DEPARTMENT OF HEALTH AND HUMAN SERVICES

Fiscal Year 2020

Indian Health Service

Justification of Estimates for Appropriations Committees

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Indian Health Service
Rockville, MD 20857

MAR 2 2 2019

I present the Indian Health Service (IHS) Fiscal Year (FY) 2020 Congressional Justification. The FY 2020 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 emphasis on bolstering direct medical services and expanding our efforts to improve medical quality at all IHS facilities.

This FY 2020 budget submission continues support for our critical work in providing a comprehensive health service delivery system managed by IHS, Tribes, and Urban Indian health programs 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 2020 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 newly published 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.

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 new 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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE

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

Date: 02/28/2019

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2020 Performance Budget Submission to Congress

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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[1]. 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.

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

INDIAN HEALTH SERVICE
Fiscal Year 2020 Budget Submission to Congress

Overview of Budget

The fiscal year (FY) 2020 Indian Health Service (IHS) Budget encompasses the integrated key priorities of people, partnerships, quality, and resources in carrying out the agency mission to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives (AI/AN) to the highest level. The Budget conveys the President's strong support of health care services for AI/ANs. While national priorities dictate fiscal austerity, this budget reflects the importance of providing health care, consistent with statutory authorities, to AI/ANs. This supports the President's agenda to address the Nation's priorities through careful investments of taxpayer resources. In addition, the budget supports the HHS Secretary's priority to combat the opioid crisis by increasing access to treatment and reducing opioid overdose-related deaths through prevention, treatment, and recovery options.

In pursuing our mission, IHS's strategic goal is to ensure that comprehensive, culturally acceptable personal and public health services are available and accessible to AI/AN people. The IHS provides a wide range of clinical, public health, community, and facilities infrastructure services to approximately 2.6 million AI/ANs who are primarily members of 573 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[1]. These facilities are predominately primary care settings and are managed by IHS, tribal, and urban (I/T/U) Indian health programs.

Tribal consultation is integral to the IHS budget process. The core of the agency's formulation process consists of the priorities and recommendations developed in consultation with Tribes through an independent annual budget formulation process.[2] This process is one to which the IHS is strongly committed, and which helps IHS ensure that this budget is relevant to the health needs and priorities of AI/AN tribes. The tribal priorities identified in the 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 include those priorities in their individual budget requests. The tribal budget consultation process is a key component of the IHS priority to build, strengthen, and sustain collaborative relationships that advance the IHS mission.

Summary of Budget Submission

The total discretionary budget authority for IHS is $5.9 billion, an increase of $391.5 million above an FY 2019 Annualized Continuing Resolution (CR). Major increases include:

Current Services: +$68.8 Million

The budget partially funds estimated current services, including medical and non-medical inflation, pay costs, and population growth, which are necessary annually to maintain health care services at the current

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

[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.

year level. Current services prevents the erosion of purchasing power. Without this funding, costs are absorbed by the programs, leading to reduced levels of health care services and access to care.

- Pay Costs (Federal and Tribal): +$3.8 million
- Inflation: +$28.4 million
- Population Growth: +$36.7 million

Staffing and Operating Costs for Newly-constructed Health Care Facilities: +$97.5 million

The budget fully funds staffing and operating costs for four newly-constructed health care facilities, including three joint venture facilities.

- Cherokee Nation Regional Health Center (JV), OK: +$78.5 million
- Yakutat Tlingit Tribe Health Center (JV), AK: +$3.8 million
- Northern California Youth Regional Treatment Center, CA: +$7.4 million
- Ysleta Del Sur Health Center, (JV), TX: +$7.8 million

Major Program Increases: +$375.1 Million

- Direct Health Care Services: +146.6 million to expand access to hospitals and health clinics, dental health, mental health, and alcohol and substance abuse.

- Contract Support Costs: +$137.0 million to support self-determination by fully funding contract support costs for Tribes that manage their own programs (CJ-197).

- Electronic Health Record Modernization: +$25.0 million to support the IHS Electronic Health Record System transition (CJ-88).

- Ending the Hepatitis C and HIV/AIDs Epidemic in Indian Country: +$25.0 million to provide an estimated 1,800 patients with treatment and case management services to prevent and treat Hepatitis C infection due to injection drug use and fund data collection to measure outcomes. The initiative would also enhance HIV testing and linkages to care in support of the Ending HIV Epidemic Initiative (CJ-64).

- National Community Health Aide Program: +$20.0 million to begin transition from the Community Health Representatives Program to the National Community Health Aide Program, which would provide outcomes driven in-home clinical health care services (CJ-67).

- New Tribes: +$11.5 million to fully fund the delivery of health care services for six newly federally-recognized Tribes, including Monacan Nation, Rappahannock Tribe, Nansemond Indian Tribe, Upper Mattaponi Tribe, Chickahominy Indian Tribe Eastern Division, and the Chickahominy Indian Tribe (CJ-67).

- Recruitment & Retention: +$8.0 million to provide competitive employment packages, including a housing subsidy for critical positions with high vacancies at remote sites and increased pay through the use of Title 38 (CJ-68).

- Quality and Oversight: +$2.0 million to implement evidence-based tools and practices, including patient centered care, patient outreach, and chronic disease management; and improve performance outcomes reporting and administrative systems to improve IHS's quality of care. Funds will also increase national quality and oversight capacity to assure an efficient, accountable, and high-performing agency (CJ-68).

Overview of Agency Performance

The IHS, in consultation with Tribes, Tribal Organizations, and Urban Indian Organizations, provides comprehensive, culturally acceptable personal and public health services to approximately 2.6 million American Indians and Alaska Natives (AI/AN) in 37 states.[1]

The IHS mission is to raise the physical, mental, social, and spiritual health of AI/ANs to the highest level. In February 2019, the IHS released the Strategic Plan (FY) 2019-2023 with three strategic goals and eight objectives:

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.
- Objective 1.2: Build, strengthen, and sustain collaborative relationships.
- Objective 1.3: Increase access to quality health care services.

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

- Objective 2.1: Create quality improvement capability at all levels of the organization.
- Objective 2.2: Provide care to better meet the health care needs of American Indian and Alaska Native communities.

Goal 3: To strengthen IHS program management and operations.

- 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.
- Objective 3.3: Modernize information technology and information systems to support data driven decisions.

The IHS performance measures support the goals and objectives listed above and are represented in the outcomes and outputs tables in the budget request. IHS performance improvement is a concerted effort by all members of the Indian health system working together to accomplish a comprehensive set of existing performance measures. This includes all clinic-based, hospital-based, and community-based programs administered by federal, tribal and urban programs. The IHS budget request reflects Government Performance and Results Act (GPRA) and GPRA Modernization Act (GPRAMA) measures that support our strategic goals and improvement of AI/AN health outcomes.

Performance Management

IHS cascades performance goals and objectives and performance-related metrics agency-wide, and realigns 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

[1] The IHS produces statistical information and publications that measure and document the progress in assuring access to health care services and improving the health status of AI/ANs, publications are available at: https://www.ihs.gov/dps/index.cfm/publications.

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.

Performance Reporting

Tribes administer over one-half of IHS resources through Indian Self-Determination and Education Assistance Act contracts and compacts and the Agency's performance management activity primarily reflects the IHS programs. However, there are several tribal programs that choose to participate in GPRA/GPRAMA performance reporting. The IHS budget measures are focused on monitoring population health (clinical measures) and strategies to assess program trends and management (non-clinical measures).

Consistent with the GPRA/GPRAMA, IHS continues to report valid and reliable clinical measures. Additionally, IHS' measures support HHS' performance product, the FY 2020 Annual Performance Plan and Report (APP/R). In FY 2020, IHS will report on two GPRAMA measures included in the HHS APP/R:

- Intimate Partner (Domestic) Violence (IP DV) Screening
  Supports FY 2018-2022 HHS Strategic Objective 3.2
- Increase telebehavioral health encounters nationally
  Supports FY 2018-2022 HHS Strategic Objective 1.3

IHS has reported electronic population level results for GPRA/GPRAMA clinical measures since 2002. The FY 2018 clinical measure results reported in the FY 2020 budget are generated from the Integrated Data Collection System Data Mart (IDCS DM). FY 2018 is the first year of reporting from IDCS DM and is a major performance reporting change for the Agency, as measure results can be calculated using any data (RPMS, non-RPMS or Fiscal Intermediary) submitted to the National Data Warehouse (NDW). With this change, IHS reports aggregated federal, tribal and urban (I/T/U) results for the first time. Tribal programs continue to have the option to participate. The IDCS DM, IHS' centralized performance data mart, produces aggregated, clinical performance measure results at an on-demand basis.

Since 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 of the following reasons:

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

National clinical GPRA/GPRAMA results now include urban data.

