Progress report under development and will be provided to OIG by 12/31/2020.
A-18-16-30540	Two Indian Health Service Hospitals Had System Security and Physical Controls for Prescription Drug and Opioid Dispensing but Could Still Improve Controls	11/28/2017	We recommend IHS deem a risk of the lack of continuity of operations to be unacceptable and take immediate action to assess all IHS facilities and ensure each facility has a tested and viable continuity of operations program to respond to and recover from a range of disasters.	Concur	2020	In Progress	Progress report under development and will be provided to OIG by 12/31/2020.
A-18-16-30540	Two Indian Health Service Hospitals Had System Security and Physical Controls for Prescription Drug and Opioid Dispensing but Could Still Improve Controls	11/28/2017	We recommend that IHS develop and implement logical access-control procedures to ensure compliance with the principle of least privilege and conduct periodic privilege-based access reviews to remove unnecessary access to RPMS.	Concur	2020	In Progress	Progress report under development and will be provided to OIG by 12/31/2020.

A-18-16-30540	Two Indian Health Service Hospitals Had System Security and Physical Controls for Prescription Drug and Opioid Dispensing but Could Still Improve Controls	11/28/2017	We recommend that IHS perform adequate information security risk assessments at all IHS hospitals in accordance with NIST 800-30.	Concur	2020	In Progress	Progress report under development and will be provided to OIG by 12/31/2020.
A-18-16-30540	Two Indian Health Service Hospitals Had System Security and Physical Controls for Prescription Drug and Opioid Dispensing but Could Still Improve Controls	11/28/2017	We recommend IHS identify all hospitals with unsupported networking equipment and implement a system development life cycle plan to ensure hardware and software replacement before EOL.	Concur	2020	In Progress	Progress report under development and will be provided to OIG by 12/31/2020.
A-18-16-30540	Two Indian Health Service Hospitals Had System Security and Physical Controls for Prescription Drug and Opioid Dispensing but Could Still Improve Controls	11/28/2017	We recommend that IHS determine if local IHS hospital system administrators are adequately trained to ensure compliance with all flaw remediation and vulnerability management procedures and, if not, develop and implement a training program.	Concur	2020	In Progress	Progress report under development and will be provided to OIG by 12/31/2020.
A-18-16-30540	Two Indian Health Service Hospitals Had System Security and Physical Controls for Prescription Drug and Opioid Dispensing but Could Still Improve Controls	11/28/2017	We recommend that IHS ensure that all vulnerabilities identified during vulnerability scanning are remediated in accordance with Federal requirements.	Concur	2020	In Progress	Progress report under development and will be provided to OIG by 12/31/2020.
OEI-06-14-00010	Indian Health Service Hospitals: More Monitoring Needed to Ensure Quality Care	10/6/2016	IHS should continue to seek new meaningful ways to monitor hospital quality through the use of outcomes and/or process measures	Concur	2020	In Progress	Implementation plan focused on establishment of the IHS Office of Quality. The reorganization establishing the OQ was effective January 2019. Implementation is underway.

OEI-06-14-00010	Indian Health Service Hospitals: More Monitoring Needed to Ensure Quality Care	10/6/2016	IHS should continue to invest in training for hospital administration and staff, and assess the value and effectiveness of training efforts	Concur	2020	In Progress	Implementation plan focused on establishment of the IHS Office of Quality. The reorganization establishing the OQ was effective January 2019. Implementation is underway.
OEI-06-14-00010	Indian Health Service Hospitals: More Monitoring Needed to Ensure Quality Care	10/6/2016	IHS should establish standards and expectations for how Area Offices/ Governing Boards oversee and monitor hospitals and monitor adherence to those standards	Concur	2020	In Progress	Implementation plan focused on establishment of the IHS Office of Quality. The reorganization establishing the OQ was effective January 2019. Implementation is underway.
OEI-06-14-00010	Indian Health Service Hospitals: More Monitoring Needed to Ensure Quality Care	10/6/2016	IHS should implement a quality-focused compliance program to support Federal requirements for health care programs	Concur	2020	In Progress	Implementation plan focused on establishment of the IHS Office of Quality. The reorganization establishing the OQ was effective January 2019. Implementation is underway.
OEI-06-14-00011	Indian Health Service Hospitals: Longstanding Challenges Warrant Focused Attention to Support Quality Care	10/6/2016	IHS should conduct a needs assessment culminating in an agency wide strategic plan with actionable initiatives and target dates	Concur	2020	In Progress	Implementation plan focused on establishment of the IHS Office of Quality. The reorganization establishing the OQ was effective January 2019. Implementation is underway.
OEI-06-14-00011	Indian Health Service Hospitals: Longstanding Challenges Warrant Focused Attention to Support Quality Care	10/6/2016	As part of OS' newly formed Executive Council, lead an examination of the quality of care delivered in IHS hospitals and use the findings to identify and implement innovative strategies to mitigate IHS's longstanding challenges	Concur	2019	Awaiting Disposition	HHS has submitted documentation requesting this recommendation be closed as implemented. The Executive Council is no longer active but the work of the Council has been institutionalized in the IHS Office of Quality effective January 2019. The IHS Office of Quality will provide leadership and promote consistency in health care quality across the agency by consolidating and enhancing oversight of these efforts at IHS headquarters working to mitigate historical IHS challenges. In addition, earlier this year the Department reinstituted the Intradepartmental Council on Native American Affairs (ICNAA), which had been dormant for almost a decade. The ICNAA is statutorily authorized by the Native American Programs Act of 1974 and serves as the internal body within the Department for coordination of health and human services issues, including developing and promoting Departmental policies to provide greater access to quality services for American Indians and Alaska Natives.

Appendix 2: OIG-GAO Closed, Unimplemented Recommendations					
Report Number	**Report Title**	**Report Date**	**Recommendation Text**	**Implementation Status**	**Reason for non-implementation**
GAO-12-446	INDIAN HEALTH SERVICE: Action Needed to Ensure Equitable Allocation of Resources for the Contract Health Service Program	6/15/2012	To make IHS's allocation of CHS program funds more equitable, the Secretary of Health and Human Services should direct the Director of the Indian Health Service to require IHS to use actual counts of CHS users, rather than all IHS users, in any formula for allocating CHS funds that relies on the number of active users.	Closed, Unimplemented	Non-concur, recommendation is no longer valid
GAO-12-446	INDIAN HEALTH SERVICE: Action Needed to Ensure Equitable Allocation of Resources for the Contract Health Service Program	6/15/2012	To make IHS's allocation of CHS program funds more equitable, the Secretary of Health and Human Services should direct the Director of the Indian Health Service to require IHS to use variations in levels of available hospital services, rather than just the existence of a qualifying hospital, in any formula for allocating CHS funds that contains a hospital access component.	Closed, Unimplemented	Non-concur, recommendation is no longer valid

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2021 Performance Budget Submission to Congress

TABLE OF CONTENTS

Significant Items in Committee Reports

THIS PAGE INTENTIONALLY LEFT BLANK

Advance Appropriations. - In 2018, the Government Accounting Office (GAO) identified considerations for Congress when considering whether to advance appropriate funds to IHS, including whether IHS has the processes in place to develop and manage an advance appropriation. The Committee directs IHS to examine its existing processes and determine what changes are needed to develop and manage an advance appropriation and report to the Committee within 180 days of enactment of this Act on the processes needed and whether additional Congressional authority is required in order to develop the processes. (p. 114).

Action taken or to be taken:

IHS is committed to working together and with Congress to examine its processes and procedures needed to ascertain the potential benefits and challenges of managing an advance appropriation.

Current Services.—The recommendation includes an increase of $81,333,000 for fixed cost increases, $20,830,000 above the budget request. The Committee directs IHS to submit the full estimated costs for current services based on the prior enacted level to the Committee each year at the same time IHS submits its annual budget justification. (p. 114).

Action taken or to be taken:

The FY 2021 Congressional funding request for Current Services is $42,440,000.

105(l) Leases. - The recommendation includes $53,000,000 for section 105(l) lease costs, $17,000,000 above the enacted level and $42,000,000 above the budget request. These funds are to supplement existing funds available for operational costs at Village Built Clinics and tribal clinics operated under an Indian Self-Determination and Education Assistance Act compact or contract where health care is delivered in space acquired through a full-service lease. The Committee directs IHS to consider whether costs associated with these leases should be a separate line item in the budget and funded in the same manner as contract support costs and report its determination to the Committee within 90 days of enactment of this Act. Additionally, the Committee directs IHS to submit the estimated amounts for the current fiscal year and the next fiscal year estimate at the same time the budget request is submitted. (p. 115).

Action taken or to be taken:

Funding for leases under the ISDEAA Section 105(l) program is proposed to be an indefinite discretionary appropriation and is moved from the Hospitals and Health Clinics line item to this new appropriation in the amount of $101,000,000.

Accreditation Emergencies. - The recommendation includes $58,000,000, as requested, to assist IHS-operated facilities that have been terminated or received notice of termination from the Centers for Medicare & Medicaid Services (CMS) Medicare program while under operation by the IHS. Funding shall be allocated to such facilities in amounts to: restore compliance; supplement purchased/referred care, including transportation, in the event of temporary closure of such facility or one or more of its

departments; and compensate for third-party collection shortfalls resulting from being out of compliance. Primary consideration should be given to facilities that have been without certification the longest. Shortfalls shall be calculated relative to the average of the collections in each of the two fiscal years preceding the year in which an agreement with CMS was terminated or put on notice of termination. Until all facilities have obtained CMS certification, the Committee rejects the proposal to allow these funds to be used for other purposes.

The Committee is concerned about financial losses from loss of CMS accreditation or of the requirement to divert patients at Service-operated facilities. The Committee considers the loss or imminent loss of accreditation to be an emergency. Funds allocated to a facility may be made available to Tribes newly assuming operation of such facilities pursuant to the Indian Self-Determination and Education Assistance Act of 1975 (P.L. 93–638) and shall be used by such Tribes to cover the following: replacement of third party revenues lost as a result of decertification, replacement of third-party carryover funds expended to respond to decertification, and reasonable costs of achieving recertification, including recruitment costs necessary to stabilize staffing.

Additionally, the Committee urges IHS to develop new strategies to improve how IHS programs, including those operated by Tribes under the Indian Self-Determination and Education Assistance Act of 1975 (P.L. 93–638), can be supported to avoid these challenges and to refocus on both the quality of health care delivery and the improvement in health outcomes for, and health status of, Indian health program beneficiaries. This requires full Tribal consultation and the participation of the Department of Health and Human Services, Center for Medicare and Medicaid Innovation, Centers for Medicare and Medicaid Services, and State Medicaid and S–CHIP programs. (p. 115-116).

Action taken or to be taken:

In 2016 the IHS established the Quality Framework to address Centers for Medicare and Medicaid Services CMS Hospital certification and accreditation failures in serval IHS hospitals. By FY2019 most of the elements of the Quality Framework were either implemented with work on optimization in progress. In FY 2019 IHS establish the IHS Strategic Plan which assumed the elements of the Quality Framework and focused IHS programs and activities on improving quality, safety, and sustained compliance across the IHS healthcare system. IHS established and filled the Deputy Director for Healthcare Quality position and established the Office of Quality (OQ) to guide the implementation of the IHS Strategic Plan and IHS priorities for healthcare quality and safety.

In FY 2019, IHS establish an education course to educate staff on quality improvement science and methods theory and application to increase quality improvement capacity across the IHS healthcare system. The OQ began implementing a Quality Assurance (QA) program to program consultation and training to IHS staff on CMS regulations and accreditation standards; implemented a credentialing and privileging software in all IHS healthcare facilities and are currently optimizing the system; and purchased a replacement Adverse Events Reporting software and successfully pilot tested the system in three IHS facilities with anticipated implementation for all IHS facilities in February 2020. The OQ worked in collaboration with the IHS Chief Medical Officer, the Office of Information Technology, and IHS Area Offices to establish primary and emergency department wait time measures. The result of this work, in FY 2018 and 2019, 41 surveys in IHS Hospitals and Health Centers have been conducted by CMS, the Joint Commission, (TJC) or the Association for Accreditation of Ambulatory Health Care (AAAHC). The surveys resulted in compliance with CMS CoP and ongoing certification or full accreditation by TJC or AAAHC. Additionally, 25 of IHS hospitals and Health Centers received designation by either TJC or AAAHC.

Electronic Health Records. - The recommendation includes $25,000,000, as requested, to improve the current IT infrastructure system in order to support the deployment of a new or modernized Electronic Health Records solution. The bill includes language prohibiting IHS from obligating or expending funds to select or implement a new IT infrastructure system unless IHS notifies the Committee at least 90 days before such funds are obligated or expended. The Committee expects IHS to include in the notification: (1) The criteria being used to select a new IT infrastructure system; (2) whether and how the new system will be interoperable with the Department of Veterans Affairs' (VA) new electronic health record system; and (3) the total projected cost for the modernization and the number of years required to implement the new system.

Additionally, the Committee urges IHS to review the VA's new electronic health record system and determine whether that system, in whole or in part, may be feasible for IHS and tribally operated facilities. IHS should also compare the cost of adopting the VA system, in whole or in part, to an entirely new system and report to the Committee within 90 days of enactment of this Act on any additional costs required to modify the VA system to IHS and tribal needs, as well as any cost savings that may occur by adopting the new VA system, in whole or in part. Finally, the Committee encourages IHS to work with other Federal agencies to find funding to upgrade network bandwidth at hospitals, health centers, and health stations. (p. 116-117).