All Purpose Table
Indian Health Service
(Dollars in Thousands)

Program	FY 2018 Final[5]	FY 2019[6] Annualized CR	FY 2020 President's Budget	FY 2020 President's Budget +/- FY 2019 Annualized CR
SERVICES:				
CLINICAL SERVICES:				
Hospitals & Health Clinics	2,055,128	2,054,562	2,363,278	308,716
Electronic Health Record System (NEW)	--	--	25,000	25,000
Dental Health	193,283	197,013	212,370	15,357
Mental Health	98,900	100,682	109,825	9,143
Alcohol & Substance Abuse	224,188	228,093	246,034	17,941
Purchased/Referred Care	962,695	963,517	968,177	4,660
Indian Health Care Improvement Fund	72,280	72,280	72,280	--
Subtotal, Clinical Services	3,606,474	3,616,147	3,996,964	380,817
PREVENTIVE HEALTH:				
Public Health Nursing	84,043	85,936	92,084	6,148
Health Education[1]	19,322	20,017	--	-20,017
Comm. Health Reps	61,888	62,888	24,000	-38,888
Immunization Programs (Alaska)	2,058	2,127	2,173	46
Subtotal, Preventive Health	167,311	170,968	118,258	-52,710
OTHER SERVICES:				
Urban Health	48,533	49,315	48,771	-544
Indian Health Professions	49,363	49,363	43,612	-5,751
Tribal Management Grant Program[2]	2,465	2,465	--	-2,465
Direct Operations	72,338	72,338	74,131	1,793
Self-Governance	5,806	5,806	4,807	-999
Subtotal, Other	178,505	179,287	171,320	-7,966
Total, Services	**3,952,290**	**3,966,402**	**4,286,541**	**320,140**
FACILITIES:				
Maintenance & Improvement	167,527	167,527	168,568	1,041
Sanitation Facilities Construction	192,033	192,033	193,252	1,219
Health Care Facilities Construction	243,480	243,480	165,810	-77,670
Facil. & Envir. Health Support	240,758	241,958	251,413	9,455
Equipment	23,706	23,706	23,983	277
Total, Facilities	**867,504**	**868,704**	**803,026**	**-65,678**
Total, Services & Facilities	**4,819,794**	**4,835,106**	**5,089,567**	**254,462**
CONTRACT SUPPORT COSTS[3]:				
Contract Support Costs	762,642	717,970	855,000	137,030
Total, Contract Support Costs	**762,642**	**717,970**	**855,000**	**137,030**
Total, Budget Authority	**5,582,436**	**5,553,076**	**5,944,567**	**391,492**
COLLECTIONS[7]:				
Medicare Collections	248,638	248,638	248,638	--
Medicaid Collections	807,605	807,605	807,605	--
Subtotal M/M	1,056,243	1,056,243	1,056,243	--
Private Insurance	109,272	109,272	109,272	--
VA/IHS Agreement	28,062	28,062	28,062	--
Subtotal M/M/PI	1,193,577	1,193,577	1,193,577	--
Rental of Staff Quarters	8,500	8,500	8,500	--
Total, Collections	**1,202,077**	**1,202,077**	**1,202,077**	--
MANDATORY:				
Special Diabetes Program for Indians	150,000	150,000	150,000	--
Total, Mandatory	**150,000**	**150,000**	**150,000**	--
Total, Program Level	**6,934,513**	**6,905,153**	**7,296,644**	**391,492**
Nonrecurring Expenses Fund[4]	N/A	185,000	N/A	N/A
Total, NEF	**N/A**	**185,000**	**N/A**	**N/A**

[1]The Health Education program is proposed for discontinuation in the FY 2020 Budget.

[2]The Tribal Management Grants program is proposed for discontinuation in the FY 2020 Budget.

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

[4]There was no Congressional notification for the planned use of the NEF funds in FY 2018. HHS has not yet notified for FY 2020.

[5]Reflects actual Contract Support Costs and a $25 million reprogramming notified to Congress on August 28, 2018.

[6]Reflects the annualized level of the continuing resolution and directed or permissive transfers. Includes an anomaly of $15.3 million for staffing of newly-constructed health care facilities.

[7]All FY 2018 collections totals represent estimates.

INDIAN HEALTH SERVICE

FY 2020 President's Budget

Detail of Changes

(Dollars in Thousands)

Program	FY 2018 Final	FY 2019 Annualized CR	Current Services: Pay Costs 3.1% [5]	Current Services: Inflation Non-Med 1.02%	Current Services: Inflation Medical 1.04%	Current Services: Inflation Total	Current Services: Pop Growth 1.8%	Current Services Total	FY 2020: FY 2020 Staffing of New Facilities	FY 2020: Electronic Health Record	FY 2020: Contract Support Cost	FY 2020: Hep C & HIV/AIDS	FY 2020: CHAP	FY 2020: Recruit/ Retain	FY 2020: Quality & Oversight	FY 2020: New Tribes (6 VA)[6]	FY 2020: Former 'NIAAA Transfer to Urban	FY 2020: *Program Adjustments*	FY 2020: Sub-Total Program Increases	FY 2020: **President's Budget**
SERVICES																				
Hospitals & Health Clinics	2,055,128	2,054,562	2,083	1,538	14,298	15,836	25,025	42,944	71,762	--	--	25,000	20,000	8,000	2,000	11,463	--	127,547	308,716	2,363,278
Electronic Health Record System (NEW)	--	--	--	--	--	--	--	--	--	25,000	--	--	--	--	--	--	--	--	25,000	25,000
Dental Health	193,283	197,013	343	59	1,378	1,437	1,759	3,539	4,841	--	--	--	--	--	--	--	--	6,977	15,357	212,370
Mental Health	98,900	100,682	54	13	825	838	908	1,800	2,754	--	--	--	--	--	--	--	--	4,589	9,143	109,825
Alcohol & Substance Abuse	224,188	228,093	41	35	2,149	2,184	2,031	4,256	7,612	--	--	--	--	--	--	--	-1,369	7,442	17,941	246,034
Purchased/Referred Care	962,695	963,517	--	--	2,544	2,544	2,116	4,660	--	--	--	--	--	--	--	--	--		4,660	968,177
Indian Health Care Improvement Fund	72,280	72,280	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	72,280
Total Clinical Services	3,606,474	3,616,147	2,521	1,645	21,194	22,839	31,839	57,199	86,969	25,000	--	25,000	20,000	8,000	2,000	11,463	-1,369	146,555	380,817	3,996,964
Public Health Nursing	84,043	85,936	147	11	625	636	751	1,534	3,431	--	--	--	--	--	--	--	--	1,183	6,148	92,084
Health Education[1]	19,322	20,017	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	-20,017	-20,017	--
Community Health Representatives	61,888	62,888	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	-38,888	-38,888	24,000
Immunization AK	2,058	2,127	--	--	21	21	18	39	--	--	--	--	--	--	--	--	--	7	46	2,173
Total Preventive Health	167,311	170,968	147	11	646	657	769	1,573	3,431	--	--	--	--	--	--	--	--	-57,715	-52,710	118,258
Urban Health	48,533	49,315	20	42	413	455	401	876	--	--	--	--	--	--	--	--	1,369	-2,789	-544	48,771
Indian Health Professions	49,363	49,363	17	416	--	416	--	433	--	--	--	--	--	--	--	--	--	-6,184	-5,751	43,612
Tribal Management Grants[2]	2,465	2,465	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	-2,465	-2,465	--
Direct Operations	72,338	72,338	92	315	--	315	--	407	--	--	--	--	--	--	--	--	--	1,386	1,793	74,131
Self-Governance	5,806	5,806	--	15	--	15	--	15	--	--	--	--	--	--	--	--	--	-1,014	-999	4,807
Total Other Services	178,505	179,287	129	788	413	1,201	401	1,731	--	--	--	--	--	--	--	--	1,369	-11,066	-7,966	171,320
TOTAL, SERVICES	**3,952,290**	**3,966,402**	**2,797**	**2,444**	**22,253**	**24,697**	**33,009**	**60,503**	**90,400**	**25,000**	**--**	**25,000**	**20,000**	**8,000**	**2,000**	**11,463**	**--**	**77,773**	**320,140**	**4,286,541**
FACILITIES																				
Maintenance & Improvement	167,527	167,527	--	771	--	771	654	1,425	--	--	--	--	--	--	--	--	--	-384	1,041	168,568
Sanitation Facilities Construction	192,033	192,033	--	666	--	666	878	1,544	--	--	--	--	--	--	--	--	--	-325	1,219	193,252
Health Care Facilities Construction	243,480	243,480	--	810	--	810	--	810	--	--	--	--	--	--	--	--	--	-78,480	-77,670	165,810
Facilities & Environ Health Support	240,758	241,958	965	1,002	241	1,243	1,975	4,183	7,073	--	--	--	--	--	--	--	--	-1,801	9,455	251,413
Equipment	23,706	23,706	--	16	193	209	172	381	--	--	--	--	--	--	--	--	--	-104	277	23,983
Total Facilities	867,504	868,704	965	3,265	434	3,699	3,679	8,343	7,073	--	--	--	--	--	--	--	--	-81,094	-65,678	803,026
TOTAL, SERVICES & FACILITIES	**4,819,794**	**4,835,106**	**3,762**	**5,709**	**22,687**	**28,396**	**36,688**	**68,845**	**97,473**	**25,000**	**--**	**25,000**	**20,000**	**8,000**	**2,000**	**11,463**	**--**	**-3,321**	**254,462**	**5,089,567**
CONTRACT SUPPORT COSTS[3]																				
Total Contract Support Costs	**762,642**	**717,970**	--	--	--	--	--	--	--	--	**137,030**	--	--	--	--	--	--	--	**137,030**	**855,000**
TOTAL, BUDGET AUTHORITY	**5,582,436**	**5,553,076**	**3,762**	**5,709**	**22,687**	**28,396**	**36,688**	**68,845**	**97,473**	**25,000**	**137,030**	**25,000**	**20,000**	**8,000**	**2,000**	**11,463**	**--**	**-3,321**	**391,492**	**5,944,567**
MANDATORY																				
Special Diabetes Program for Indians (SDPI)[4]																				
Subtotal, Special Diabetes Program for Indians	150,000	150,000	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	150,000
Total, Mandatory	**150,000**	**150,000**	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	**150,000**
TOTAL, IHS Appropriations	**5,732,436**	**5,703,076**	**3,762**	**5,709**	**22,687**	**28,396**	**36,688**	**68,845**	**97,473**	**25,000**	**137,030**	**25,000**	**20,000**	**8,000**	**2,000**	**11,463**	**--**	**-3,321**	**391,492**	**6,094,567**

[1]The Health Education program is proposed for discontinuation in the FY 2020 Budget.

[2]The Tribal Management Grants program is proposed for discontinuation in the FY 2020 Budget.

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

[4]The Budget requests a two year extension of the Special Diabetes Program for Indians through FY 2021.

[5]Pay Costs cover Commissioned Corps pay increases only.

[6]Funding for New Tribes is currently reflected in Hospital & Health Clinics. However, final funding will need to be reflected in the appropriate Program, Project, or Activity (PPA or budget line) when these numbers are identified.

INDIAN HEALTH SERVICE

STAFFING and OPERATING COSTS FOR NEWLY-CONSTRUCTED HEALTHCARE FACILITIES

FY 2020 Budget -- Estimates

(Dollars in Thousands)

	Tahlequah, OK Cherokee Nation Regional Health Center (JV)		Yakutat, AK Yakutat Tlingit Health Center (JV)		Davis, CA Northern California Youth Regional Treatment Center		El Paso, TX Ysleta Del Sur Health Center (JV)				
Opening Date	July 2019		July 2019		July 2019		May 2020		**TOTAL**		
Sub Sub Activity	Pos	Amount	Pos	Amount	FTE	Amount	Pos	Amount	**FTE**	**Pos**	**AMOUNT**
Hospitals & Health Clinics	506	$64,931	9	$1,485	0	$0	46	$5,346	0	561	$71,762
Dental Health	37	$3,155	3	$1,116	0	$0	5	$570	0	45	$4,841
Mental Health	19	$2,137	2	$272	0	$0	3	$345	0	24	$2,754
Alcohol & Substance Abuse	7	$781	0	$0	65	$6,696	1	$135	65	8	$7,612
Purchased/Referred Care	0	$0	0	$0	0	$0	0	$0	0	0	$0
Total, Clinical Services	569	$71,004	14	$2,873	65	$6,696	55	$6,396	65	638	$86,969
Public Health Nursing	16	$2,231	4	$596	0	$0	4	$604	0	24	$3,431
Health Education[1]	0	$0	0	$0	0	$0	0	$0	0	0	$0
Comm. Health Representatives	0	$0			0	$0	0	$0	0	0	$0
Total, Preventive Health	16	$2,231	4	$596	0	$0	4	$604	0	24	$3,431
Total, Services	585	$73,235	18	$3,469	65	$6,696	59	$7,000	65	662	$90,400
Facilities Support	8	$4,648	1	$286	5	$741	3	$676	5	12	$6,351
Environmental Health Support	4	$555	1	$16	0	$0	1	$151	0	6	$722
Total, FEHS	12	$5,203	2	$302	5	$741	4	$827	5	18	$7,073
Total, Facilities	12	$5,203	2	$302	5	$741	4	$827	5	18	$7,073
Grand Total[2]	**597**	**$78,438**	**20**	**$3,771**	**70**	**$7,437**	**63**	**$7,827**	**70**	**680**	**$97,473**

[1]The Health Education program is proposed for discontinuation in the FY 2020 Budget.

[2]Includes Utilities

Statement of Personnel Resources
INDIAN HEALTH SERVICE

	FY 2018 Final	FY 2019 Annual CR	FY 2020 PB
Direct:			
Hospitals & Health Clinics	5,950	5,950	6,011
Dental Health	556	556	556
Mental Health	183	183	183
Alcohol & Substance Abuse	232	232	297
Purchased/Referred Care	0	0	0
Total, Clinical Services	6,921	6,921	7,047
Public Health Nursing	193	193	193
Health Education	17	17	0
Community Health Reps	3	3	3
Immunization, AK	0	0	0
Total, Preventive Health	213	213	196
Urban Health	7	7	7
Indian Health Professions	23	23	23
Tribal Management	0	0	0
Direct Operations	264	264	264
Self Governance	12	12	12
Total, SERVICES	7,440	7,440	7,549
Maint. & Improvement	0	0	0
Sanitation Facilities	119	119	119
Hlth Care Facs Construction	0	0	0
Facil. & Envir. Hlth Support	1,030	1,030	1,035
Equipment	0	0	0
Total, FACILITIES	1,149	1,149	1,154
Total, Direct FTE	8,589	8,589	8,703
Special Diabetes Program for Indians (SDPI):			
Direct	21	21	21
Reimburseable	106	106	106
Total, Special Diabetes Program for Indians	127	127	127
Reimbursable:			
Buybacks	1,247	1,247	1,247
Medicare	808	808	808
Medicaid	3,874	3,874	3,874
Private Insurance	597	597	597
Quarters	43	43	43
Total, Reimbursable FTE	6,569	6,569	6,569
TOTAL FTE	**15,285**	**15,285**	**15,399**
Total, Civilian FTE	**13,427**	**13,427**	**13,541**
Total, Military FTE	**1,858**	**1,858**	**1,858**

FY 2018 Crosswalk
Budget Authority
Final Distribution

(dollars in thousands)

Sub Activity	Federal Health Administration							Tribal Health Administration							FY 2018 Final
	Clinical Services	Preventive Health	Indian Health Professions	Federal Administration	Self-Governance	Facilities	TOTAL Federal Health Admini-stration	Clinical Services	Preventive Health	Urban Health	Management Training	Contract Support	Facilities	TOTAL Tribal Health Admini-stration	
SERVICES															
Hospitals & Health Clinics	887,614	0	0	0	0	0	887,614	1,167,514	0	0	0	0	0	1,167,514	2,055,128
Dental Health	78,798	0	0	0	0	0	78,798	114,485	0	0	0	0	0	114,485	193,283
Mental Health	40,116	0	0	0	0	0	40,116	58,784	0	0	0	0	0	58,784	98,900
Alcohol & Substance Abuse	68,400	0	0	0	0	0	68,400	155,788	0	0	0	0	0	155,788	224,188
Purchased/Referred Care	400,310						400,310	562,385						562,385	962,695
IHCIF	15,472	0	0	0	0	0	15,472	56,808	0	0	0	0	0	56,808	72,280
Subtotal (CS)	1,490,710	0	0	0	0	0	1,490,710	2,115,764	0	0	0	0	0	2,115,764	3,606,474
Public Health Nursing	0	28,988	0	0	0	0	28,988	0	55,055	0	0	0	0	55,055	84,043
Health Education	0	3,614	0	0	0	0	3,614	0	15,708	0	0	0	0	15,708	19,322
Community Health Repr.	0	1,595	0	0	0	0	1,595	0	60,293	0	0	0	0	60,293	61,888
Immunization AK	0	0	0	0	0	0	0	0	2,058	0	0	0	0	2,058	2,058
Subtotal (PH)	0	34,197	0	0	0	0	34,197	0	133,114	0	0	0	0	133,114	167,311
Urban Health Project	0	0	0	0	0	0	0	0	0	48,533	0	0	0	48,533	48,533
Indian Health Professions	0	0	49,363	0	0	0	49,363	0	0	0	0	0	0	0	49,363
Tribal Management	0	0	74	0	0	0	74	0	0	2,391	0	0	0	2,391	2,465
Direct Operations	0	0	0	53,164	0	0	53,164	0	0	0	19,174	0	0	19,174	72,338
Self-Governance	0	0	0	0	5,806	0	5,806	0	0	0	0	0	0	0	5,806
Subtotal (OS)	0	0	49,437	53,164	5,806	0	108,407	0	0	50,924	19,174	0	0	70,098	178,505
Total, Services	1,490,710	34,197	49,437	53,164	5,806	0	1,633,314	2,115,764	133,114	50,924	19,174	0	0	2,318,976	3,952,290
CONTRACT SUPPORT COSTS	0	0	0	0	0	0	0	0	0	0	0	762,642	0	762,642	762,642
FACILITIES															
Maintenance & Improvement	0	0	0	0	0	87,455	87,455	0	0	0	0	0	80,072	80,072	167,527
Sanitation Facilities Constr.	0	0	0	0	0	67,212	67,212	0	0	0	0	0	124,821	124,821	192,033
Health Care Facs. Constr.	0	0	0	0	0	122,530	122,530	0	0	0	0	0	120,950	120,950	243,480
Facs. & Env. Health Sup	0	0	0	0	0	150,331	150,331	0	0	0	0	0	90,427	90,427	240,758
Equipment	0	0	0	0	0	7,276	7,276	0	0	0	0	0	16,430	16,430	23,706
Total, Facilities	0	0	0	0	0	434,804	434,804	0	0	0	0	0	432,700	432,700	867,504
TOTAL, IHS	1,490,710	34,197	49,437	53,164	5,806	434,804	2,068,118	2,115,764	133,114	50,924	19,174	762,642	432,700	3,514,318	5,582,436
% Federal Health Admin.							37.0%								
% Tribal and Urban Health Admin.															63.0%

FY 2019 Crosswalk
Budget Authority
Estimated Distribution

(dollars in thousands)