Action taken or to be taken:

The final bill included $8 million to support the IHS modernization effort. IHS in the process of reworking the project plan and deliverables to adjust from $25 million over 12 months to $8 million over 8 months due to the change in final funding and length of the CR. Initial activities will include the creation a project governance body and a project management office to support the project. IHS does not plan to select a new system with the $8 million provided and does not anticipate notification until October 1, 2020, or upon a final 2021 budget enacted with additional funds to support the procurement process. The planning in 2020 will allow IHS to support the requested information in the notification. IHS will continue to document outreach to other federal agencies such as the VA, DOD, FCC, CMS, ONC, and OMB.

Electronic Dental Records.—The Committee applauds the Service for successfully installing an electronic dental record (EDR) system. The Committee understands that 240 dental centers have been brought into the system. With sufficient continued funding for maintenance and computer enhancements, the EDR could allow dentists and pharmacists to communicate directly about opioid prescriptions for oral pain. This will be a vital addition for addressing the opioid crisis in Indian Country. Within the amounts requested, the Committee includes $2,500,000 to enable the Service to complete the implementation process for 10 dental centers and manage the current electronic dental record system. The Committee also understands that the Service is currently evaluating the electronic health records system to examine the needs of the program. The Committee directs the Service to include EDR in its assessment and incorporate EDR in overall efforts to enhance the electronic health records system. (p. 117).

Action taken or to be taken:

Since 2008, the IHS has implemented the IHS version of the Dentrix Electronic Dental Record (EDR) system to more than 240 IHS dental clinics (Federal/Tribal/and Urban). After Tribal shares have been allocated from the $2.5M, the remaining funds would be directed towards implementing EDR at the 10 non-EDR equipped IHS dental clinics currently in the implementation queue. Any remaining funds would be used for planning / developing greater data / information exchange between the IHS [medical] Electronic Health Record (EHR) system and the EDR system. IHS is already planning for updating its overall Health Information Technology (HIT) platform and the existing IHS EDR system is actively

discussed and engaged in the current HIT update dialogue. Development of improved connectivity between the existing EDR, (RPMS-based) EHR system and the Health and Human Services (HHS) data repositories will be planned to ensure their functionality beyond the eventual IHS EHR HIT modernization development and implementation.

Indian Health Care Improvement Act. - It has been over nine years since the permanent reauthorization of the Indian Health Care Improvement Act (IHCIA), yet many of the provisions in the law remain unfunded. Tribes have specifically requested that priority areas for funding focus on diabetes treatment and prevention, behavioral health, and health professions. The Committee requests that the Service provide, no later than 90 days after enactment, a detailed plan with specific dollars identified to fully fund and implement the IHCIA. (p. 119).

Action taken or to be taken:

A comprehensive plan, including dollar amounts would require significantly more time than the 90 days allotted in the report.

Maternal and Child Health. - The Committee encourages IHS to establish a pilot program to determine the most effective ways to: (1) educate IHS health care providers on how to evaluate risk factors that could interfere with successfully meeting breastfeeding goals; (2) provide necessary support to AI/AN mothers to prevent or address delayed initiation of milk production during the critical period immediately following birth; and (3) provide support to AI/AN mothers to help them understand the benefits of long-term breastfeeding and improve clinically recommended rates, particularly when they return to work. The Committee also directs IHS, where possible and within scope of agency authority, to encourage breastfeeding support recommendations within the workplace which encourage job retention. (p. 119).

Action taken or to be taken:

The IHS participates in the Baby-Friendly Hospital Initiative to support breastfeeding. All IHS federal facilities that provide route obstetric delivery services have been designated Baby-Friendly, with re-designation occurring every 5 years. In 2019, five IHS federal facilities completed, or are in the process of, re-designation. Designation includes provision of staff education on risk factors that could interfere with breastfeeding as well as education and support to AI/AN mothers to prevent or address delayed initiation of milk production following birth, and to help them understand the benefits of long-term breastfeeding.

To educate and assist staff in supporting breastfeeding, the IHS offers a Breastfeeding Toolkit, *www.ihs.gov/healthed/resources/breastfeedingtoolkit*. IHS support for breastfeeding, including a link to this toolkit, was highlighted in August 2019 as part of National Breastfeeding Month. https://www.ihs.gov/newsroom/announcements/2019-announcements/august-is-national-breastfeeding-month/

In 2020, the IHS will begin development of a culturally appropriate educational handbook/app for AI/AN women to promote healthy pregnancies, which will include breastfeeding advice, tips, support and education.

The IHS has encouraged public health nurses (PHN) to obtain International Board of Lactation Consultant certifications and to provide lactation education and support during prenatal and post-partum public health nursing visits. This postpartum support can assist in improving breastfeeding rates, including when women return to work. The first PHN program to be 100 percent certified is expected in October 2020.

Since 2017 the IHS Lactation Support Program has supported American Indian and Alaska Native women, infants, children, and families by allowing women who choose to breastfeed to express or pump

breast milk at work for a period of one year after returning to work. *https://www.ihs.gov/ihm/pc/part-4/p4c7/*

Green Infrastructure. - The Committee includes $10,000,000 to incorporate planning, design, and operations of buildings to reduce costs, minimize environmental impacts, use renewable energy and incorporate green infrastructure and the most current energy efficiency codes and standards to the maximum extent practicable. The Committee directs IHS to submit a report to the Committee within 90 days of enactment of this Act explaining how it proposes to use the funds provided for green infrastructure and renewable energy. (p. 120).

Action taken or to be taken:

IHS intends to purchase and install renewable energy collection equipment (e.g. photo voltaic panels) at existing healthcare facilities. Facilities will be chosen at a later date based on engineering considerations.

Village Built Clinics. - The Committee has provided resources for village built clinics [VBCs] leasing costs and other associated leasing costs. The Committee is aware the Service has testified that these resources are being used not only to pay for the traditional VBCs but also for new costs relating to litigation which requires that section 105(*l*) of the Indian Self-Determination Act (Public 114 Law 93–638) mandates payment of leasing costs when Tribal facilities are used to operate IHS programs. The Committee has not included proposed language in this recommendation for the 105(l) costs but does believe these costs should be accounted for separately in the fiscal year 2021 budget request from those funded needed for village built clinics. (p. 113-114).

Action taken or to be taken:

Funding for leases under ISDEAA Section 105(l) is proposed to be an indefinite discretionary appropriation and is moved from the Hospitals and Health Clinics line item to this new appropriation.

Alcohol and Substance Abuse. - The recommendation includes $247,828,000 for alcohol and substance abuse programs, an increase of $2,262,000 above the enacted level. The bill also continues $10,000,000 for opioid abuse and is described below. The bill retains increases provided in previous fiscal years of $6,500,000 for the Generation Indigenous initiative; $1,800,000 for the youth pilot project; and $2,000,000 to fund essential detoxification related services as provided herein. The Committee has continued bill language which allocates $2,000,000 to continue funding for essential detoxification and related services provided by the Service's public and private partners to IHS beneficiaries and expects these funds to be allocated in a manner consistent with previous years. The Service is directed to report to the Committee within 60 days of enactment of this act regarding distribution of these funds. The Service shall continue its partnership with Na'Nizhoozhi Center in Gallup, N.M., and work with the Center and other Federal, State, local, and Tribal partners to develop a sustainable model for clinical capacity, as provided by the statement to accompany Public Law 115–31. (P .115).

The Committee is concerned that alcohol and opioid use disorders continue to be some of the most severe public health and safety problems facing American Indian and Alaska Native [AI/AN] individuals, families, and communities. To address this problem, the Committee continues to direct IHS to increase its support for culturally competent preventive, educational, and treatment services programs and partner with academic institutions with established AI/AN training and health professions programs to research and promote culturally responsive care. Additionally, the Committee encourages the Service to employ the full spectrum of medication assisted treatments [MAT] for alcohol and opioid use disorders, including non-narcotic treatment options that are less subject to diversion combined with counseling services. (P .115).

Action taken or to be taken:
In the 2017 Senate Appropriations Committee Report 114-281, the Committee directed IHS to "allocate $2,000,000 of the increase provided for the alcohol and substance abuse program to fund essential detoxification and related services." Specifically, in the report the number of alcohol related deaths in the community of Gallup, New Mexico was addressed with the report

stating, “these deaths underscore the urgent need for substance abuse treatment, residential services and detoxification services” in this community. In response, the IHS used the increased appropriated funds provided to address this urgent need in the city of Gallup, New Mexico. In addition to Gallup, New Mexico, IHS was aware of the urgent need for alcohol detoxification services in the Great Plains Area after the removal of liquor licenses in White Clay, Nebraska, leading to the potential for increased mortality if services were unavailable for alcohol detoxification. As a result, funds were also made available to address this urgent need. The funds provided to Gallup, New Mexico and the Great Plains Area (specifically the Oglala Sioux Tribe) to address the need for social detox services were made available in FY 2017 through a competitive cooperative agreement. The funding announcement was released in FY 2017 and two projects were selected and funded. The project period is for 5 years and will run from September 15, 2017, to September 14, 2022. In FY 2019, the Gallup site has been able to support admission of approximately 30,000 clients in their social detoxification program; with the majority of those clients males; the services expanded through this work include increased coordination to safe housing and transportation services with the Emergency Department. Finally, a contract with the Gallup Police Department was established and provides transportation services to the detoxification center. The Great Plains’ site, has used funding to implement a recovery support coach model to provide additional services for follow-up care and treatment compliance. These funds also supported increase coordination with behavioral health programs, provided additional screenings and brief interventions to individuals incarcerated in jails, and serve as an immediate placement for individuals who are in need of treatment services following detoxification. In fact, of the nearly 1,000 unique clients served in this program, 851 alcohol and drug assessments were completed to identify an appropriate level of care.
In June 2019, IHS released the Special General Memorandum *Assuring Access to MAT* that requires Federal Indian Health Service Facilities to create an action plan to identify or create local medication assisted treatment resources and coordinate patient access to these services when indicated. Key components of these approaches include enhanced screening and early identification of Opioid Use Disorders; improved care coordination and patient referral for treatment; and workforce development strategies to increase education and resources surrounding using medications in the support of recovery.

The Indian Health Service does face challenges in providing MAT in certain sectors within Indian Country. The rural and frontier nature of where American Indians/Alaska Natives live creates barriers to accessing health facilities. This is especially evident in Alaska where patients often only have access to a community health aide serving within a village-based clinic, hours away by plane from a larger health center. Additionally, IHS has felt the impact of a declining supply of specific health professionals who could support the IHS workforce and address behavioral health needs. The IHS recognizes that telemedicine is one tool for increasing access to specialized medical services, such as MAT. The IHS has published a policy in the Indian Health Manual (Chapter 38) entitled Internet Eligible Controlled Substance Prescriber Designation to assure access to MAT using telemedicine models for remotely located Tribal members.

The IHS has also created a robust workforce development strategy to include didactic training. In September 2019, the IHS launched its Pain Management and Opioid Use Disorder Continuing Medical Education webinar series. The IHS has hosted learning sessions in this series that include buprenorphine prescribing in pregnancy as well as an auricular acupuncture-training program. Additional sessions are scheduled in FY20. The IHS has also recently facilitated dedicated access to tele-consultation services for IHS clinicians to receive on-demand substance use expert recommendations and tailored clinical guidance for IHS healthcare providers of all experience levels. This service is also available to assist IHS health systems with creating clinic policies and procedures to support creation of integrated MAT services in IHS facilities. In 2019,

IHS also provided a 4.25 hour training, titled "Prescriber Data Waiver Training." This training session assisted participants with meeting the SAMHSA and DEA requirements to apply for a DATA waiver to prescribe buprenorphine in the treatment of opioid use disorder.

To provide ongoing clinical support for providers, IHS, in partnership with the University of New Mexico Pain Center, provides a weekly Chronic Pain and Opioid Management ECHO (Extension for Community Healthcare Outcomes). ECHO is a case-based learning model in which consultation is offered through virtual clinics to primary care clinicians by an expert team to share knowledge and elevate the level of specialty care available to patients. In FY 2019, 178 IHS, tribal, and urban clinicians participated in ECHO. The ECHO continues in FY 2020.

IHS Substance Abuse and Suicide Prevention (SASP): The SASP is a nationally-coordinated grant program that focuses on providing targeted substance abuse and suicide prevention and intervention resources to AI/AN communities with the greatest need for these programs. There is mutual development and implementation of the SASP, formerly known as the Methamphetamine and Suicide Prevention Initiative, with Tribes, Tribal programs, and other Federal agencies which now provides support to 175 IHS, Tribal, and Urban Indian health programs nationally. This initiative promotes the use and development of evidence-based programs (EBP) and practice-based models that represent culturally-appropriate prevention and treatment approaches to methamphetamine abuse and suicide prevention from a community-driven context. Data from FY 2017-2018 indicate that 93 percent of grantees reported use of an EBP, and 86 percent of grantees have integrated cultural services into project activities over 16,500 community members have been trained in suicide and substance use prevention.

IHS will focus on establishing academic partnerships that can provide evaluation of culturally-informed behavioral health services. Currently, IHS, Division of Behavioral Health has partnerships with academic institutes to support the IHS Strategic Plan *Goal 1 Objective 1.1 to recruit, develop, and retain a dedicated, competent and caring workforce*. IHS will work with tribal communities, especially SASP grantees, to encourage collaborative efforts that support documentation and sharing of successful interventions that have integrated cultural and traditional practices into evidence-based programs.

Opioid Grants. - To better combat the opioid epidemic, the Committee has continued funding of $10,000,000 and instructs the Service, in coordination with the Assistant Secretary for Mental Health and Substance Abuse, to use the funds provided to continue a Special Behavioral Health Pilot Program as authorized by Public Law 116–6. The Director of IHS, in coordination with the Assistant Secretary for Mental Health and Substance Use, shall award grants for providing services, provide technical assistance to grantees under this section collect, and evaluate performance of the program. (p. 116).

Action taken or to be taken:

IHS initiated tribal consultation and urban confer on June 17, 2019 regarding the development of an IHS Opioid Grant Pilot Program to distribute the Fiscal Year (FY) 2019 opioid funding. The open comment period closed on September 3, 2019 and IHS received 119 comments from representatives of all 12 IHS areas. In the immediate future, IHS plans to issue a Notice of Funding Opportunity (NOFO) in the spring of 2020, taking into consideration the recommendations submitted from the Tribal Consultation and Confer. Objectives, eligibility criteria, and allocation details will be outlined in the NOFO. Although the language specifies the use of the SDPI program as a model for funding distribution, the total of $10,000,000 limits the application of the SDPI model to effectively address and target services at the opioid epidemic.

Prescription Drug Monitoring. - The Committee is concerned that IHS and tribally operated health facilities are not participating in State Prescription Drug Monitoring Programs and emergency department information exchanges. The Committee strongly encourages these facilities to participate in these programs. Accordingly, within 90 days of enactment of this act, the Service shall provide the Committee with a report outlining by State such facilities that are participating and those that are not, and any issues preventing facilities from uploading data to these programs or exchanges. (p. 117).

Action taken or to be taken:

The IHS has also implemented IHM Chapter 32 "State Prescription Drug Monitoring Programs" that establishes policy requirement for Federal facilities to participate with state-based Prescription Drug Monitoring Programs (PDMP). Controlled substance prescribers working in IHS federal-government-operated facilities must query state Prescription Drug Monitoring Program databases prior to prescribing opioids for pain treatment longer than seven days and periodically throughout chronic pain treatment. To reduce barriers to nation-wide PDMP implementation and integration and data sharing efforts to improve interoperability of systems In FY 2019 IHS has developed and released software programming to automate controlled substance dispensing reports to state-based PDMPs to near real-time reporting to improve the fidelity of IHS dispensing data in state PDMP databases. The IHS has been in preliminary planning and design discussions to evaluate feasibility of PDMP interoperability into the IHS Electronic Health Record. These efforts supporting the IHS Strategic Plan *Goal 3, Objective 3.3 Modernize information technology and information systems to support data driven decisions.*

IHS Facilities are configured to report to PDMPs in all federal facilities except one in Nebraska. Reporting to PDMPs is required by IHS's policy on State Prescription Drug Monitoring Programs (Chapter 32) of the Indian Health Manual.

- 82 out of 83 facilities with pharmacies participate in state PDMPs.
- 17 out of 18 States that have an IHS facility with a pharmacy are coordinating with state PDMPs. Exception: Nebraska

An MOA has been submitted to the state of Nebraska to have access, and we are awaiting approval.

THIS PAGE INTENTIONALLY LEFT BLANK

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2021 Performance Budget Submission to Congress

TABLE OF CONTENTS

Operating Division-Specific Requirements

THIS PAGE INTENTIONALLY LEFT BLANK

Department of Health & Human Services
Indian Health Service
Number of Service Units and Facilities
Operated by IHS and Tribes, October 1, 2018

Type of Facility	TOTAL	IHS Total	TRIBAL Total	TRIBAL Title I [a]	TRIBAL Title V [b]
Service Units	172	54	118		
Hospitals	46	24	22	2	20
Ambulatory	556	85	471	117	354
Health Centers	335	50	285	88	197
School Health Centers	16	11	5	0	5
Health Stations	78	24	54	24	30
Alaska Village Clinics	127	0	127	5	122

[a] Operated under P.L. 93-638, Self Determination Contracts
[b] Operated under P.L. 106-260, Tribal Self-Governance Amendment of 2000

Indian Health Service
Summary of Inpatient Admissions and Outpatient Visits
Federal and Tribal
FY 2018 Data

Direct Care Admissions

	IHS	Tribal	TOTAL
TOTAL	**14,601**	**25,893**	**40,494**
Alaska	*	12,341	12,341
Albuquerque	649	*	649
Bemidji	36	*	36
Billings	718	*	718
California	*	*	0
Great Plains	2,018	*	2,018
Nashville	*	1,010	1,010
Navajo	6,263	4,807	11,070
Oklahoma	1,150	7,057	8,207
Phoenix	3,767	417	4,184
Portland	*	*	0
Tucson	*	261	261

* No direct inpatient facilities in FY 2018

Direct Care Outpatient Visits

	IHS	Tribal	TOTAL
TOTAL	**4,926,325**	**8,826,072**	**13,752,397**
Alaska	**	1,896,799	1,896,799
Albuquerque	484,093	144,568	628,661
Bemidji	270,267	653,325	923,592
Billings	408,128	123,368	531,496
California	1,484	565,566	567,050
Great Plains	869,111	145,008	1,014119
Nashville	21,692	542,029	563,721
Navajo	1,093,218	819,765	1,912,983
Oklahoma	698,501	2,485,368	3,183,869
Phoenix	798,079	534,650	1,332,729
Portland	281,752	633,773	915,525
Tucson	**	281,853	281,853

** No IHS facilities in FY 2018

INDIAN HEALTH SERVICE
Immunization Expenditures[1]

	FY 2017 Estimate	FY 2018 Estimate	FY 2019 Estimate	FY 2020 Estimate	FY 2021 Estimate	Increase or Decrease
Infants, ≤2 yrs†	$18,234,078	$18,370,977	$17,637,372	$16,999,814	$27,697,493	+$10,697,679
Children, 4 yrs*	--	--	--	--	$1,903,618	NA
Children, 11 yrs*	--	--	--	--	$2,638,457	NA
Children, 16 yrs*	--	--	--	--	$492,106	NA
Influenza, 3-18 yrs*	--	--	--	--	$7,011,952	NA
Adolescents, 13-17 yrs**	$14,184,614	$14,416,586	$14,539,873	$14,751,715	--	NA
HPV vaccine, Female 19-26 yrs	$7,116,136	$3,365,850	$1,888,480	$2,234,867	$1,661,872	-$572,995
HPV Vaccine, Males 19-26 yrs†	$5,339,282	$3,617,239	$3,007,340	$3,471,040	$8,348,651	+$4,877,611
Tdap, 19+ yrs	$4,369,742	$4,986,405	$5,642,763	$6,881,091	$8,011,379	+$1,130,288
Hepatitis B for diabetics, 19-59 yrs	$5,400,839	$3,458,933	$5,001,855	$2,596,434	$983,972	-$1,612,462
Influenza, 19+ yrs	$25,539,057	$25,865,678	$26,722,962	$26,869,430	$28,389,102	+$1,519,672
Zoster, 50+ yrs†	$598,728	$634,156	$749,722	$600,430	$5,072,640	+$4,472,210
Pneumococcal (PPSV23), 65+ yrs	$270,111	$826,614	$1,263,179	$367,796	$1,766,053	+1,398,257
Pneumococcal (PCV13), 65+ yrs	$4,790,620	$5,105,479	$6,107,426	$6,676,690	$7,371,107	+$694,417
Monitoring	$127,100	$132,057	$137,207	$138,579	$143,984	+$5,405
TOTAL	$85,970,307	$80,780,034	$82,698,180	$81,587,886	$101,492,384	+19,904,498

†Expanded age range beginning with FY 2021 estimate
*Newly added stratified measures beginning FY 2021 for improved capture and accuracy of estimates among thes patient groups
**Retired aggregrate measure replaced with newly added stratified measures as indicated

The Indian Health Service (IHS) patient care data system does not calculate itemized costs for the treatment of various conditions. Because the cost of vaccines for children < 19 years of age is covered by the Vaccines for Children (VFC) program, only the costs for vaccine administration, which are not covered by the VFC program, are included for this age group. Vaccine administration fees were based on an average of the CMS Maximum Regional Charges for vaccine administration, multiplied by the number of doses of vaccine routinely recommended for each age group (e.g., 25 total vaccine doses for children ≤ 2 yrs).

Estimated immunization expenditures include projected costs for routine, on-schedule immunizations among core patient demographic groups based on current age-appropriate immunization schedules. Other individuals outside these core patient groups may be regular recipients of immunizations (e.g., health care workers; patients at specific increased risk for certain vaccine-preventable diseases). However, there is not currently a methodology to

1. The immunization estimates do not include the Hepatitis B and Haemophilus Immunization (AK) program; estimates for these immunizations are included under the Immunization Alaska budget.

accurately estimate the size or vaccination coverage rates for all of these patient groups. Therefore, some special patient groups are excluded from these expenditure estimates.

Costs for monitoring of immunization coverage were also included and represent a 3.9 percent increase over the FY 2020 estimate:

- FY 2017 Estimated Costs = FY 2016 cost plus 3.7 percent
- FY 2018 Estimated Costs = FY 2017 cost plus 3.9 percent
- FY 2019 Estimated Costs = FY 2018 cost plus 3.9 percent
- FY 2020 Estimated Costs = FY 2019 cost plus 1.0 percent
- FY 2021 Estimated Costs = FY 2020 cost plus 3.9 percent

For FY 2021, $101,348,400 is estimated for vaccine costs, and $143,984 for immunization monitoring costs, for a total of $101,492,384 estimated for all immunization expenditures. This represents a $19,904,498 increase from the FY 2020 estimate attributable to enhanced stratification of age groups that captures additional patients receiving immunizations, changes in recommendations including expanded age ranges for select vaccines (e.g., Zoster, HPV), changes in vaccine costs, shifting population sizes among age categories targeted for immunization, and progress towards immunization coverage goals aligned with Healthy People 2020 targets (i.e., fewer individuals still needing vaccination which translates to reduced forecasted costs). Calculations for the costs included as part of the FY 2021 estimated immunization costs were based on the assumptions outlined in the table below:

	Estimated User Population (FY 2019)	Coverage Goal†	Current Coverage*	No. to be vaccinated	Vaccine costs (per dose)**	Admin fee (per dose)§	No. of doses per patient	Total Immun expenditures per patient	Total
Infants, ≤2 yrs	63,731	80%	NA	50,985	$0.00	$21.73	25	$543.25	$27,697,493
Children, 4 yrs	27,376	80%	NA	21,901	$0.00	$21.73	4	$86.92	$1,903,618
Children, 11 yrs	30,355	80%	NA	24,284	$0.00	$21.73	5	$108.65	$2,638,457
Children, 16 yrs	28,308	80%	NA	22,646	$0.00	$21.73	1	$21.73	$492,106
Influenza, 3-18 years	460,979	70%	NA	322,685	$0.00	$21.73	1	$21.73	$7,011,952
HPV Females, 19-26 yrs	110,756	60%	57%	3,323	$144.99	$21.73	3	$500.16	$1,661,872
HPV Males, 19-26 yrs	98,188	60%	43%	16,692	$144.99	$21.73	3	$500.16	$8,348,651
Tdap, 19+ yrs	1,140,491	90%	75%	171,074	$25.10	$21.73	1	$46.83	$8,011,379
Hepatitis B for diabetics, 19-59 yrs	127,474	60%	55%	6,374	$29.73	$21.73	3	$154.38	$983,972
Influenza, 19+ yrs	1,140,491	70%	NA	798,344	$13.83	$21.73	1	$35.56	$28,389,102
Zoster, 50+ yrs	407,016	40%	35%	20,351	$102.90	$21.73	2	$249.26	$5,072,640
Pneumococcal (PPSV23) 65yrs+	167,373	90%	78%	20,085	$66.20	$21.73	1	$87.93	$1,766,053
Pneumococcal (PCV13) 65yrs+	167,373	30%	UNK	50,212	$125.07	$21.73	1	$146.80	$7,371,107
Vaccine Costs									$101,348,400
Monitoring									$143,984
Total Costs									$101,492,384

† Based on Healthy People 2020, where applicable.

*****Coverage estimates based on most current coverage levels available (FY 2019 Quarter 3); coverage estimates for diabetics ages 19-59 years includes those patients immune to Hepatitis B for reasons other than immunization; HPV estimate is based on 3 dose series;

coverage listed as ‘NA’ either not applicable due to age-related cohort turnover each year or recurring annual immunization requirement each year (i.e., influenza); coverage estimate noted as ‘UNK’ is currently unknown and unavailable.
******Cost per dose for routine childhood vaccines administered up to and including age 18 are covered by the Vaccines for Children program; cost per dose determined from the CDC Adult Vaccine Price List dated December 2, 2019. Lowest published price is generally used where multiple products or formulations are available.
https://www.cdc.gov/vaccines/programs/vfc/awardees/vaccine-management/price-list/index.html
§Based on an average of the state CMS Maximum Regional Charges for Vaccine administration.

Overall, the estimated costs above reflect projected costs for routine, on-schedule immunizations but with caveats::

1. Other individuals outside these core patient groups are regular recipients of immunizations (e.g., immunization for health care workers and those at specific risk for other vaccine-preventable diseases). However, there is not currently a methodology to estimate the size of these groups to effectively track vaccination coverage rates.
2. The CMS Maximum Regional Charges for Vaccine administration was used to estimate indirect costs because there is no specific methodology to estimate indirect costs or administrative overhead associated with the administration of immunizations system-wide, or operation of the overall immunization program.