Sub Activity	Federal Health Administration							Tribal Health Administration							FY 2019 Ann. CR
	Clinical Services	Preventive Health	Indian Health Professions	Federal Administration	Self-Governance	Facilities	TOTAL Federal Health Admini-stration	Clinical Services	Preventive Health	Urban Health	Management Training	Contract Support	Facilities	TOTAL Tribal Health Admini-stration	
SERVICES															
Hospitals & Health Clinics	887,571	0	0	0	0	0	887,571	1,166,991	0	0	0	0	0	1,166,991	2,054,562
Dental Health	85,110	0	0	0	0	0	85,110	111,903	0	0	0	0	0	111,903	197,013
Mental Health	41,279	0	0	0	0	0	41,279	59,403	0	0	0	0	0	59,403	100,682
Alcohol & Substance Abuse	68,428	0	0	0	0	0	68,428	159,665	0	0	0	0	0	159,665	228,093
Purchased/Referred Care	404,677	0	0	0	0	0	404,677	558,840	0	0	0	0	0	558,840	963,517
IHCIF	15,472	0	0	0	0	0	15,472	56,808	0	0	0	0	0	56,808	72,280
Subtotal (CS)	1,502,537	0	0	0	0	0	1,502,537	2,113,610	0	0	0	0	0	2,113,610	3,616,147
Public Health Nursing	0	29,218	0	0	0	0	29,218	0	56,718	0	0	0	0	56,718	85,936
Health Education	0	3,743	0	0	0	0	3,743	0	16,274	0	0	0	0	16,274	20,017
Community Health Repr.	0	1,634	0	0	0	0	1,634	0	61,254	0	0	0	0	61,254	62,888
Immunization AK	0	0	0	0	0	0	0	0	2,127	0	0	0	0	2,127	2,127
Subtotal (PH)	0	34,595	0	0	0	0	34,595	0	136,373	0	0	0	0	136,373	170,968
Urban Health Project	0	0	0	0	0	0	0	0	0	49,315	0	0	0	49,315	49,315
Indian Health Professions	0	0	49,363	0	0	0	49,363	0	0	0	0	0	0	0	49,363
Tribal Management	0	0	74	0	0	0	74	0	0	2,391	0	0	0	2,391	2,465
Direct Operations	0	0	0	53,164	0	0	53,164	0	0	0	19,174	0	0	19,174	72,338
Self-Governance	0	0	0	0	5,806	0	5,806	0	0	0	0	0	0	0	5,806
Subtotal (OS)	0	0	49,437	53,164	5,806	0	108,407	0	0	51,706	19,174	0	0	70,880	179,287
Total, Services	1,502,537	34,595	49,437	53,164	5,806	0	1,645,539	2,113,610	136,373	51,706	19,174	0	0	2,320,863	3,966,402
CONTRACT SUPPORT COSTS	0	0	0	0	0	0	0	0	0	0	0	717,970	0	717,970	717,970
FACILITIES															
Maintenance & Improvement	0	0	0	0	0	87,455	87,455	0	0	0	0	0	80,072	80,072	167,527
Sanitation Facilities Constr.	0	0	0	0	0	67,212	67,212	0	0	0	0	0	124,821	124,821	192,033
Health Care Facs. Constr.	0	0	0	0	0	122,530	122,530	0	0	0	0	0	120,950	120,950	243,480
Facs. & Env. Health Sup	0	0	0	0	0	150,982	150,982	0	0	0	0	0	90,976	90,976	241,958
Equipment	0	0	0	0	0	7,276	7,276	0	0	0	0	0	16,430	16,430	23,706
Total, Facilities	0	0	0	0	0	435,455	435,455	0	0	0	0	0	433,249	433,249	868,704
TOTAL, IHS	1,502,537	34,595	49,437	53,164	5,806	435,455	2,080,994	2,113,610	136,373	51,706	19,174	717,970	433,249	3,472,082	5,553,076

FY 2020 Crosswalk
Budget Authority
Estimated Distribution

(dollars in thousands)

Sub Activity	Federal Health Administration							Tribal Health Administration							FY 2020 PB
	Clinical Services	Preventive Health	Indian Health Professions	Federal Administration	Self-Governance	Facilities	TOTAL Federal Health Admini-stration	Clinical Services	Preventive Health	Urban Health	Management Training	Contract Support	Facilities	TOTAL Tribal Health Admini-stration	
SERVICES															
Hospitals & Health Clinics	1,020,936	0	0	0	0	0	1,020,936	1,342,342	0	0	0	0	0	1,342,342	2,363,278
Electronic Health Record	25,000	0	0	0	0	0	25,000	0	0	0	0	0	0	0	25,000
Dental Health	87,072	0	0	0	0	0	87,072	125,298	0	0	0	0	0	125,298	212,370
Mental Health	44,589	0	0	0	0	0	44,589	65,236	0	0	0	0	0	65,236	109,825
Alcohol & Substance Abuse	73,811	0	0	0	0	0	73,811	172,223	0	0	0	0	0	172,223	246,034
Purchased/Referred Care	406,634	0	0	0	0	0	406,634	561,543	0	0	0	0	0	561,543	968,177
IHCIF	15,472	0	0	0	0	0	15,472	56,808	0	0	0	0	0	56,808	72,280
Subtotal (CS)	1,673,514	0	0	0	0	0	1,673,514	2,323,450	0	0	0	0	0	2,323,450	3,996,964
Public Health Nursing	0	31,308	0	0	0	0	31,308	0	60,776	0	0	0	0	60,776	92,084
Health Education	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Community Health Repr.	0	720	0	0	0	0	720	0	23,280	0	0	0	0	23,280	24,000
Immunization AK	0	0	0	0	0	0	0	0	2,173	0	0	0	0	2,173	2,173
Subtotal (PH)	0	32,028	0	0	0	0	32,028	0	86,229	0	0	0	0	86,229	118,258
Urban Health Project	0	0	0	0	0	0	0	0	0	48,771	0	0	0	48,771	48,771
Indian Health Professions	0	0	43,612	0	0	0	43,612	0	0	0	0	0	0	0	43,612
Tribal Management	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Direct Operations	0	0	0	54,116	0	0	54,116	0	0	0	20,015	0	0	20,015	74,131
Self-Governance	0	0	0	0	4,807	0	4,807	0	0	0	0	0	0	0	4,807
Subtotal (OS)	0	0	43,612	54,116	4,807	0	102,535	0	0	48,771	20,015	0	0	68,786	171,320
Total, Services	1,673,514	32,028	43,612	54,116	4,807	0	1,808,077	2,323,450	86,229	48,771	20,015	0	0	2,478,465	4,286,541
CONTRACT SUPPORT COSTS	0	0	0	0	0	0	0	0	0	0	0	855,000	0	855,000	855,000
FACILITIES															
Maintenance & Improvement	0	0	0	0	0	87,992	87,992	0	0	0	0	0	80,576	80,576	168,568
Sanitation Facilities Constr.	0	0	0	0	0	67,638	67,638	0	0	0	0	0	125,614	125,614	193,252
Health Care Facs. Constr.	0	0	0	0	0	83,402	83,402	0	0	0	0	0	82,408	82,408	165,810
Facs. & Env. Health Sup	0	0	0	0	0	156,882	156,882	0	0	0	0	0	94,531	94,531	251,413
Equipment	0	0	0	0	0	7,363	7,363	0	0	0	0	0	16,620	16,620	23,983
Total, Facilities	0	0	0	0	0	403,277	403,277	0	0	0	0	0	399,749	399,749	803,026
TOTAL, IHS	1,673,514	32,028	43,612	54,116	4,807	403,277	2,211,354	2,323,450	86,229	48,771	20,015	855,000	399,749	3,733,214	5,944,567

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2020 Performance Budget Submission to Congress

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Appropriation Accounts

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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, $4,286,541,000, together with payments received during the fiscal year pursuant to 42 U.S.C. 238(b) and 238b, for services furnished by the Indian Health Service: Provided, That funds made available to tribes and tribal organizations through contracts, grant agreements, or any other agreements or compacts authorized by the Indian Self-Determination and Education Assistance Act of 1975 (25U.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 $968,177,000 for Purchased/Referred Care, including $51,500,000 for the Indian Catastrophic Health Emergency Fund, shall remain available until expended: Provided further, That, of the funds provided, up to $36,000,000 shall remain available until expended for implementation of the loan repayment program under section 108 of the Indian Health Care Improvement Act: Provided further, That, of the funds provided, $11,000,000 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 not less than $58,000,000 shall be for accreditation emergencies, including supplementing activities funded under the heading "Indian Health Facilities": 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 the Act (25 U.S.C. 1616a-1) and shall remain available until expended and, notwithstanding section 108A(c) of the Act (25 U.S.C. 1616a-1(c)), funds shall be available to make new awards under the loan repayment and scholarship programs under sections 104 and 108 of the Act (25 U.S.C. 1613a and 1616a): Provided further, That, notwithstanding any other provision of law, the amounts made available within this account for the Substance Abuse and Suicide Prevention Program, for the Domestic Violence Prevention Program, for the Zero Suicide Initiative, for Aftercare Pilot Program at Youth Regional Treatment Centers, for transformation and modernization costs of the IHS Electronic Health Record system, for an initiative to improve the recruitment and retention of health care providers and certain other critical professions, for national quality and oversight activities, for initiatives to treat or reduce the transmission of Hepatitis-C and HIV-AIDs or both in high priority

areas, to improve collections from public and private insurance at Indian Health Service and tribally operated facilities, and for accreditation emergencies shall be allocated at the discretion of the Director of the Indian Health Service and shall remain available until expended: Provided further, That funds provided in this Act may be used for annual contracts and grants that fall within 2 fiscal years, provided the total obligation is recorded in the year the funds are appropriated: Provided further, That the amounts collected by the Secretary of Health and Human Services under the authority of title IV of the Indian Health Care Improvement Act shall remain available until expended for the purpose of achieving compliance with the applicable conditions and requirements of titles XVIII and XIX of the Social Security Act, except for those related to the planning, design, or construction of new facilities: Provided further, That funding contained herein for scholarship programs under the Indian Health Care Improvement Act (25 U.S.C. 1613) shall remain available until expended: Provided further, That amounts received by tribes and tribal organizations under title IV of the Indian Health Care Improvement Act shall be reported and accounted for and available to the receiving tribes and tribal organizations until expended: Provided further, That the Bureau of Indian Affairs may collect from the Indian Health Service, tribes and tribal organizations operating health facilities pursuant to Public Law 93–638, such individually identifiable health information relating to disabled children as may be necessary for the purpose of carrying out its functions under the Individuals with Disabilities Education Act (20 U.S.C. 1400, et seq.): Provided further, That the Indian Health Care Improvement Fund may be used, as needed, to carry out activities typically funded under the Indian Health Facilities account.