FISCAL YEAR 2021 DHHS LEGISLATIVE PROPOSAL
Indian Health Service

Contractibility of IHS Facilities by Unanimous Resolutions

Proposal: Ensure Indian Health Service (IHS) health care facilities serving more than one Tribe may be contracted or compacted by an eligible Tribe or Tribal Organization (T/TO) only if approved through Tribal resolution by all Tribes primarily benefitting from the IHS health care facility.

Current Law: The Indian Self-Determination and Education Assistance Act (ISDEAA) enables T/TOs to contract or compact for IHS-operated health programs or portions thereof. In instances where an IHS facility serves more than one Tribe, each Tribe could contract for its share of that program. *See* 25 U.S.C. §§ 5321(a)(1), 5324(i)(1). This would create a division wherein part(s) of the program is/are carried out by one T/TO and part(s) of it is/are carried out by IHS or the other T/TO.

Alternately, a T/TO may contract/compact for a greater portion of the program if it obtains supporting Tribal resolutions from one or more of the other Tribes served by that facility. *See, e.g.*, 25 U.S.C. §§ 5304(l), 5381(b); 25 C.F.R. § 900.8(d).

Rationale: When programs in one facility must be divided, it creates a myriad of practical issues. It also inevitably reduces the scope of the overall program due to a reduction in economies of scale. For example, if an IHS-operated health care facility predominantly serves two Tribes and the IHS receives an ISDEAA proposal to assume one-half of the programs at the facility, the IHS must consider how the division of health care services would affect health care to eligible members, particularly if the Tribe that wants to contract does not want to serve the Tribe that did not provide a resolution to contract on its behalf. Problems include, but are not limited to:

1) Whether and how to operate two separate health programs in the same facility (they may be required to operate as two separate and distinct legal entities, with separate entrances, waiting rooms, privileging, credentialing, billing arrangements, Medicare enrollment requirements, accreditations, etc.);
2) How to divide the space and/or how to pay for new space (perhaps through section 105(*l*) lease funding or contract support costs (CSC)) for one of the programs;
3) How to divide equipment and/or how to pay for new equipment (perhaps through CSC funding) for one of the programs;
4) How to ensure the contracting T/TO follows IHS's "Open Door" Policy, which would require it to provide services to members of the other Tribe without receiving funding associated with those patients; and
5) What to do if all beneficiaries choose one program over the other (even though the funding has been split).

Budget Impact: None

Effective Date: Upon enactment.

FISCAL YEAR 2021 DHHS LEGISLATIVE PROPOSAL
Indian Health Service

Elevating the IHS Director to Assistant Secretary of Indian Health

Proposal: Amend Federal law to designate the Director of the Indian Health Service (IHS) to be a reference to the Assistant Secretary of Indian Health.

Current Law: The IHS was established by statute as an agency of the Department of Health and Human Service (HHS) and is headed by a Director whose position was established by the same law. 25 U.S.C. § 1661.

Rationale: The IHS is the principal federal health care provider and health advocate for American Indian and Alaska Native people, and its mission is to raise their health status to the highest level. IHS was established to carry out the responsibilities, authorities, and functions of the United States, as provided in Federal statute or treaties, to provide health care services to Indians and Indian tribes. In carrying out such responsibilities, the IHS provides a comprehensive health service delivery system for approximately 2.2 million American Indians and Alaska Natives who are members of 574 federally recognized tribes in 37 states.

Elevating the position of Director to Assistant Secretary would enable the head of IHS to more effectively carry out the government's health care responsibilities to Indians, bring greater access and collaboration among the sister agencies, HHS offices and the Public Health Service on matters concerning Indian health, and emphasize the work being done throughout HHS to meet the Secretary's Priorities as they relate to American Indians and Alaska Natives. In addition, memorializing the Director as an Assistant Secretary in 25 U.S.C. § 1661 would bolster the statutory framework of IHS, which would help to show that IHS exists in statute, independent from the Patient Protection and Affordable Care Act, Public Law No. 111-148, 124 Stat. 119 (2010).

Budget Impact: None.

Effective Date: Upon enactment.

FISCAL YEAR 2021 HHS LEGISLATIVE PROPOSAL
Indian Health Service

Medicare
Extend Medicare Telehealth Services for IHS and Tribal Facilities

Proposal: Permit all Indian Health Service (IHS) and Tribal facilities to bill Medicare for telehealth services under the Physician Fee Schedule (PFS) when they host a Medicare beneficiary who receives telehealth from a distant provider, even if the facility does not meet the requirements for being located in certain rural or shortage areas. Distant care physicians and practitioners providing telehealth care to a beneficiary located in an IHS or Tribal facility, regardless of their location in another state, would be able to bill Medicare for their services, so long as they otherwise meet Medicare eligibility requirements.

Payment to the IHS and Tribal facilities for telehealth care would align with existing Medicare PFS reimbursement, which includes a flat fee to the originating site and applicable reimbursement for the service provided by the eligible physician or practitioner at a distant site.

Current Policy: Currently, Medicare covers some telehealth services, but does not expressly cover telehealth services provided across state lines. Telehealth practitioners in the IHS system are often located in a different state from the patient and are not licensed, registered, or subject to the law of the state where the patient is located and receiving such services. Under section 1834(m) of the Social Security Act, Medicare pays the distant site for the physician service and the originating site a facility fee, but the originating site must meet certain requirements, which some IHS sites do not meet.

Rationale: The Snyder Act and the Indian Health Care Improvement Act provide broad authority for IHS and tribal health programs to operate telehealth programs, including the provision of telehealth services between originating and distant sites that operate across state lines. Explicitly authorizing IHS and tribal health programs to receive applicable Medicare reimbursement when telehealth services are provided across state lines will accommodate the unique structures and federal authorities that allow IHS and tribal health programs to operate across state lines and without regard to state licensure requirements.

Federal law exempts tribal employees and health programs from in-state licensure requirements. See 25 U.S.C. § 1621t and 1647a, respectively. Because state laws are generally inapplicable to such programs, IHS and tribal health programs are in a unique position to implement telehealth programs that operate across state lines in any number of ways that are not currently recognized or reimbursed by Medicare. While this gives IHS and tribal health programs greater flexibility to operate telehealth programs to serve patients living in remote areas, it does not guarantee that the program will be reimbursed for such services if a patient is covered by Medicare.

Budget Impact: None.

Effective Date: Upon enactment.

Key Information: As a general principle of law, state laws are inapplicable to federal employees and federal contractors performing within the scope of their duties. The Supreme Court held in *Miller v. Arkansas*, 352 U.S.187 (1956), that a state may not require a federal contractor to be licensed by the state as a precondition of being able to perform under a federal contract. Accordingly, state licensure laws are inapplicable to federal contractors in performance of their duties. These legal principles apply to federal health care practitioners. *See Taylor v. United States*, 821 F.2d 1428, 1431 (9th Cir. 1987); *see also Lucas v. United States*, 807 F.2d 414 (5th Cir. 1986).

FISCAL YEAR 2021 HHS LEGISLATIVE PROPOSAL
Indian Health Service

To Authorize the Indian Health Service to Establish Concurrent Federal and State Jurisdiction at IHS Federal Enclave Property

Proposal: Amend the Indian Health Care Improvement Act (IHCIA) to authorize the Indian Health Service (IHS) to establish concurrent federal and state jurisdiction at IHS federal enclave property by adding a new subsection (3) to 25 U.S.C. § 1661(d).

Problem: IHS is an independent landholding agency and owns approximately fourteen properties, such as hospitals in Claremore, Oklahoma and Winslow, Arizona, under exclusive federal jurisdiction due to the land's status as "federal enclave" property. Since federal criminal law applies to the exclusion of state law at these locations, the property is often left without a response by nearby first responders with law enforcement authority because they lack criminal jurisdiction.

Rationale: This is problematic for IHS in a variety of ways related to community safety, opioid abuse, and law enforcement. Some locations have been hampered by threats and assaults on patients, health care providers, and staff, while other locations have experienced drug-related crime.

Also, when IHS patients are in need of mental health and substance abuse services that IHS is unable to provide, the lack of concurrent jurisdiction means that patients are not able to access state benefits such as transport by state law enforcement to non-IHS facilities for examination, emergency detention, protective custody, and inpatient services. Last, the lack of response by first responders affects retention of health care providers, who are vulnerable to the threats and assaults by patients and visitors to the facilities.

While IHS has worked creatively with federal and state law enforcement officials to develop partial patchwork fixes at these locations, legislation is necessary to resolve the problem. Prior IHS interactions with Congress on this issue have resulted in a recommendation that IHS and other stakeholders develop an administrative, rather than legislative, solution. In a few cases, an administrative solution can be achieved (for example, cross-deputization agreements); however, in most cases, a legislative solution is required.

Some Tribes and local governments in some locations may be reluctant to embrace cessation of exclusive federal jurisdiction. A discretionary authority - authorizing IHS to cede authority where it determines doing so is necessary - would give IHS the ability to interface with these stakeholders FY 2021 to develop the best solution on a case-by-case basis, while respecting the sovereignty of Tribal, state, and local governments.

Federal law authorizes concurrent State-Federal jurisdiction for numerous agencies including Veterans Administration; Departments of Defense, Agriculture, Commerce, Interior (Fish and Wildlife, Park Service); NASA; and General Services Administration (on easements). It is an accepted remedy for addressing issues faced by federal agencies in similar jurisdictional situations. A detailed list of examples is provided below.

The proposal has direct bearing on the Presidential initiative to address the opioid epidemic. Due to the opioid epidemic, and the illegal drug epidemic generally, the lack of security at IHS facilities and the lack of response by first responders to these facilities has become a great concern for the Agency. Providing IHS with another tool to curb drug diversion and ensure physical security for its patients and providers at its facilities would further the Presidential initiative.

Budget Impact: None.

Effective Date: Upon enactment.

Locations of Potential Use: Claremore, OK and Winslow, AZ. Both of these locations are federal enclave properties with little access to federal law enforcement agencies, but located in municipalities with state and local law enforcement nearby. 911 calls from these locations are directed to local law enforcement agencies with no criminal jurisdiction on facility grounds. The Claremore facility is federally owned and operated. The Winslow facility is federally owned but contracted by Winslow Indian Health Care Center, a tribal organization operating under an Indian Self-Determination and Education Assistance Act compact.

Examples of Federal Laws authorizing concurrent state-federal jurisdiction:

Department of Veterans Affairs –
38 U.S.C. § 8112
The Secretary, on behalf of the United States, may relinquish to the State in which any lands or interests therein under the supervision or control of the Secretary are situated, such measure of legislative jurisdiction over such lands or interests as is necessary to establish concurrent jurisdiction between the Federal Government and the State concerned. Such partial relinquishment of legislative jurisdiction shall be initiated by filing a notice thereof with the Governor of the State concerned, or in such other manner as may be prescribed by the laws of such State, and shall take effect upon acceptance by such State.

Department of Defense –
10 U.S.C. § 2683(a)
Notwithstanding any other provision of law, the Secretary concerned may, whenever he considers it desirable, relinquish to a State, or to a Commonwealth, territory, or possession of the United States, all or part of the legislative jurisdiction of the United States over lands or interests under his control in that State, Commonwealth, territory, or possession. Relinquishment of legislative jurisdiction under this section may be accomplished (1) by filing with the Governor (or, if none exists, with the chief executive officer) of the State, Commonwealth, territory, or possession concerned a notice of relinquishment to take effect upon acceptance thereof, or (2) as the laws of the State, Commonwealth, territory, or possession may otherwise provide.

Department of Agriculture –
7 U.S.C. § 2268
Notwithstanding any other provision of law, the Secretary of Agriculture may, whenever he considers it desirable, relinquish to a State all or part of the legislative jurisdiction of the United States over lands or interests under his control in that State. Relinquishment of legislative jurisdiction under this section may be accomplished (1) by filing with the Governor of the State concerned a notice of relinquishment to take effect upon acceptance thereof, or (2) as the laws of the State may otherwise provide.

FISCAL YEAR 2021 DHHS LEGISLATIVE PROPOSAL
Indian Health Service

Federal Tort Claims Act (FTCA) Coverage for Urban Indian Organizations

Proposal: The Indian Health Service (IHS) requests approval of the proposal to amend the Indian Health Care Improvement Act (IHCIA) to provide Federal Tort Claims Act (FTCA) coverage to IHS-funded Urban Indian Organizations (UIOs) in the same manner as Indian Self-Determination and Education Assistance Act (ISDEAA) contractors and mandate that all medical malpractice claims and judgments be paid from the Department of Treasury's Judgment Fund. This amendment would cover medical, dental, pharmaceutical, and behavioral health counseling related health care services including ancillary services provided to eligible Urban American Indians and Alaska Natives (AI/AN) pursuant to grants and contracts awarded by the IHS, as authorized by 25 U.S.C. Subchapter IV – *Health Services for Urban Indians* of the IHCIA.

Current Law: It is well settled law that Congress must specifically authorize, in statute, the extension of federal tort coverage to certain groups or individuals. Currently, federal law extends FTCA coverage to ISDEAA contractors' employees and personal services contractors. 25 U.S.C. § 5321(d). Federal law does not provide tort liability coverage for injuries to Urban AI/AN patients that result from health care services provided by UIOs with IHS funds.