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, such sums as may be necessary: Provided, That amounts obligated but not expended by a tribe or tribal organization for contract support costs for such agreements for the current fiscal year shall be applied to contract support costs otherwise due for such agreements for subsequent fiscal years: Provided further, That, notwithstanding any other provision of law, no amounts made available under this heading shall be available for transfer to another budget account.

INDIAN HEALTH FACILITIES

For construction, repair, maintenance, improvement, and equipment of health and related auxiliary facilities, including quarters for personnel; preparation of plans, specifications, and drawings; acquisition of sites, purchase and erection of modular buildings, and purchases of trailers; and for provision of domestic and community sanitation facilities for Indians, as authorized by section

7 of the Act of August 5, 1954 (42 U.S.C. 2004a), the Indian Self- Determination Act, and the Indian Health Care Improvement Act, and for expenses necessary to carry out such Acts and titles II and III of the Public Health Service Act with respect to environmental health and facilities support activities of the Indian Health Service, $803,026,000, 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:

ADMINISTRATIVE PROVISIONS - INDIAN HEALTH SERVICE

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

unless identified in the budget justification and provided in this Act, or the House and Senate Committees on Appropriations are notified through the reprogramming process: Provided further, That notwithstanding any other provision of law, funds previously or herein made available to a tribe or tribal organization through a contract, grant, or agreement authorized by title I or title V of the Indian Self-Determination and Education Assistance Act of 1975 (25 U.S.C. 450), may be deobligated and reobligated to a self-determination contract under title I, or a self-governance agreement under title V of such Act and thereafter shall remain available to the tribe or tribal organization without fiscal year limitation: Provided further, That none of the funds made available to the Indian Health Service in this Act shall be used to implement the final rule published in the Federal Register on September 16, 1987, by the Department of Health and Human Services, relating to the eligibility for the health care services of the Indian Health Service until the Indian Health Service has submitted a budget request reflecting the increased costs associated with the proposed final rule, and such request has been included in an appropriations Act and enacted into law: Provided further, That with respect to functions transferred by the Indian Health Service to tribes or tribal organizations, the Indian Health Service is authorized to provide goods and services to those entities on a reimbursable basis, including payments in advance with subsequent adjustment, and the reimbursements received therefrom, along with the funds received from those entities pursuant to the Indian Self- Determination Act, may be credited to the same or subsequent appropriation account from which the funds were originally derived, with such amounts to remain available until expended: Provided further, That reimbursements for training, technical assistance, or services provided by the Indian Health Service will contain total costs, including direct, administrative, and overhead associated with the provision of goods, services, or technical assistance: Provided further, That, notwithstanding any other provision of law, for any lease under section 105(l) of the Indian Self-Determination and Education Assistance Act, as amended, no additional compensation is required by the Act above the amount provided to the tribe or tribal organization under section 106(a)(1), except the Secretary, in the discretion of the Secretary, may award compensation for such leases, above the section 106(a)(1) amount, and if the Secretary awards such additional compensation the amount of such compensation may be based on such reasonable expenses, if any, as the Secretary determines to be appropriate, which may include the expenses described in section 105(l)(2), and the exercise of this discretion to award additional compensation and determine its amount is not subject to sections 102(a)-(b), (e) or 507(b)-(d) of the Act.

General Provisions

Contract Support Costs, Fiscal Year 2020 Limitation

Sec. 405. Amounts provided by this Act for fiscal year 2020 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 with the Bureau of Indian Affairs, the Bureau of Indian Education, 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.

Language Provision	*Explanation*
INDIAN HEALTH SERVICE PROVISIONS	
Provided further, That, notwithstanding any other provision of law, the amounts made available within this account for the Substance Abuse and Suicide Prevention Program, for the Domestic Violence Prevention Program, for the Zero Suicide Initiative, for Aftercare Pilot Program at Youth Regional Treatment Centers, for transformation and modernization costs of the IHS Electronic Health Record system, for an initiative to improve the recruitment and retention of health care providers and certain other critical professions, for national quality and oversight activities, for initiatives to treat or reduce the transmission of Hepatitis-C and HIV-AIDs or both in high priority areas, to improve collections from public and private insurance at Indian Health Service and tribally operated facilities, and for accreditation emergencies shall be allocated at the discretion of the Director of the Indian Health Service and shall remain available until expended.	*New language is included for the following nationwide or directed activities: transformation and modernization costs of the Electronic Health Record system, recruitment and retention of health care providers and professionals, quality and oversight activities, and working to end Hepatitis C and HIV/AIDs in Indian Country.*
Provided further, That, of the funds provided, $11,000,000 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 not less than $58,000,000 shall be for accreditation emergencies, including supplementing activities funded under the heading "Indian Health Facilities".	*Language is changed to add clarity regarding the minimum funding for accreditation emergencies and to allow accreditation emergencies funding to be used to pay for related facilities activities.*

INDIAN HEALTH FACILITIES PROVISION	
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:	*The provision limits IHS's spending on ambulances acquired through GSA to $2.7 million. IHS no longer directly purchases ambulances from GSA and now provides a price subsidy. This provision no longer serves any purpose and IHS proposes to eliminate it.*
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.	*IHS has a backlog of structures which require demolition and this limitation, which is approximately 20 years old, having been introduced in the FY 2000 Omnibus Appropriations Act (P.L. 106–113). This limitation leaves intact structures which may be hazardous and good stewardship of IHS facilities requires IHS to demolish these structures.*
SEC.405. Amounts provided by this Act for fiscal year 2020 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 with the Bureau of Indian Affairs, the Bureau of Indian Education, 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 or payments for settlements or judgments awarding contract support costs for prior years.	*Added to ensure that the FY 2020 appropriation for Contract Support Costs will not be used to pay prior year contract support costs claims or to repay the Judgment Fund for payments on prior year claims.*

INDIAN HEALTH SERVICE
Amounts Available for Obligations

SERVICES

	FY 2018	FY 2019*	FY 2020
General Fund Discretionary Appropriation:			
Appropriation (Interior)	$3,952,290,000	$3,966,402,000	$4,286,541,000
Across-the-board reductions (Interior)	$0	$0	$0
Subtotal, Appropriation (Interior)	$3,952,290,000	$3,966,402,000	$4,286,541,000
Mandatory Appropriation:			
Appropriation	$150,000,000	$150,000,000	$150,000,000
Offsetting Collections:			
Federal sources	($441,000,000)	($441,000,000)	($441,000,000)
Non-federal sources	($1,210,000,000)	($1,164,000,000)	($1,174,000,000)
Subtotal, Offsetting Collections	($1,651,000,000)	($1,605,000,000)	($1,615,000,000)
Unobligated Balances:			
Discretionary, Start of Year	$1,006,000	$1,220,000,000	$1,222,000,000
Mandatory, Start of Year	$1,218,994,000	$2,000,000	$0
End of Year	$1,220,000,000	$1,222,000,000	$1,222,000,000
Total Obligations, Services	$2,451,290,000	$2,511,402,000	$2,821,541,000

*FY 2019 reflects the Annualized Continuing Resolution.

INDIAN HEALTH SERVICE
Amounts Available for Obligations

FACILITIES

	FY 2018	FY 2019*	FY 2020
General Fund Discretionary Appropriation:			
Appropriation (Interior)	$867,504,000	$868,704,000	$803,026,000
Across-the-board reductions (Interior)	$0	$0	$0
Subtotal, Appropriation (Interior)	$867,504,000	$868,704,000	$803,026,000
Offsetting Collections:			
Federal sources	(59,000,000)	($59,000,000)	(59,000,000)
Subtotal, Offsetting Collections	(59,000,000)	($59,000,000)	(59,000,000)
Unobligated Balances:			
Discretionary, Start of Year	$309,000,000	$620,000,000	$912,000,000
End of Year	$620,000,000	$912,000,000	$1,137,000,000
Total Obligations, Facilities	$497,504,000	$517,704,000	$519,026,000

*FY 2019 reflects the Annualized Continuing Resolution.

INDIAN HEALTH SERVICE
Amounts Available for Obligations

CONTRACT SUPPORT COSTS

	FY 2018	FY 2019*	FY 2020
General Fund Discretionary Appropriation:			
Appropriation (Interior)	$762,642,000	$717,970,000	$855,000,000
Across-the-board reductions (Interior)	$0	$0	$0
Subtotal, Appropriation (Interior)	$762,642,000	$717,970,000	$855,000,000
Total Obligations, CSC	$762,642,000	$717,970,000	$855,000,000

*FY 2019 reflects the Annualized Continuing Resolution.