Rationale: The IHS enters into limited, competing contracts and grants with forty-one (41) 501(c)(3) non-profit organizations to provide health care and referral services for Urban Indians throughout the United States. UIOs are defined by 25 U.S.C. § 1603(29) as a nonprofit corporate body situated in an urban center, governed by an Urban Indian controlled board of directors, and providing for the maximum participation of all interested Indian groups and individuals, which body is capable of legally cooperating with other public and private entities for the purpose of performing the activities described in 25 U.S.C. § 1653(a). UIOs define their scope of work and services based upon the service population, health status, and documented unmet needs of the Urban Indian community they serve.

In calendar year 2017, 35 UIOs provided 653,614 health care visits for 75,194 Urban Indians, who do not have access to the resources offered through IHS or tribally operated health care facilities because they do not live on or near a reservation. This does not include six UIOs that provide residential and outpatient substance abuse treatment programs and that did not report.

UIOs are evaluated in accordance with the IHCIA, as amended, at 25 U.S.C. § 1655. The IHS UIO On-Site Review Manual is used to conduct annual onsite reviews of the IHS-funded UIOs to monitor compliance with Federal Acquisition Regulation contractual requirements that are established through legislation. Currently, UIOs are seeking or maintaining accreditation from several health care accreditation organizations, including the Joint Commission (JC), Accreditation Association for Ambulatory Healthcare (AAAHC), Commission on Accreditation of Rehabilitation Facilities (CARF), and National Committee for Quality Assurance (NCQA). Some UIOs have also achieved recognition as Patient Centered Medical Homes (PCMH), with additional UIOs currently working towards PCMH recognition, as well as AAAHC accreditation.

UIOs are expending scarce resources to purchase malpractice insurance, when those resources could be better utilized to expand services available to Urban AI/AN patients. The rising cost of medical malpractice insurance and the general cost of providing health care services adversely impact the ability of UIOs to provide needed services. As a result, certain kinds of staff and health services, such as dental services, have been substantially reduced or eliminated. UIOs are an integral part of the IHS health care

system and they provide high quality, culturally relevant health care services and are often the only health care providers accessible to Urban AI/AN patients.

Amending the IHCIA to extend FTCA coverage to IHS-funded UIOs would be consistent with the current and long-standing policy of providing FTCA coverage for other providers in the IHS health care system that provide services to AI/AN, the IHS, and Tribal facilities. The extension of FTCA coverage under this provision would be limited to services provided to Urban AI/AN patients who are eligible for services under the IHCIA and would not cover services to other individuals, which would need to be covered by other resources, such as private malpractice insurance maintained by the UIO or FTCA coverage already provided under 42 U.S.C. § 233(g)-(n) to Health Center Program grantees that obtain deemed employee status for purposes of FTCA coverage for those activities. Currently, seven IHS-funded UIOs are also Health Center Program grantees that have obtained deemed employee status for purposes of FTCA coverage for the activities provided under that grant, but the FTCA coverage does not extend to activities performed under their contracts/grants from IHS.

The IHS-funded UIO is distinct from the Health Resources and Services Administration (HRSA) federal community health center (CHC) program. For example, the IHS-funded UIOs are much smaller in terms of the size of the population served. Therefore, the level of FTCA claims that might arise in relation to the IHS-funded UIOs is not expected to rise to the level of FTCA claims associated with the Health Center Program.

If Congress were to authorize settlement payments and judgments be paid from the Judgment Fund, as they are for IHS and tribal contractors, there would be no direct impact on the IHS budget.

In the 115th Congress, the bills H.R. 5874 and S. 1250 included a section that provided liability protections to employees of IHS UIOs.

The Urban AI/AN population is often invisible in the urban setting and faces unique challenges when accessing health care services. There is also a lack of sufficient data on Urban AI/AN health care issues. UIOs are an important support to Urban AI/AN families and individuals seeking to maintain their values and ties with each other and with their tribal cultures. UIOs provide a wide range of programs that serve as a safety net to Urban AI/AN children and families. To address these challenges and meet the growing needs of this diverse Urban AI/AN population, UIOs need to recruit and hire more providers. Extending FTCA coverage to UIOs in the same manner as ISDEAA contractors will provide additional funding for health care services, increase the ability of UIOs to attract and recruit highly qualified clinicians by removing the high cost of medical liability insurance as a hindrance, and ultimately, improve and expand health care services available to Urban AI/AN patients.

Budget Impact: None

Effective Date: Upon enactment.

FISCAL YEAR 2021 HHS LEGISLATIVE PROPOSAL
Indian Health Service

Provide Federal Tort Claim Act (FTCA) Coverage for Persons Volunteering their Services at the Indian Health Service Hospitals and Clinics and in Authorized Community Settings

Proposal: To amend the Public Health Service Act (42 U.S.C. § 233) to provide Federal Tort Claim Act (FTCA) coverage for persons volunteering their services at the Indian Health Service (IHS) hospitals and clinics, and in authorized community settings where IHS services are being provided.

Current Law: It is well settled law that only Congress may authorize FTCA coverage because it is a limited waiver of the federal government's sovereign immunity. FTCA is the exclusive remedy for acts of malpractice and other negligence committed by commissioned officers or employees of the Public Health Service (PHS). *See* 42 U.S.C. § 233.

Currently, federal law does not provide FTCA coverage for volunteers providing services at IHS hospitals and clinics, or in authorized community settings. This is despite the fact that federal law allows volunteers to be used in the operation of a PHS health care facility. *See* 42 U.S.C. § 217b.

Rationale: To ensure FTCA coverage of volunteers at IHS hospitals and clinics, and in authorized community settings, federal law at 42 U.S.C. § 233 should be amended to specifically include coverage of volunteers under the FTCA. Should such coverage be extended, IHS volunteers would be considered federal employees only for FTCA purposes.

Providing FTCA coverage has the potential to help IHS address significant health care provider shortages in IHS hospitals and clinics by increasing the number of health care providers available to treat IHS beneficiaries. It will also enable IHS to expand access to care by facilitating health care delivery in authorized community settings. The proposal is expected to improve the ability of the IHS to attract and recruit highly qualified volunteers by removing the high cost of medical liability insurance as a hindrance.

Budget Impact: None

Effective Date: Upon enactment.

FISCAL YEAR 2021 DHHS LEGISLATIVE PROPOSAL
Indian Health Service

Waiver of Indian Preference

Proposal: Amend 25 U.S.C. § 5117 to authorize the HHS Secretary to waive Indian Preference laws, and issue related regulations, applicable to IHS positions that fall under specific conditions in order to fill positions in cases where the Secretary determines there is an urgent staffing crisis or chronic persistent vacancies in health professions.

Problem: In August 2018, GAO reported that the IHS had a 25 percent vacancy rate for providers, including physicians, nurses, dentists, pharmacists, nurse practitioners, certified registered nurse anesthetists, certified nurse midwives, and physician assistants (GAO-18-580). This equates to over 1,400 current vacancies in IHS in these health professions. Long-standing vacancies have a negative effect on patient access, quality of care, and employee morale. IHS needs additional flexibilities to rapidly address chronic staffing needs. While extremely important, Indian Preference sometimes impacts the Agency's ability to hire highly competent personnel for essential provider or facility Chief Executive Officer (CEO) positions (e.g., in circumstances when an Indian Preference candidate is only qualified at the most basic level, or where an Indian Preference candidate has poor references, a record of disciplinary issues in Federal employment, or both). Allowing the HHS Secretary to waive Indian Preference under specific circumstances, as proposed, may help to mitigate the persistent vacancies experienced across the Agency for providers and CEOs.

Rationale: The proposal would allow the HHS Secretary to grant a waiver of the application of Indian Preference laws without the written waiver now required at 25 U.S.C. § 5117(c) from concerned tribal organizations, for any personnel action involving filling a vacant position at an IHS service unit in which 15 percent or more of the total positions or specific health profession positions in the service unit are not filled by a full-time employee of the IHS for a period of 6 months or longer. This flexibility will help IHS expedite recruitment and hiring for critical provider positions or a CEO position at any facility that is not able to fill vacancies for an extended period of time under the Indian Preference laws. Also, it can be impractical to obtain a Tribal waiver, as is currently required, at locations where an IHS facility serves multiple Tribes, for example the IHS Rapid City Service Unit. The IHS will provide the Secretary adequate justification for the waiver when a situation at a facility meets the criteria.

Budget Impact: IHS currently uses temporary contractors, at 2-3 times the cost of federal staff, to fill vacancies. If the proposal is approved, there could be a significant cost savings as federal employees and commissioned officers would be used instead of contracted personnel.

Effective Date: Upon enactment.

FISCAL YEAR 2021 DHHS LEGISLATIVE PROPOSAL
Indian Health Service

ISDEAA Section 105(*l*) Lease Authority

Proposal: To provide a new appropriation account for the IHS with a lease prospectus requirement for compensation provided to a Tribe or Tribal organization for a lease under section 105(*l*) of the Indian Self-Determination and Education Assistance Act (ISDEAA).

Current Law: The Indian Self-Determination and Education Assistance Act (ISDEAA) at 25 U.S.C. § 5324(*l*), also referred to as section 105(*l*), requires the IHS to enter a cost agreement, or "lease," with a Tribe or Tribal organization for reasonable costs associated with a facility used by the Tribe in support of its tribally operated ISDEAA contract or compact. A 2016 Federal Court's decision (*Maniilaq Association v. Burwell*, 170 F. Supp. 3d 243 (D.D.C. 2016)) prohibits IHS from capping funding under section 105(*l*) at the level that IHS would have otherwise spent to operate a facility if it were carrying out the Federal health programs. Since IHS receives funds for operational expenses through the lump-sum "Indian Health Services" (Services) appropriation account, the entire Services account is legally available and required to be used for funding the mandatory ISDEAA leases. Tribes had never before asserted such a mandatory entitlement to section 105(*l*) during the first twenty years that the law was in effect.

Rationale: IHS does not have a dedicated funding source to pay for ISDEAA section 105*(l)* leases. Due to IHS's lump-sum Services appropriation, IHS will continue to be forced to divert increasing amounts of resources from direct health care services to pay for 105(*l*) leases. Since the IHS cannot reduce the amount of funds provided to Tribes and Tribal organizations through existing ISDEAA contracts and compacts, the only funds remaining available for reprogramming are those intended for the IHS-operated health services for non-contracting/compacting Tribes.

A new indefinite discretionary appropriation for section 105*(l)* leases would ensure that IHS could fund the lease costs without impacting the other Services budgets and programs.

Adding a facility size and lease prospectus requirement to a new section 105(*l*) appropriation account would impose a Congressional approval requirement for costly section 105(*l*) leases supporting major medical facilities. Leases up to 40,000 square feet, the typical size of a health center, would continue to be funded up to the amount appropriated by Congress. A prospectus requirement is common among agencies with independent leasing authority and is necessary and appropriate for the purposes of mitigating unfettered Federal real property acquisition and engaging Congress in its fiscal accountability and oversight roles

Budget Impact: An estimated $101 million in FY 2021. Approval and implementation of this discretionary proposal would mitigate the need for congressional reprogramming requests and protect resources allocated for direct health services.

Personnel Requirements: Approval and implementation of this discretionary proposal may generate a need for additional staff to process increasing 105(*l*) lease proposals and agreements. Since FY 2017, when the first leases were negotiated, existing IHS staff have processed 105(*l*) lease proposals as collateral duties. As the number of proposals increases, additional staff would be needed to ensure appropriate and timely review, evaluation, and negotiation of proposals.

Effective Date: Upon enactment.

FISCAL YEAR 2021 HHS LEGISLATIVE PROPOSAL
Indian Health Service

Meet Loan Repayment/Scholarship Service Obligations on a Half-Time Basis

Proposal: Permit both Indian Health Service (IHS) scholarship and loan repayment recipients to fulfill service obligations through half-time clinical practice, under authority similar to that now available to the National Health Service Corps (NHSC) Loan Repayment Program (LRP) and Scholarship Program.

Authority similar to Section 331(i) of the Public Health Service Act would allow IHS loan repayment and scholarship recipients more options and flexibility to satisfy their service obligations through half-time clinical work (a minimum of 20 hours per week) for double the amount of service time (e.g., clinician who works 20 hours a week performing clinical duties with a two-year service obligation would increase to a four-year service obligation) or to accept half the amount of loan repayment award in exchange for a two-year service obligation. This would provide parity with NHSC programs and enable IHS to make better use of these tools to recruit and retain key professionals in a highly competitive environment.

Current Law: Sections 104 and 108 of the Indian Health Care Improvement Act require employees who receive IHS scholarships or loan repayments to provide clinical services on a full-time basis. Section 331(i) of the Public Health Service Act was amended by § 10501(n) of the Affordable Care Act to permit certain NHSC loan repayment and scholarship recipients to satisfy their service obligations through half-time clinical practice for double the amount of time or, for NHSC loan repayment recipients, to accept half the loan repayment award amount in exchange for a two-year service obligation.

Section 331(j) of the Public Health Service Act (42 U.S.C. § 254d(j)) defines "full-time" clinical practice as a minimum of 40 hours per week, for a minimum of 45 weeks per year. It also defines "half-time" as a minimum of 20 hours per week (not to exceed 39 hours per week), for a minimum of 45 weeks per year.

Rationale: The IHS, as a rural healthcare provider, has difficulty recruiting and retaining healthcare professionals. Recruiting physicians and other primary care clinicians has been especially challenging. Permitting IHS scholarship and loan repayment health professional employees to fulfill their service obligations through half-time clinical practice for double the amount of time and to offer half the loan repayment award amount in exchange for a two-year service obligation could increase the number of providers interested in serving in the Indian health system. Additional half-time direct care employees could also reduce the number and cost of Purchased/Referred Care program referrals, especially at sites that do not need full-time specialty care services. There are also a number of smaller rural IHS sites where clinicians will be able to provide a minimum of half-time clinical services with the remainder of their time devoted to much needed administrative/management responsibilities. This proposal will provide flexibility for providers who might not otherwise consider service in IHS by allowing part-time practice in IHS to coincide with a part-time private practice, as well as part-time practice in IHS combined with part-time administrative duties within the IHS.

The NHSA was authorized to establish a demonstration project permitting loan repayment recipients to meet their service obligations through less than full-time clinical service in response to requests from clinicians and sites. The Affordable Care Act replaced this demonstration with permanent authority for two specific kinds of NHSC options (described above under Current Law). The IHS is equally concerned with the requests from clinicians and prospective candidates for loan repayment awards for half-time service by clinicians. Having similar authority as the NHSC would increase the ability for the IHS to recruit and retain healthcare clinicians to provide primary healthcare and specialty services (e.g., Surgery, OG/GYN, Psychiatry, Radiology, and Anesthesiology) and otherwise support the IHS and HHS priorities.

The ability to provide scholarship and loan repayment awards for half-time clinical service would make these recruitment and retention tools more flexible and cost-effective, providing incentives for an additional pool of clinicians and other medical providers that otherwise may not consider a commitment to the IHS federal, Tribal and Urban Indian sites. Having similar authority as the NHSC would increase the ability for the IHS to recruit and retain healthcare clinicians to provide primary healthcare and specialty services and otherwise support the IHS and HHS priorities.

Budget Impact: This is a budget related and discretionary proposal. Direct hire medical staff costs are lower than the costs to hire temporary, contractor staff.

Effective Date: Upon enactment.

FISCAL YEAR 2021 DHHS LEGISLATIVE PROPOSAL
Indian Health Service

Subsequent Adjustment of ISDEAA Funding in Unique Circumstances

Proposal: Allow the Indian Health Service (IHS) to reduce an Indian Self-Determination and Education Assistance Act (ISDEAA) contractor's or compactor's ISDEAA funding in subsequent years if an increase in the contractor/compactor's funding was made pursuant to a statutory or regulatory "deemed approved" provision.

Current Law: The ISDEAA provides that the Secretary is directed to enter into ISDEAA contracts (under Title I of the ISDEAA) or compacts (under Title V of the ISDEAA) upon the request of any Tribe or Tribal organization (T/TO) for its share of IHS programs, services, functions, and activities. Under Title I, once a contract proposal is received by the IHS, unless an extension is awarded by the proposed contractor, the Agency has ninety days to "approve the proposal and award the contract" or decline the proposal under five limited statutory criteria. 25 U.S.C. § 5321(a)(2)(A)-(E). The implementing regulations provide that if the proposal is not declined within the ninety days, it is "deemed approved". 25 C.F.R. § 900.18*; Seneca Nation of Indians v. Nashville Area Chief Contracting Officer, Indian Health Service*, IBIA 12-041 (June 30, 2016); *see also Navajo Nation v. U.S. Dep't of Interior*, 852 F.3d 1124 (D.D.C. 2017).

Conversely, under Title V, the parties may continue to negotiate with no statutory limitation. However, if the parties reach impasse on an issue, the proposed compactor may submit a "final offer". 25 U.S.C. § 5387(b). Once a "final offer" is received by the IHS, the Agency must either accept the final offer or reject it based on four limited rejection criteria within forty-five days. *Id.* at (b), (c). "In the absence of a timely rejection of the offer . . . [it] shall be deemed agreed to by the Secretary." *Id*. at (b). The effect of these provisions is that, if IHS misses the statutory or regulatory deadline, the proposal or final offer, no matter how inequitable or incorrect the proposed funding may be, will be "deemed approved".

Additionally, the ISDEAA at 25 U.S.C. § 5325(b) (referred to as "the reductions clause") provides that funding required by subsection (a) "shall not be reduced by the Secretary in subsequent years except pursuant to" the following:

(A) a reduction in appropriations from the previous fiscal year for the program or function to be contracted;
(B) a directive in the statement of the managers accompanying a conference report on an appropriation bill or continuing resolution;
(C) a tribal authorization;
(D) a change in the amount of pass-through funds needed under a contract; or
(E) completion of a contracted project, activity, or program

The effect of the reductions clause, when read together with the statutory and regulatory deadline provisions, is that IHS is prohibited from reducing any "deemed approved" funding made due to a missed deadline in subsequent years, resulting in a possible windfall to those contractors/compactors in perpetuity. For example, a contractor who receives $7 million annually could propose an increase of $15 million, and IHS would be required to pay that amount in perpetuity, should the IHS fail to decline by the 90-day deadline.
This issue cannot be addressed through either negotiated rulemaking or internal Agency policy. As explained above, the "deemed approved" provision is found in the ISDEAA's implementing regulations for Title I contracts and in the ISDEAA itself for Title V compacts. Therefore, while negotiated rulemaking may be able to address the issue on the Title I side, it would not solve the problem on the

Title V side. In addition, it is unlikely that the Tribes would agree to this change through negotiated rulemaking or tribal consultation.

With regards to the implementation of Agency policy and internal safeguards to prevent missing deadlines, IHS currently works diligently to track the deadlines and has already implemented internal safeguards to limit the concern. However, there are actual logistical issues that impact IHS's ability in this regard. Neither the ISDEAA nor the regulations provide what constitutes a proposal under Title I or who may accept a proposal. This results in uncertainty as to whether any communication from a T/TO, written or verbal, given to any IHS staff member at any location could constitute a proposal starting the ninety-day clock. Additionally, much of the work that goes into negotiating a contract under the ISDEAA takes a significant amount of time. For example, in negotiating leases under section 105(*l*) of the ISDEAA, the required assessment of the operating expenses is impossible to complete within the ninety days allotted by the statute. While the IHS may request an extension to this timeline, the contractor/compactor has sole discretion as to whether or not to grant the extension. 25 U.S.C. § 5321(a)(2).

Rationale: Providing the authority for the IHS to reduce ISDEAA funding in subsequent years, for that portion of increased funding that was awarded as a result of missing a statutory or regulatory deadline, would ensure the Agency will not be required to pay inappropriate funding amounts in perpetuity. This will still ensure the contractor/compactor is awarded its proposed funding amount in the year in which the IHS failed to timely award or decline the proposal, in accordance with the statute.

Currently, when the IHS misses a statutory or regulatory deadline, the IHS must allocate its services appropriation funding, which is meant to be used for healthcare, as the IHS is not appropriated any additional funding for this purpose.

Additionally, as neither the statute nor regulations provide any limitation to the "deemed approved" provisions, requiring the IHS to pay any amount that a contractor/proposes, in perpetuity could have devastating effects on the Agency and the beneficiaries it serves.

Budget Impact: None.

Effective Date: Upon enactment.

FISCAL YEAR 2021 HHS LEGISLATIVE PROPOSAL
Indian Health Service

Provide Tax Exemption for Indian Health Service Health Professions Scholarship and Loan Repayment Programs

Proposal: The Indian Health Service (IHS) seeks tax treatment similar to that provided to recipients of National Health Service Corps (NHSC) and Armed Forces Health Professions scholarships, to allow scholarship funds for qualified tuition and related expenses received under the Indian Health Service Health Professions Scholarships to be excluded from gross income under Section 117(c)(2) of the Internal Revenue Code (IRC) and to allow participants in the IHS Loan Repayment Program to exclude from gross income payments made by the IHS Loan Repayment program under Section 108(f)(4) of the IRC. In addition, IHS is seeking exemption from any Federal Employment Tax (FICA), making the IHS programs comparable to the current NHSC status.

Current Law: Generally, benefits awarded in the form of scholarship awards and loan repayments are regarded as federal taxable income by the IRS under Title 25 of the Internal Revenue Code. However, three federal laws currently provide for the non-taxability of federal scholarship awards and loan repayment programs:

- Section 413 of P.L. 107-16, the Economic Growth and Tax Relief Reconciliation Act of 2001, provides that tuition, fee, and other related cost payments by the National Health Service Corps and F. Edward Hebert Armed Forces Health Professions Scholarships and Financial Assistance Program scholarships are not taxable. This tax exemption was made permanent by Congress in December 2012 but did not include IHS scholarships.
- 26 U.S.C. § 108(f)(4) provides that funds received through the National Health Service Corps Loan Repayment Program authorized under 338B(g) of the Public Health Service Act or a state loan repayment program described in section 338I of the Public Health Service Act are permanently not subject to federal income tax.
- 26 U.S.C. § 3401(a)(19) excludes NHSC loan repayment from federal employment tax.

As IHS programs are not included in the exceptions, IHS health professions scholarships and loan repayment awards are taxed under the IRC.

Rationale: The IHS, as a rural healthcare provider, has difficulty recruiting and retaining healthcare professionals. There are over 1,330 vacancies for healthcare professionals including: physicians, dentists, nurses, pharmacists, physician assistants, and nurse practitioners. The IHS Health Professions Scholarship Program and the Loan Repayment Program play a significant role in the recruitment and retention of the healthcare professionals needed to fill these vacancies. The IHS Health Professions Scholarship and IHS Loan Repayment Program are very similar to other programs that receive preferred tax treatment, and should therefore receive similar tax treatment. Currently, benefits awarded through IHS in the form of loan repayment and scholarships are regarded as federal taxable income to the recipient; however, the same benefits offered under the NHSC are not taxable. This disparate tax treatment of IHS-funded scholarship and loan repayment awards increases the overall tax bracket for the participants and creates a financial disincentive for those otherwise willing to serve American Indian and Alaska Native patients by working in Indian health facilities.

The ability to exempt scholarship and loan repayment funds from gross income would make this recruitment and retention tool more attractive to potential participants. Based on our calculations, exempting the IHS Loan Repayment Program would allow IHS to award an additional 190 loan repayment contracts in a given year. Thus the IHS would be better able to increase the number of

healthcare providers entering and remaining within the IHS to provide primary healthcare and specialty services.

Budget Impact:

Federal Tax Revenue Foregone (in 2016 dollars):

Loan	$8,920,705
Scholarship	$267,222*
Total	$9,187,927

*Number indicates taxes withheld by IHS at student's request.

Budget impact is the amount of tax revenue withheld by IHS from IHS Health Professions Scholarship and Loan Repayment and forwarded to the Internal Revenue Service. This also includes the tax liability owed by the scholarships recipients.

Effective Date: Upon enactment.

FISCAL YEAR 2021 HHS LEGISLATIVE PROPOSAL
Indian Health Service

Provide the Indian Health Service Discretionary Use of all Title 38 Personnel Authorities

Proposal: The Indian Health Service (IHS) is seeking the discretionary use of all United States Code Title 38 authorities under Part V, Chapter 74, "Veterans Health Administration – Personnel", that are primarily available to the Department of Veterans Affairs (VA) in relation to health care positions. The term "health care occupations" refers to positions, other than positions in the Senior Executive Service, that provide direct patient-care services or services incident to direct patient-care which would normally be covered by Title 5 of the United States Code.

Current Law: Title 38 Part V, Chapter 74, governs all aspects of personnel administration for the Veterans Health Administration (VHA) unless expressly overridden by another law or regulation. In many areas of personnel administration, the VHA is exempt from Title 5 laws and regulations by virtue of Title 38. The U.S. Office of Personnel Management (OPM), under the authority of section 1104 and 5371 of Title 5 of the United States Code, has authorized the Department of Health and Human Services (HHS) to use the Title 38 provisions pertaining to pay rates and systems, premium pay, classification, and hours of work. This delegation of authority is described in a delegation of agreement between OPM and HHS – the latest version of which was effective March 6, 2019. If HHS, or an HHS Operating Division under the delegation of authority, chooses to use a Title 38 provision, the comparable authority under Title 5 is waived. However, 5 U.S.C. § 5371 does not provide authority to apply all personnel provisions of Title 38 in lieu of comparable Title 5 provisions.

Rationale: The IHS, as a primarily rural healthcare provider, has difficulty recruiting healthcare professionals. The IHS has critical hiring needs for healthcare professionals in IHS, Tribal, and Urban Indian programs including, but not limited to physicians, dentists, nurses, pharmacists, physician assistants, and nurse practitioners. The ability to use Title 38 for pay purposes as discussed above is beneficial because the IHS can offer market pay to physicians and dentists, and special salary rates to individuals in other health care occupations. However, the IHS's use of these compensation authorities is not adequate by itself to compete with other public sector agencies and private sector organizations.

Typically, the private sector and the VHA can offer candidates better scheduling options and paid time off — particularly important benefits to providers who serve in remote and rural locations. The IHS faces specific public sector competition in the area of annual leave accrual. The VHA provides 1 day of annual leave per pay period for all (including new) physicians, dentists, podiatrists, optometrists, and chiropractors and 8 hours of annual leave accrual per pay period for all (including new) nurses, physician assistants, and expanded-function dental auxiliaries. Due to the limited scope of 5 U.S.C. § 5371, the IHS does not have the authority covered by 38 U.S.C. § 7421. "Personnel Administration: in general" that includes "leaves of absence of employees". Thus, when a candidate with just a few years of experience is choosing between the IHS and the VHA, he or she will invariably choose the organization offering 1 day/8 hours of annual leave accrual per pay period, as opposed to just 4 or 6 hours of annual leave accrual per pay period that the IHS offers. Supervisors report anecdotally that the IHS has lost many candidates due to this difference in accrual rates.