INDIAN HEALTH SERVICE

SERVICES

Summary of Changes

FY 2019 Annualized CR	3,966,402,000
Total estimated budget authority	3,966,402,000
Less Obligations	(3,966,402,000)
FY 2020 Estimate	4,286,541,000
Less Obligations	(4,286,541,000)
Net Change	320,140,000
Less Obligations	(320,140,000)

		FY 2019 Annualized CR Base		Change from Base	
		FTE	BA	FTE/Pos	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2019 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2020 Pay Raise CO (9months)	--	n/a	--	3,235,000
3	Annualization of FY 2019 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2020 Pay Raise CS (9months)	--	n/a	--	0
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	0
7	Increased Cost of Travel	--	37,645,861	--	824,985
8	Increased Cost of Transportation & Things	--	6,466,382	--	137,914
9	Increased Cost of Printing	--	88,902	--	2,079
10	Increased Cost of Rents, Communications, & Utilities	--	28,591,337	--	605,078
11	Increased Cost of Health Care Provided under Contracts & Grants	--	583,192,327	--	12,329,731
12	Increased Cost of Supplies	--	83,114,666	--	1,738,628
13	Increased Cost of Medical or other Equipment	--	5,536,059	--	125,450
14	Increased Cost of Land & Structure	--	183,509,440	--	3,853,698
15	Increased Cost of Grants	--	2,085,694,842	--	42,159,207
16	Increased Cost of Insurance / Indemnities	--	6,963,561	--	148,730
17	Increased Cost of Interest / Dividends	--	153,867	--	0
18	Population Growth	--	n/a	--	66,262,410
	Subtotal, Built-In	--	3,020,957,244	--	131,422,911
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	65	90,400,000
C. Program Adjustments		--	0	--	147,745,000
D. Program Increases		--	0	44	92,849,000
TOTAL INCREASES		--	3,020,957,244	109	462,416,911
DECREASES					
A. Built-In					
Absorption of Built-In Increases		--	0	--	(70,919,911)
B. Program Adjustments		--	0	--	(71,357,000)
TOTAL DECREASES		--	0	--	(142,276,911)
NET CHANGE		--	**3,020,957,244**	**109**	**320,140,000**

INDIAN HEALTH SERVICE
CLINICAL Services
Summary of Changes

FY 2019 Annualized CR 1/	3,616,147,000
Total estimated budget authority	3,616,147,000
Less Obligations	(3,616,147,000)
FY 2020 Estimate 1/ 2/	3,996,964,000
Less Obligations	(3,996,964,000)
Net Change	380,817,000
Less Obligations	(380,817,000)

	FY 2019 Annualized CR Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 Annualization of FY 2018 CO Pay Raise (3months)	--	n/a	--	0
2 FY 2019 Pay Raise CO (9months)	--	n/a	--	2,959,000
3 Annualization of FY 2018 CS Pay Raise (3months)	--	n/a	--	0
4 FY 2019 Pay Raise CS (9months)	--	n/a	--	0
5 One Days Pay	--	n/a	--	0
6 Tribal Pay Cost	--	n/a	--	0
7 Increased Cost of Travel	--	35,163,321	--	738,430
8 Increased Cost of Transportation & Things	--	5,629,203	--	118,213
9 Increased Cost of Printing	--	70,664	--	1,484
10 Increased Cost of Rents, Communications, & Utilities	--	27,813,620	--	584,086
11 Increased Cost of Health Care Provided under Contracts & Grants	--	552,678,226	--	11,606,243
12 Increased Cost of Supplies	--	80,028,866	--	1,680,606
13 Increased Cost of Medical or other Equipment	--	4,766,776	--	100,102
14 Increased Cost of Land & Structure	--	183,509,440	--	3,853,698
15 Increased Cost of Grants	--	1,879,292,003	--	39,465,132
16 Increased Cost of Insurance / Indemnities	--	911,329	--	19,138
17 Increased Cost of Interest / Dividends	--	153,867	--	0
18 Population Growth	--	n/a	--	63,789,606
Subtotal, Built-In	--	2,770,017,315	--	124,915,738
B. Phasing-In of Staff & Operating Cost of New Facilities:	--	0	65	86,969,000
C. Program Adjustments	--	0	--	146,555,000
D. Program Increases	--	0	44	91,463,000
TOTAL INCREASES	--	2,770,017,315	109	449,902,738
DECREASES				
A. Built-In				
Absorption of Built-In Increases	--	0	--	(67,716,738)
B. Transfer				
Transfer of NIAAA Programs from Alcohol to Urban	--	0	--	(1,369,000)
TOTAL DECREASES	--	0	--	(69,085,738)
NET CHANGE	--	**2,770,017,315**	**109**	**380,817,000**

INDIAN HEALTH SERVICE
Hospitals & Health Clinics
Summary of Changes

FY 2019 Annualized CR 1/	2,126,842,000
Total estimated budget authority	2,126,842,000
Less Obligations	(2,126,842,000)
FY 2020 Estimate 1/ 2/	2,460,558,000
Less Obligations	(2,460,558,000)
Net Change	333,716,000
Less Obligations	(333,716,000)

		FY 2019 Annualized CR Base		Change from Base	
		FTE	BA	FTE/Pos	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2019 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2020 Pay Raise CO (9months)	--	n/a	--	2,521,000
3	Annualization of FY 2019 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2020 Pay Raise CS (9months)	--	n/a	--	0
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	0
7	Increased Cost of Travel	--	4,916,592	--	103,248
8	Increased Cost of Transportation & Things	--	4,856,086	--	101,978
9	Increased Cost of Printing	--	65,325	--	1,372
10	Increased Cost of Rents, Communications, & Utilities	--	27,055,680	--	568,169
11	Increased Cost of Health Care Provided under Contracts & Grants	--	181,629,395	--	3,814,217
12	Increased Cost of Supplies	--	51,333,936	--	1,078,013
13	Increased Cost of Medical or other Equipment	--	3,716,124	--	78,039
14	Increased Cost of Land & Structure	--	1,000,000	--	21,000
15	Increased Cost of Grants	--	1,130,129,793	--	23,732,726
16	Increased Cost of Insurance / Indemnities	--	791,906	--	16,630
17	Increased Cost of Interest / Dividends	--	133,783	--	0
18	Population Growth	--	n/a	--	36,982,116
	Subtotal, Built-In	--	1,405,628,620	--	69,018,508
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	--	71,762,000
C. Program Adjustments		--	0	44	127,547,000
D. Program Increases 2/		--	0	--	91,463,000
	TOTAL INCREASES	--	1,405,628,620	44	359,790,508
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(26,074,508)
B. Adjustments		--	0	--	0
	TOTAL DECREASES	--	0	--	(26,074,508)
NET CHANGE		--	**1,405,628,620**	**44**	**333,716,000**

1/ Includes $72.3 million in Indian Health Care Improvement Fund broken out seperately in the APT table.
2/ Includes the requested $25.0 million for the Electronic Health Record, broken out seperately in the detail of changes table.

INDIAN HEALTH SERVICE
Dental Health
Summary of Changes

FY 2019 Annualized CR	197,013,000
Total estimated budget authority	197,013,000
Less Obligations	(197,013,000)
FY 2020 Estimate	212,370,000
Less Obligations	(212,370,000)
Net Change	15,357,000
Less Obligations	(15,357,000)

		FY 2019 Annualized CR Base		Change from Base	
		FTE	BA	Pos	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2019 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2020 Pay Raise CO (9months)	--	n/a	--	343,000
3	Annualization of FY 2019 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2020 Pay Raise CS (9months)	--	n/a	--	0
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	0
7	Increased Cost of Travel	--	533,587	--	11,205
8	Increased Cost of Transportation & Things	--	382,278	--	8,028
9	Increased Cost of Printing	--	587	--	12
10	Increased Cost of Rents, Communications, & Utilities	--	158,633	--	3,331
11	Increased Cost of Health Care Provided under Contracts & Grants	--	6,481,397	--	136,109
12	Increased Cost of Supplies	--	6,514,615	--	136,807
13	Increased Cost of Medical or other Equipment	--	670,938	--	14,090
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	116,082,473	--	2,437,732
16	Increased Cost of Insurance / Indemnities	--	41,024	--	862
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	3,546,234
	Subtotal, Built-In	--	130,865,532	--	6,637,410
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	--	4,841,000
C. Program Adjustment		--	0	--	6,977,000
D. Program Increase		--	0	--	0
TOTAL INCREASES		--	130,865,532	--	18,455,410
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(3,098,410)
TOTAL DECREASES		--	0	--	(3,098,410)
NET CHANGE		--	**130,865,532**	--	**15,357,000**

INDIAN HEALTH SERVICE
Mental Health
Summary of Changes

FY 2019 Annualized CR	100,682,000
Total estimated budget authority	100,682,000
Less Obligations	(100,682,000)
FY 2020 Estimate	109,825,000
Less Obligations	(109,825,000)
Net Change	9,143,000
Less Obligations	(9,143,000)

		FY 2019 Annualized CR Base		Change from Base	
		FTE	BA	Pos	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2019 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2020 Pay Raise CO (9months)	--	n/a	--	54,000
3	Annualization of FY 2019 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2020 Pay Raise CS (9months)	--	n/a	--	0
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	0
7	Increased Cost of Travel	--	285,271	--	5,991
8	Increased Cost of Transportation & Things	--	237,342	--	4,984
9	Increased Cost of Printing	--	0	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	13,880	--	291
11	Increased Cost of Health Care Provided under Contracts & Grants	--	4,649,814	--	97,646
12	Increased Cost of Supplies	--	2,202,770	--	46,258
13	Increased Cost of Medical or other Equipment	--	20,551	--	432
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	64,719,801	--	1,359,116
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	1,812,276
	Subtotal, Built-In	--	72,129,430	--	3,380,994
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	--	2,754,000
C. Program Adjustments		--	0	--	4,589,000
	TOTAL INCREASES	--	72,129,430	--	10,723,994
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(1,580,994)
	TOTAL DECREASES	--	0	--	(1,580,994)
NET CHANGE		--	**72,129,430**	--	**9,143,000**

INDIAN HEALTH SERVICE
Alcohol and Substance Abuse
Summary of Changes

FY 2019 Annualized CR	228,093,000
Total estimated budget authority	228,093,000
Less Obligations	(228,093,000)
FY 2020 Estimate	246,034,000
Less Obligations	(246,034,000)
Net Change	17,941,000
Less Obligations	(17,941,000)

		FY 2019 Annualized CR Base		Change from Base	
		FTE	BA	FTE/Pos	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2019 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2020 Pay Raise CO (9months)	--	n/a	--	41,000
3	Annualization of FY 2019 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2020 Pay Raise CS (9months)	--	n/a	--	0
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	0
7	Increased Cost of Travel	--	611,192	--	12,835
8	Increased Cost of Transportation & Things	--	153,301	--	3,219
9	Increased Cost of Printing	--	0	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	319,390	--	6,707
11	Increased Cost of Health Care Provided under Contracts & Grants	--	11,488,816	--	241,265
12	Increased Cost of Supplies	--	838,589	--	17,610
13	Increased Cost of Medical or other Equipment	--	359,164	--	7,542
14	Increased Cost of Land & Structure	--	182,509,440	--	3,832,698
15	Increased Cost of Grants	--	2,778,087	--	58,340
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	4,105,674
	Subtotal, Built-In	--	199,057,980	--	8,326,892
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	65	7,612,000
C. Program Adjustment		--	0	--	7,442,000
TOTAL INCREASES		--	199,057,980	65	23,380,892
DECREASES					
A. Built-In					
Absorption of Built-In Increases		--	0	--	(4,070,892)
B. Transfer					
Transfer of NIAAA Programs from Alcohol to Urban		--	0	--	(1,369,000)
TOTAL DECREASES		--	0	--	(5,439,892)
NET CHANGE		--	**199,057,980**	**65**	**17,941,000**

INDIAN HEALTH SERVICE
Purchased/Referred Care
Summary of Changes

FY 2020 Annualized CR	963,517,000
Total estimated budget authority	963,517,000
Less Obligations	(963,517,000)
FY 2020 Estimate	968,177,000
Less Obligations	(968,177,000)
Net Change	4,660,000
Less Obligations	(4,660,000)

		FY 2019 Annualized CR Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2019 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2020 Pay Raise CO (9months)	--	n/a	--	0
3	Annualization of FY 2019 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2020 Pay Raise CS (9months)	--	n/a	--	0
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	0
7	Increased Cost of Travel	--	28,816,679	--	605,150
8	Increased Cost of Transportation & Things	--	196	--	4
9	Increased Cost of Printing	--	4,752	--	100
10	Increased Cost of Rents, Communications, & Utilities	--	266,037	--	5,587
11	Increased Cost of Health Care Provided under Contracts & Grants	--	348,428,803	--	7,317,005
12	Increased Cost of Supplies	--	19,138,956	--	401,918
13	Increased Cost of Medical or other Equipment	--	0	--	0
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	565,581,849	--	11,877,219
16	Increased Cost of Insurance / Indemnities	--	78,399	--	1,646
17	Increased Cost of Interest / Dividends	--	20,084	--	0
18	Population Growth	--	n/a	--	17,343,306
	Subtotal, Built-In	--	962,335,754	--	37,551,935
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	--	0
C. Program Adjustment		--	0	--	0
	TOTAL INCREASES	--	962,335,754	--	37,551,935
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(32,891,935)
	TOTAL DECREASES	--	0	--	(32,891,935)
NET CHANGE		--	**962,335,754**	--	**4,660,000**

INDIAN HEALTH SERVICE
PREVENTIVE Health
Summary of Changes

FY 2019 Annualized CR	170,968,000
Total estimated budget authority	170,968,000
Less Obligations	(170,968,000)
FY 2020 Estimate	118,258,000
Less Obligations	(118,258,000)
Net Change	(52,710,000)
Less Obligations	52,710,000

	FY 2019 Annualized CR Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 Annualization of FY 2019 CO Pay Raise (3months)	--	n/a	--	0
2 FY 2020 Pay Raise CO (9months)	--	n/a	--	147,000
3 Annualization of FY 2019 CS Pay Raise (3months)	--	n/a	--	0
4 FY 2020 Pay Raise CS (9months)	--	n/a	--	0
5 One Days Pay	--	n/a	--	0
6 Tribal Pay Cost	--	n/a	--	0
7 Increased Cost of Travel	--	251,999	--	3,606
8 Increased Cost of Transportation & Things	--	703,267	--	14,401
9 Increased Cost of Printing	--	5,439	--	83
10 Increased Cost of Rents, Communications, & Utilities	--	159,486	--	1,594
11 Increased Cost of Health Care Provided under Contracts & Grants	--	4,328,491	--	67,989
12 Increased Cost of Supplies	--	2,335,041	--	33,647
13 Increased Cost of Medical or other Equipment	--	82,100	--	711
14 Increased Cost of Land & Structure	--	0	--	0
15 Increased Cost of Grants	--	134,353,938	--	1,227,550
16 Increased Cost of Insurance / Indemnities	--	0	--	0
17 Increased Cost of Interest / Dividends	--	0	--	0
18 Population Growth	--	n/a	--	1,585,134
Subtotal, Built-In	--	142,219,760	--	3,081,715
B. Phasing-In of Staff & Operating Cost of New Facilities:	--	0	0	3,431,000
C. Program Adjustment	--	0	--	1,190,000
TOTAL INCREASES	--	142,219,760	0	7,702,715
DECREASES				
A. Built-In				
Absorption of Built-In Increases	--	0	--	(1,508,715)
B. Program Reductions	--	0	--	(58,905,000)
TOTAL DECREASES	--	0	--	(60,413,715)
NET CHANGE	--	**142,219,760**	**0**	**(52,710,000)**

INDIAN HEALTH SERVICE
Public Health Nursing
Summary of Changes

FY 2019 Annualized CR	85,936,000
Total estimated budget authority	85,936,000
Less Obligations	(85,936,000)
FY 2020 Estimate	92,084,000
Less Obligations	(92,084,000)
Net Change	6,148,000
Less Obligations	(6,148,000)

		FY 2019 Annualized CR Base		Change from Base	
		FTE	BA	Pos	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2019 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2020 Pay Raise CO (9months)	--	n/a	--	147,000
3	Annualization of FY 2019 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2020 Pay Raise CS (9months)	--	n/a	--	0
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	0
7	Increased Cost of Travel	--	171,717	--	3,606
8	Increased Cost of Transportation & Things	--	685,747	--	14,401
9	Increased Cost of Printing	--	3,971	--	83
10	Increased Cost of Rents, Communications, & Utilities	--	75,926	--	1,594
11	Increased Cost of Health Care Provided under Contracts & Grants	--	3,237,559	--	67,989
12	Increased Cost of Supplies	--	1,602,226	--	33,647
13	Increased Cost of Medical or other Equipment	--	33,867	--	711
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	56,396,461	--	1,184,326
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	1,546,848
	Subtotal, Built-In	--	62,207,474	--	3,000,205
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	0	3,431,000
C. Program Adjustment		--	0	0	1,183,000
	TOTAL INCREASES	--	62,207,474	0	7,614,205
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(1,466,205)
B. Program Reductions		--	0	--	0
	TOTAL DECREASES	--	0	--	(1,466,205)
NET CHANGE		--	**62,207,474**	**0**	**6,148,000**

INDIAN HEALTH SERVICE
Health Education
Summary of Changes

FY 2019 Annualized CR	20,017,000
Total estimated budget authority	20,017,000
Less Obligations	(20,017,000)
FY 2020 Estimate	0
Less Obligations	0
Net Change	(20,017,000)
Less Obligations	20,017,000

		FY 2019 Annualized CR Base		Change from Base	
		FTE	BA	Pos	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2019 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2020 Pay Raise CO (9months)	--	n/a	--	0
3	Annualization of FY 2019 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2020 Pay Raise CS (9months)	--	n/a	--	0
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	0
7	Increased Cost of Travel	--	65,610	--	0
8	Increased Cost of Transportation & Things	--	17,520	--	0
9	Increased Cost of Printing	--	1,468	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	82,663	--	0
11	Increased Cost of Health Care Provided under Contracts & Grants	--	274,065	--	0
12	Increased Cost of Supplies	--	344,925	--	0
13	Increased Cost of Medical or other Equipment	--	44,963	--	0
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	15,710,591	--	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	--	16,541,804	--	0
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	--	0
	TOTAL INCREASES	--	16,541,804	--	0
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	0
B. Program Reductions		--	0	--	(20,017,000)
	TOTAL DECREASES	--	0	--	(20,017,000)
NET CHANGE		**--**	**16,541,804**	**--**	**(20,017,000)**

INDIAN HEALTH SERVICE
Community Health Representatives
Summary of Changes

FY 2019 Annualized CR	62,888,000
Total estimated budget authority	62,888,000
Less Obligations	(62,888,000)
FY 2020 Estimate	24,000,000
Less Obligations	(24,000,000)
Net Change	(38,888,000)
Less Obligations	38,888,000

		FY 2019 Annualized CR Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2019 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2020 Pay Raise CO (9months)	--	n/a	--	0
3	Annualization of FY 2019 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2020 Pay Raise CS (9months)	--	n/a	--	0
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	0
7	Increased Cost of Travel	--	14,671	--	0
8	Increased Cost of Transportation & Things	--	0	--	0
9	Increased Cost of Printing	--	0	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	898	--	0
11	Increased Cost of Health Care Provided under Contracts & Grants	--	816,867	--	0
12	Increased Cost of Supplies	--	387,889	--	0
13	Increased Cost of Medical or other Equipment	--	3,270	--	0
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	60,188,585	--	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	--	61,412,180	--	0
	TOTAL INCREASES	--	61,412,180	--	0
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	0
B. Program Reductions		--	0	--	(38,888,000)
	TOTAL DECREASES	--	0	--	(38,888,000)
NET CHANGE		--	**61,412,180**	**--**	**(38,888,000)**

INDIAN HEALTH SERVICE
Immunization AK
Summary of Changes

FY 2019 Annualized CR	2,127,000
Total estimated budget authority	2,127,000
Less Obligations	(2,127,000)
FY 2020 Estimate	2,173,000
Less Obligations	(2,173,000)
Net Change	46,000
Less Obligations	(46,000)