In addition to better scheduling options and paid time off, the IHS is seeking access to other Title 38 authorities to increase its competitive stance in the healthcare labor market and to create a more efficient and effective human resources program. This would include the potential for instituting two-year probationary periods for staff appointed under Title 38 and to have jurisdiction over appeals for adverse actions involving professional conduct or competence pertaining to direct patient care and clinical competence instead of going through the Merit Systems Protection Board. Title 38 also exempts the VHA

from collective bargaining and associated grievance procedures relating to issues concerning professional conduct competence, and peer review. In contrast, Title 5 permits the establishment of grievance procedures on any issue through the collective bargaining process.

Budget Impact: This proposal is budget neutral. The IHS will accommodate funding requirements within existing resources.

Effective Date: Upon enactment.

Withholding Annuity and Retiree Pay for Retired Civil Service Employees Convicted of Moral Turpitude

Proposal: Amend 5 U.S.C. § 8312 to allow for withholding or revoking of annuity and retiree pay for retired civil service employees convicted of moral turpitude, including crimes against children and rape, during the commission of their federal duties.

Current Law: Under 5 U.S.C. § 8312, a retired civilian employee's annuity and retiree pay may only be withheld for specific high crimes of treason, aiding the enemy, perjury, and subordination of perjury. The federal government needs additional authorities to address the pay of retirees who commit certain egregious and reprehensible crimes that outrage and offend the American Public's moral sensibility. Expansion of the list of offenses minimally should include crimes against children and rape perpetrated by federal employees during the commission of their federal duties, on federal property, or while otherwise using their federal position.

Rationale: In September 2018, a former U.S. Public Health Service Commissioned Corps officer and civil service employee at the IHS was convicted of sexual assault and exploitation of children, for crimes he committed while an active duty Corps officer assigned to the IHS facility in Browning, Montana. He was also convicted in South Dakota for similar allegations while assigned to the IHS facility in Pine Ridge, South Dakota. The sexual assailant's conviction exposes the limitations of current statute to fully address and adjudicate crimes of moral turpitude committed by retired federal employees during the commission of their duties while in the federal civil service.

In keeping with the limited scope of 5 U.S.C. § 8312, the proposed amendment may be limited to the commission of crimes against children and rape, specifically while on duty, on federal property, or while using or misusing the authority of their federal position.

This proposed amendment is in line with the Department's mission of protecting vulnerable, underserved populations, and the Presidential Task Force on Protecting Native American Children in the Indian Health Service System.

The U.S. Public Health Service Commissioned Corps has proposed a related amendment of 42 U.S.C. § 212 to allow for the involuntary recall of an officer from retirement in order to potentially change the characterization of his/her service from Honorable to Other than Honorable and withhold retiree pay for crimes of moral turpitude. Both amendments are needed to address the Commissioned Corps as a uniformed service in Title 42, separate and apart from the federal civil service, governed under Title 5.

Budget Impact: None.

Effective Date: Upon enactment.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2021 Performance Budget Submission to Congress

TABLE OF CONTENTS

Self Determination

THIS PAGE INTENTIONALLY LEFT BLANK

Indian Health Service

Indian Self Determination

Indian Health Service Philosophy – The Indian Health Service (IHS) implements the Indian Self-Determination and Education Assistance Act (ISDEAA), Public Law (Pub. L. No.) 93-638, as amended, which recognizes the unique legal and political relationship between the United States and American Indian and Alaska Native peoples. Accordingly, the IHS supports Tribal sovereignty: (1) by assisting Tribes in exercising their right to administer the IHS health programs, or portions thereof, and (2) by continuing to directly provide services to Tribes that choose the IHS as their health care provider. A Tribal decision to enter or not enter into ISDEAA agreements are equal expressions of self-determination.

Title I Contracts and Title V Self-Governance Compacts – Titles I and V of the ISDEAA provide Tribes the option to exercise the right to self-determination by assuming control and management of programs previously administered by the federal government. Since 1975, the IHS has entered agreements with Tribes and Tribal organizations to plan, conduct, and administer programs authorized under Section 102 of the Act. Today, over $3.2 billion of the Agency's appropriation is transferred to Tribes and Tribal Organizations through Title I contracts and Title V compacts. Under Title I, there are 210 Tribes and Tribal Organizations operating 244 contracts and annual funding agreements. Under Title V, IHS is party to 104 compacts and 130 funding agreements; through which approximately $2.4 billion of the IHS budget is transferred to Tribes and Tribal organizations. Sixty-five percent of federally recognized Tribes participate in Title V.

Indian Health Service
Self-Governance Funded Compacts FY 2019
(Dollars in Thousands)

Compacts by State	IHS Services	IHS Facilities	Contract Support Costs (Direct)	Contract Support Costs (Indirect)	Total
ALABAMA	**4,397**	**170**	**156**	**767**	**5,491**
Poarch Band of Creek Indians	4,397	170	156	767	5,491
ALASKA	**440,432**	**48,094**	**57,102**	**176,306**	**721,934**
Alaska Native Tribal Health Consortium	36,389	20,270	11,946	21,771	90,376
Aleutian Pribilof Islands Association, Inc.	1,647	23	151	1,130	2,951
Arctic Slope Native Association, Ltd	23,009	2,542	3,374	7,894	36,819
Bristol Bay Area Health Corporation	21,673	1,126	2,269	9,593	34,661
Chickaloon Native Village	58	1	15	13	88
Chugachmiut	3,763	28	230	1,852	5,873
Copper River Native Association	5,601	412	497	1,954	8,463
Council of Athabascan Tribal Governments	1,806	148	102	1,247	3,303
Eastern Aleutian Tribes, Inc.	2,881	28	182	1,850	4,942
Kenaitze Indian Tribe, I.R.A.	12,056	1,121	407	5,180	18,764
Ketchikan Indian Community	5,107	197	564	3,463	9,332
Knik Tribal Council	73	1	11	10	94
Kodiak Area Native Association	6,982	147	467	2,771	10,367
Maniilaq Association	27,099	1,295	2,896	14,459	45,748
Metlakatla Indian Community	6,280	994	488	1,177	8,939
Mount Sanford Tribal Consortium	799	1	84	287	1,170
Native Village of Eklutna	179	2	6	63	249
Native Village of Eyak	913	37	91	243	1,284
Norton Sound Health Corporation	45,854	4,355	4,453	12,606	67,269
Seldovia Village Tribe	1,859	73	90	710	2,732
Southcentral Foundation	80,312	4,977	10,296	32,758	128,343
SouthEast Alaska Regional Health Consortium	36,322	2,023	3,662	16,970	58,977
Tanana Chiefs Conference	61,050	4,204	5,818	15,620	86,693
Yakutat Tlingit Tribe	1,164	9	3,093	1,610	5,875
Yukon-Kuskokwim Health Corporation	57,554	4,079	5,913	21,077	88,623
ARIZONA	**197,437**	**17,594**	**7,697**	**50,106**	**272,834**
Ak-Chin Indian Community	42	0	7	9	57
Gila River Indian Community	76,782	8,807	1,815	21,002	108,406
Pascua Yaqui Tribe	15,537	240	188	3,244	19,209
Salt River Pima-Maricopa Indian Community	5,625	64	268	2,418	8,374
Tohono O'Odham Nation	35,529	3,674	2,490	6,815	48,508
Tuba City Regional Health Care Corporation	41,520	3,676	2,114	9,141	56,451
Winslow Indian Health Care Center, Inc.	22,402	1,133	814	7,479	31,828
CALIFORNIA	**83,121**	**6,221**	**3,937**	**35,993**	**129,272**
Chapa-De Indian Health Program, Inc.	6,775	370	184	3,509	10,838
Consolidated Tribal Health Project, Inc.	3,924	105	105	1,502	5,636
Feather River Tribal Health, Inc.	5,944	1,526	168	1,946	9,583
Hoopa Valley Tribe	5,283	302	270	2,293	8,148
Indian Health Council, Inc.	8,655	289	284	3,727	12,954
Lake County Tribal Health Consortium, Inc	6,565	1,004	171	2,596	10,336
Karuk Tribe of California	3,102	208	94	1,471	4,876
Northern Valley Indian Health, Inc.	4,210	391	115	1,556	6,271
Pinoleville Pomo Nation	90	0	3	16	108
Redding Rancheria Tribe	8,073	792	589	3,432	12,886
Riverside-San Bernardino County Indian Health, Inc.	21,677	815	890	10,091	33,474
Rolling Hills Clinic	46	15	1	64	125
Santa Ynez Band of Chumash Mission Indians	1,819	94	35	645	2,593
Southern Indian Health Council, Inc.	5,247	226	866	2,402	8,741
Susanville Indian Rancheria	1,712	85	162	743	2,702

Indian Health Service
Self-Governance Funded Compacts FY 2019
(Dollars in Thousands)

Compacts by State	IHS Services	IHS Facilities	Contract Support Costs (Direct)	Contract Support Costs (Indirect)	Total
CONNECTICUT	**2,477**	**71**	**0**	**694**	**3,242**
Mohegan Tribe of Indians of Connecticut	2,477	71	0	694	3,242
FLORIDA	**7,791**	**559**	**997**	**1,900**	**11,247**
Seminole Tribe of Florida	7,791	559	997	1,900	11,247
IDAHO	**15,947**	**843**	**1,933**	**5,910**	**24,633**
Coeur D'Alene Tribe	6,133	342	1,414	3,317	11,206
Kootenai Tribe of Idaho	663	29	79	283	1,054
Nez Perce Tribe	9,152	471	441	2,310	12,374
KANSAS	**6,007**	**136**	**21**	**1,439**	**7,603**
Iowa Tribe of Kansas and Nebraska	1,250	16	0	0	1,265
Prairie Band Potawatomi Nation	4,757	121	21	1,439	6,338
LOUISANA	**1,213**	**99**	**128**	**214**	**1,654**
Chitimacha Tribe of Louisiana	1,213	99	128	214	1,654
MAINE	**3,432**	**103**	**174**	**823**	**4,532**
Penobscot Indian Nation	3,432	103	174	823	4,532
MASSACHUSETTS	**714**	**32**	**225**	**0**	**971**
Wampanoag Tribe of Gay Head	714	32	225	0	971
MICHIGAN	**28,818**	**1,197**	**2,293**	**3,358**	**35,666**
Grand Traverse Band of Ottawa and Chippewa Indians	2,898	195	318	494	3,905
Keweenaw Bay Indian Community	3,447	274	835	527	5,082
Little River Band of Ottawa Indians	2,093	70	257	335	2,755
Match-E-Be-Nash-She-Wish Band of Pottawatomi	1,155	14	27	254	1,450
Nottawaseppi Huron Band Of The Potawatomi	1,778	88	55	206	2,126
Sault Ste. Marie Tribe of Chippewa Indians	17,448	556	800	1,543	20,347
MINNESOTA	**20,839**	**773**	**2,915**	**2,299**	**26,826**
Bois Forte Band of Chippewa Indians	2,677	90	413	608	3,789
Fond du Lac Band of Lake Superior Chippewa	12,136	483	1,256	798	14,672
Mille Lacs Band of Ojibwe	4,255	188	1,229	564	6,236
Shakopee Mdewakanton Sioux Community	1,771	11	17	329	2,129
MISSISSIPPI	**37,734**	**3,811**	**1,282**	**0**	**42,827**
Mississippi Band of Choctaw Indians	37,734	3,811	1,282	0	42,827
MONTANA	**33,548**	**1,643**	**1,900**	**4,657**	**41,748**
Chippewa Cree Tribe of the Rocky Boy's Reservation	10,564	831	1,084	2,378	14,857
Confederated Salish and Kootenai Tribes of the Flathead Nation	22,984	812	816	2,279	26,891
NEBRASKA	**17,599**	**2,572**	**1,702**	**2,926**	**24,799**
Winnebago Tribe of Nebraska	17,599	2,572	1,702	2,926	24,799
NEW MEXICO	**12,722**	**203**	**1,368**	**2,130**	**16,422**
Pueblo of Jemez	9,821	160	995	1,649	12,625
Pueblo of Sandia	1,982	39	155	238	2,415
Taos Pueblo	919	4	217	243	1,383
NEW YORK	**8,817**	**324**	**330**	**1,930**	**11,402**
St. Regis Mohawk Tribe	8,817	324	330	1,930	11,402
NEVADA	**28,734**	**1,258**	**2,243**	**7,587**	**39,822**
Duck Valley Shoshone-Paiute Tribes	6,957	476	794	1,864	10,091
Duckwater Shoshone Tribe	1,091	18	207	1,131	2,447
Ely Shoshone Tribe	1,347	15	65	418	1,845
Fort McDermitt Paiute and Shoshone Tribe	1,626	95	7	210	1,939
Las Vegas Paiute Tribe	3,466	65	123	310	3,964
Reno-Sparks Indian Colony	7,056	309	696	1,815	9,876
Washoe Tribe of Nevada and California	5,134	187	243	1,579	7,142
Yerington Paiute Tribe of Nevada	2,056	92	107	261	2,517
NORTH CAROLINA	**26,301**	**1,084**	**1,027**	**8,352**	**36,764**
Eastern Band of Cherokee Indians	26,301	1,084	1,027	8,352	36,764
NORTH DAKOTA	**11,006**	**292**	**1,579**	**1,171**	**14,048**
Spirit Lake Tribe	11,006	292	1,579	1,171	14,048

Indian Health Service
Self-Governance Funded Compacts FY 2019
(Dollars in Thousands)

Compacts by State	IHS Services	IHS Facilities	Contract Support Costs (Direct)	Contract Support Costs (Indirect)	Total
OKLAHOMA	**485,361**	**60,935**	**42,330**	**98,833**	**687,459**
Absentee Shawnee Tribe of Oklahoma	18,166	1,626	1,995	8,315	30,101
Cherokee Nation	165,652	22,290	14,177	25,399	227,519
Chickasaw Nation	85,821	16,437	10,449	18,453	131,161
Choctaw Nation of Oklahoma	88,450	12,826	6,568	24,486	132,330
Citizen Potawatomi Nation	22,194	1,674	1,693	9,257	34,818
Kaw Nation of Oklahoma	2,915	107	218	689	3,930
Kickapoo Tribe of Oklahoma	9,977	162	299	1,612	12,051
Modoc Tribe of Oklahoma	51	50	6	15	121
Muscogee Creek Nation	51,912	4,612	5,848	4,440	66,813
Northeastern Tribal Health System	7,687	92	158	1,175	9,112
Osage Nation	12,907	100	382	1,968	15,356
Ponca Tribe of Oklahoma	6,090	66	244	844	7,244
Quapaw Tribe of Oklahoma	159	0	30	83	272
Sac and Fox Nation of Oklahoma	9,887	78	171	1,043	11,179
Seminole Nation of Oklahoma	498	709	51	253	1,511
Wyandotte Nation	2,996	104	40	799	3,940
OREGON	**32,382**	**976**	**2,903**	**12,174**	**48,435**
Confederated Tribes of Grand Ronde	7,627	115	590	2,453	10,785
Confederated Tribes of Siletz Indians of Oregon	8,123	211	787	4,258	13,378
Confederated Tribes of the Coos, Lower Umpqua & Siuslaw Indians	1,860	58	308	564	2,789
Confederated Tribes of the Umatilla Reservation	8,935	318	773	2,735	12,761
Coquille Indian Tribe	2,119	86	244	1,378	3,826
Cow Creek Band of Umpqua Tribe of Indians	3,719	188	201	787	4,895
UTAH	**7,869**	**66**	**1,847**	**3,425**	**13,208**
Utah Navajo Health System, Inc.	7,869	66	1,847	3,425	13,208
WASHINGTON	**61,489**	**2,663**	**3,053**	**22,079**	**89,284**
Cowlitz Indian Tribe	7,054	116	24	1,219	8,414
Jamestown S'Klallam Indian Tribe	1,313	57	97	506	1,973
Kalispel Tribe of Indians	1,117	53	23	88	1,281
Lower Elwha Klallam Tribe	1,923	87	115	464	2,589
Lummi Indian Nation	8,274	465	284	3,696	12,719
Makah Indian Tribe	4,026	265	320	1,388	5,999
Muckleshoot Tribe	7,444	269	221	3,709	11,643
Nisqually Indian Tribe	2,373	106	122	468	3,068
Port Gamble S'Klallam Tribe	2,698	143	150	2,045	5,036
Quinault Indian Nation	5,755	424	242	1,820	8,241
Samish Indian Nation	1,166	3	99	409	1,678
Shoalwater Bay Indian Tribe	1,825	41	309	846	3,020
Skokomish Indian Tribe	2,123	71	123	519	2,837
Squaxin Island Indian Tribe	2,830	171	218	1,155	4,373
Suquamish Tribe	1,780	24	163	945	2,912
Swinomish Indian Tribal Community	2,314	52	195	1,072	3,633
Tulalip Tribes of Washington	7,474	314	350	1,730	9,867
WISCONSIN	**35,287**	**1,486**	**2,550**	**4,629**	**43,952**
Forest County Potawatomi Community	2,010	218	778	379	3,385
Ho-Chunk Nation	8,261	551	939	863	10,614
Oneida Tribe of Indians of Wisconsin	21,699	526	330	2,614	25,169
Stockbridge-Munsee Community	3,317	192	504	773	4,785
Grand Total	**1,611,473**	**153,205**	**141,695**	**449,701**	**2,356,075**

Indian Health Service
FY 2019 Self-Governance Funding Agreements
By Area
(Dollars in Thousands)

Area	Program Tribal Shares	Area Office Tribal Shares	Headquarters Tribal Shares	Contract Support Costs (Direct)	Contract Support Costs (Indirect)	Total
ALASKA	465,670	13,459	9,397	57,102	176,306	721,934
ALBUQUERQUE	11,675	924	326	1,368	2,130	16,422
BEMIDJI	84,849	1,856	1,695	7,759	10,286	106,445
BILLINGS	32,400	1,882	909	1,900	4,657	41,748
CALIFORNIA	83,590	3,346	2,406	3,937	35,993	129,272
GREAT PLAINS	29,942	1,188	338	3,282	4,096	38,846
NASHVILLE	92,631	5,058	1,442	4,319	14,680	118,129
NAVAJO	72,514	2,119	2,032	4,776	20,045	101,487
OKLAHOMA	527,753	11,069	13,617	42,352	100,272	695,063
PHOENIX	117,778	1,930	1,603	4,333	31,015	156,660
PORTLAND	107,511	3,718	3,071	7,890	40,163	162,352
TUCSON	51,651	2,582	747	2,679	10,058	67,717
Total, IHS	**1,677,965**	**49,130**	**37,583**	**141,696**	**449,701**	**2,356,075**

THIS PAGE INTENTIONALLY LEFT BLANK

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2021 Performance Budget Submission to Congress

TABLE OF CONTENTS

Nonrecurring Expenses Fund

THIS PAGE INTENTIONALLY LEFT BLANK

Nonrecurring Expenses Fund
Budget Summary

Indian Health Service

(Dollars in Thousands)

Notification[1]	FY 2019[2]	FY 2020[3]	FY 2021[4]
IHS NEF	**$185,000**	**TBD**	**TBD**

1 Pursuant to Section 223 of Division G of the Consolidated Appropriation Act, 2008, notification is required of planned use.
2 Notification submitted to the Committees on Appropriations in the House of Representatives and the Senate on December 4, 2018.
3 HHS has not yet notified for FY 2020.
4 HHS has not yet notified for FY 2021.

Authorization Legislation……Section 223 of Division G of the Consolidated Appropriations Act, 2008
Allocation Method……..Direct Federal, Competitive Contract

Program Description and Accomplishments

The Nonrecurring Expenses Fund (NEF) permits HHS to transfer unobligated balances of expired discretionary funds into the NEF account. Congress authorized use of the funds for capital acquisitions necessary for the operation of the Department, specifically information technology (IT) and facilities infrastructure acquisitions.

Information Technology Related Accomplishments

The Indian Health Service (IHS) Health Information Technology (HIT) Program uses secure and reliable information technology (IT) in innovative ways to improve health care delivery and quality, enhance access to care, reduce medical errors, and modernize administrative functions. IHS HIT provides support for the IHS, Tribal, and Urban (I/T/U) programs that care for 2.6 million American Indian and Alaska Native (AI/AN) people across the Indian health system. IHS provides the technology infrastructure for a nationwide health care system, including a secure wide area network, enterprise e- mail services, and regional and national Help Desk support for approximately 20,000 network users. IHS HIT also supports the mission-critical health care operations of the I/T/U with comprehensive health information solutions including an Electronic Health Record (EHR) and more than eighty applications. The IHS HIT program directly supports better ways to 1) care for patients, 2) pay providers, 3) refer care when needed 4) recover costs, and 5) distribute information, resulting in better care, wiser spending of our health dollars, and healthier communities, economy, and country.

NEF funds have allowed IHS to make capital investments through the Health IT Systems and Support (HITSS) project, enabling targeted upgrades toward its quarterly release schedule for the IHS electronic health records system software applications. New upgrades/accomplishments include:

- **Improving Patient Care Program (IPC):** Made critical upgrades to the iCare capability, National Patient Information Reporting System (NPIRS), and Clinical Reporting System (CRS) as part of IPC to support field level quality improvement activities.

- **Bar Code Medication Administration (BCMA):** Continued implementation of a VA-developed

[1] Pursuant to Section 223 of Division G of the Consolidated Appropriation Act, 2008, notification is required of planned use.

BCMA solution, which is designed to prevent medication errors in healthcare settings and improve the quality and safety of medication administration, across the Indian health system.

- **Emergency Department (ED) Whiteboard**: Developed and implemented the ED Whiteboard to facilitate the electronic tracking of patients. The ED Whiteboard will support clinical staff to avoid mistakes that could lead to patient safety issues.

- **Suicide Risk Assessment**: Created a report to track results of the RPMS Suicide Risk Assessment, which previously would have been a manual process of counting records. This allows sites to locally track their suicide intervention efforts, which may be used to report on grants, such as the Methamphetamine and Suicide Prevention Initiative (MSPI).

- **New Medicare Card Initiative Phases I & II**: Developed and implemented Phase 1 of NMCI facilitating the documentation in RPMS of newly issued Medicare Beneficiary ID numbers; began NMCI Phase II development work.

- **Windows 10 Infrastructure Upgrade**: Upgraded the EHR and HITSS components to support migration to modernized platform; successfully tested, on behalf of the Department of Veterans Affairs and IHS, VistA Imaging (VI) against Win10 and gained FDA approval to use VI across over 400 sites.

- **Medication Information Management, Prescription Drug Monitoring**: Development related to the Medication Information Management and Prescription Drug Monitoring program (PDMP). continued to support final phases for meeting the DEA regulations and HHS Office of National Coordinator (ONC) 2014 certification requirements for the IHS mandated project Electronic Prescribing of Controlled Substance (EPCS)

Facilities Accomplishments

The IHS Facility Construction Program has received $258.3 million for 24 projects funded by NEF allocations since 2015. One priority project, the Phoenix Indian Medical Center SE, Phoenix, AZ was completed. In addition, 95 staff quarters units and one dental unit was completed.

The IHS Biomedical program received $70 million to replace over-age medical equipment. IHS Area Offices held numerous Biomedical Equipment Governance Committee meetings to review and prioritize the most pressing equipment needs to maintain accreditation/health delivery at the service units/healthcare sites. These funds were distributed to procure prioritized medical equipment across ten IHS Area Offices, and have allowed replacement of a wide range of equipment including mobile mammography equipment, digital radiology, central patient monitoring systems, nurse call systems, x-rays, ultrasounds, fetal monitoring systems, medical pumps, dental equipment.

FY 2019 Budget Allocation

For FY 2019, HHS notified for $185 million in NEF funds for IHS to address the Health Care Facilities Construction Priority List backlog and modernize IHS' aging health IT systems. These investments will facilitate improved access to modern facilities and data systems for health care providers and support accurate clinical diagnosis and effective therapeutic procedures to assure the best possible health outcomes.

Information Technology - $64,615,000

- **Infrastructure Modernization, $30,480,000:**

IHS will make critical investments to modernize the IT infrastructure, reducing operating costs, increasing the security and reliability of IHS's IT systems, and making key improvements necessary to the replacement of IHS's Resource and Patient Management System (RPMS). IHS's primarily rural health care facility network often lack reliable high speed data connects, a critical limitation in reducing IHS's EHR record from hundreds of separately maintained instances down to a single one. In addition, replacements for IHS's network infrastructure equipment will be acquired and installed. The Albuquerque Data Center will be modernized, with new storage, backup, and server systems being acquired and deployed.

Key activities with these funds include:
- EaaS transition to Microsoft Office 365 Email
- Albuquerque Data Center Modernization
  Replacement of Virtual Private Network (VPN) Gateway Appliance, Lifecycle Replacement of Routers and Switches, and Lifecycle Replacement of Voice Equipment
- Network Bandwidth Upgrades to Support EHR Modernization
- Network Switch Upgrades for Rural Healthcare Facilities

- **IT Security Operations, $465,000**
  IHS will purchase forensic hardware, lab equipment and improved network resources to improve its IT security capabilities and enable improved cybersecurity log retention.

- **IT Governance, $7,875,000**
  These funds will allow IHS to acquire and implement a Portfolio & Project Management System, critical to managing a billion dollar investment in modernized IT systems. IHS will also invest in the capital planning / architecture development necessary to implement a new EHR system.

- **Health IT Systems and Support Capabilities Expansion, $25,795,000**
  HITSS investments will acquire and deploy components to modernized IHS's Health Information Exchange (HIE), purchase upgrades to the 3rd Party Billing and Accounts Receivable system, and design and deploy a improved IHS National Data Warehouse (NDW); along with other key investments.

Facilities Funding - $120,332,562

With NEF funds, IHS will engage in a program of critical facility replacements, renovations and improvements to existing facilities and address key equipment issues:
- $35,933,000 will support three facility replacements in Arizona, Alaska and New Mexico,
- $83,199,562 will provide for renovation, improvement and expansion of 6 facilities across the US, including in Oklahoma, Minnesota, South Dakota, Arizona and Alaska, and
- $1,200,000 will support the HVAC replacement of an Alaska based facility.

Indian Health Service, FY2019 NEF Funding

IHS Investment Categories	Amount Allocated
IT Capital Investment	**$64,615,000**
Infrastructure Modernization	**$30,480,000**
IT Security Operations	**$465,000**
IT Governance	**$7,875,000**

Health IT Systems and Support (HITSS) Capabilities Expansion	**$25,795,000**
Facility Capital Investment	**$120,332,562**
Renovation and Improvements	**$83,199,562**
Facility Replacement	**$35,933,000**
Equipment Replacement/Improvement	**$1,200,000**
Total IHS NEF Investment[5]	**$184,947,562**

[5]Amount is the allocation within the total amount notified for FY 2019.