		FY 2019 Annualized CR Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2019 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2020 Pay Raise CO (9months)	--	n/a	--	0
3	Annualization of FY 2019 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2020 Pay Raise CS (9months)	--	n/a	--	0
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	0
7	Increased Cost of Travel	--	0	--	0
8	Increased Cost of Transportation & Things	--	0	--	0
9	Increased Cost of Printing	--	0	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	0	--	0
11	Increased Cost of Health Care Provided under Contracts & Grants	--	0	--	0
12	Increased Cost of Supplies	--	0	--	0
13	Increased Cost of Medical or other Equipment	--	0	--	0
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	2,058,301	--	43,224
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	38,286
	Subtotal, Built-In	--	2,058,301	--	81,510
B. Program Adjustment		--	0	--	7,000
	TOTAL INCREASES	--	2,058,301	--	88,510
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(42,510)
B. Program Reductions		--	0	--	0
	TOTAL DECREASES	--	0	--	(42,510)
NET CHANGE		--	**2,058,301**	--	**46,000**

INDIAN HEALTH SERVICE
OTHER Services
Summary of Changes

FY 2019 Annualized CR	179,287,000
Total estimated budget authority	179,287,000
Less Obligations	(179,287,000)
FY 2020 Estimate	171,320,000
Less Obligations	(171,320,000)
Net Change	(7,966,000)
Less Obligations	7,966,000

		FY 2019 Annualized CR Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2019 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2020 Pay Raise CO (9months)	--	n/a	--	129,000
3	Annualization of FY 2019 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2020 Pay Raise CS (9months)	--	n/a	--	0
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	0
7	Increased Cost of Travel	--	2,230,542	--	82,949
8	Increased Cost of Transportation & Things	--	133,912	--	5,300
9	Increased Cost of Printing	--	12,799	--	512
10	Increased Cost of Rents, Communications, & Utilities	--	618,231	--	19,398
11	Increased Cost of Health Care Provided under Contracts & Grants	--	26,185,610	--	655,500
12	Increased Cost of Supplies	--	750,759	--	24,375
13	Increased Cost of Medical or other Equipment	--	687,183	--	24,637
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	72,048,901	--	1,466,525
16	Increased Cost of Insurance / Indemnities	--	6,052,233	--	129,593
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	887,670
	Subtotal, Built-In	--	108,720,169	--	3,425,457
B. Program Increase		--	0	--	1,386,000
C. Transfer					
	Transfer of NIAAA Programs from Alcohol to Urban	--	0	--	1,369,000
	TOTAL INCREASES	--	108,720,169	--	6,180,457
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(1,694,457)
B. Program Reductions		--	0	--	(12,452,000)
	TOTAL DECREASES	--	0	--	(14,146,457)
NET CHANGE		--	**108,720,169**	--	**(7,966,000)**

INDIAN HEALTH SERVICE
Urban Indian Health
Summary of Changes

FY 2019 Annualized CR	49,315,000
Total estimated budget authority	49,315,000
Less Obligations	(49,315,000)
FY 2020 Estimate	48,771,000
Less Obligations	(48,771,000)
Net Change	(544,000)
Less Obligations	544,000

		FY 2019 Annualized CR Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2019 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2020 Pay Raise CO (9months)	--	n/a	--	20,000
3	Annualization of FY 2019 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2020 Pay Raise CS (9months)	--	n/a	--	0
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	0
7	Increased Cost of Travel	--	182,346	--	3,829
8	Increased Cost of Transportation & Things	--	2,981	--	63
9	Increased Cost of Printing	--	0	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	261,287	--	5,487
11	Increased Cost of Health Care Provided under Contracts & Grants	--	20,541,706	--	431,376
12	Increased Cost of Supplies	--	285,867	--	6,003
13	Increased Cost of Medical or other Equipment	--	148,911	--	3,127
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	19,752,904	--	414,811
16	Increased Cost of Insurance / Indemnities	--	5,915,466	--	124,225
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	887,670
	Subtotal, Built-In	--	47,091,469	--	1,896,591
B. Program Adjustment		--	0	--	0
C. Transfer					
	Transfer of NIAAA Programs from Alcohol to Urban	--	0	--	1,369,000
	TOTAL INCREASES	--	47,091,469	--	3,265,591
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(1,020,591)
B. Program Reductions		--	0	--	(2,789,000)
	TOTAL DECREASES	--	0	--	(3,809,591)
NET CHANGE		--	**47,091,469**	--	**(544,000)**

INDIAN HEALTH SERVICE
Indian Health Professions
Summary of Changes

FY 2019 Annualized CR	49,363,000
Total estimated budget authority	49,363,000
Less Obligations	(49,363,000)
FY 2020 Estimate	43,612,000
Less Obligations	(43,612,000)
Net Change	(5,751,000)
Less Obligations	5,751,000

		FY 2019 Annualized CR Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2019 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2020 Pay Raise CO (9months)	--	n/a	--	17,000
3	Annualization of FY 2019 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2020 Pay Raise CS (9months)	--	n/a	--	0
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	0
7	Increased Cost of Travel	--	41,946	--	881
8	Increased Cost of Transportation & Things	--	0	--	0
9	Increased Cost of Printing	--	0	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	0	--	0
11	Increased Cost of Health Care Provided under Contracts & Grants	--	24,554	--	516
12	Increased Cost of Supplies	--	4,092	--	86
13	Increased Cost of Medical or other Equipment	--	0	--	0
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	46,992,553	--	986,844
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	--	47,063,145	--	1,005,326
B. IHP Restoration		--	0	--	0
	TOTAL INCREASES	--	47,063,145	--	1,005,326
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(572,326)
B. Program Adjustments		--	0	--	(6,184,000)
	TOTAL DECREASES	--	0	--	(6,756,326)
NET CHANGE		--	**47,063,145**	--	**(5,751,000)**

INDIAN HEALTH SERVICE
Tribal Management
Summary of Changes

FY 2019 Annualized CR	2,465,000
Total estimated budget authority	2,465,000
Less Obligations	(2,465,000)
FY 2020 Estimate	0
Less Obligations	0
Net Change	(2,465,000)
Less Obligations	2,465,000

		FY 2019 Annualized CR Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2019 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2020 Pay Raise CO (9months)	--	n/a	--	0
3	Annualization of FY 2019 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2020 Pay Raise CS (9months)	--	n/a	--	0
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	0
7	Increased Cost of Travel	--	0	--	0
8	Increased Cost of Transportation & Things	--	0	--	0
9	Increased Cost of Printing	--	0	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	0	--	0
11	Increased Cost of Health Care Provided under Contracts & Grants	--	0	--	0
12	Increased Cost of Supplies	--	0	--	0
13	Increased Cost of Medical or other Equipment	--	0	--	0
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	2,465,000	--	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. TMG Restoration		--	0	--	0
	TOTAL INCREASES	--	2,465,000	--	0
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	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 2019 Annualized CR	72,338,000
Total estimated budget authority	72,338,000
Less Obligations	(72,338,000)
FY 2020 Estimate	74,131,000
Less Obligations	(74,131,000)
Net Change	1,793,000
Less Obligations	(1,793,000)

		FY 2019 Annualized CR Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2019 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2020 Pay Raise CO (9months)	--	n/a	--	92,000
3	Annualization of FY 2019 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2020 Pay Raise CS (9months)	--	n/a	--	0
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	0
7	Increased Cost of Travel	--	1,900,390	--	76,016
8	Increased Cost of Transportation & Things	--	130,931	--	5,237
9	Increased Cost of Printing	--	12,799	--	512
10	Increased Cost of Rents, Communications, & Utilities	--	337,620	--	13,505
11	Increased Cost of Health Care Provided under Contracts & Grants	--	5,558,010	--	222,320
12	Increased Cost of Supplies	--	453,107	--	18,124
13	Increased Cost of Medical or other Equipment	--	537,145	--	21,486
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	277,000	--	11,080
16	Increased Cost of Insurance / Indemnities	--	131,352	--	5,254
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	0
	Subtotal, Built-In	--	9,338,353	--	465,534
B. Program Adjustments		--	0	--	1,386,000
	TOTAL INCREASES	--	9,338,353	--	1,851,534
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(58,534)
B. Program Reductions		--	0	--	0
	TOTAL DECREASES	--	0	--	(58,534)
NET CHANGE		**--**	**9,338,353**	**--**	**1,793,000**

INDIAN HEALTH SERVICE
Self-Governance
Summary of Changes

FY 2019 Annualized CR	5,806,000
Total estimated budget authority	5,806,000
Less Obligations	(5,806,000)
FY 2020 Estimate	4,807,000
Less Obligations	(4,807,000)
Net Change	(999,000)
Less Obligations	999,000

		FY 2019 Annualized CR Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2019 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2020 Pay Raise CO (9months)	--	n/a	--	0
3	Annualization of FY 2019 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2020 Pay Raise CS (9months)	--	n/a	--	0
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	0
7	Increased Cost of Travel	--	105,860	--	2,223
8	Increased Cost of Transportation & Things	--	0	--	0
9	Increased Cost of Printing	--	0	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	19,324	--	406
11	Increased Cost of Health Care Provided under Contracts & Grants	--	61,340	--	1,288
12	Increased Cost of Supplies	--	7,693	--	162
13	Increased Cost of Medical or other Equipment	--	1,126	--	24
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	2,561,443	--	53,790
16	Increased Cost of Insurance / Indemnities	--	5,415	--	114
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	0
	Subtotal, Built-In	--	2,762,202	--	58,006
B. Self-Governance Restoration		--	0	--	0
	TOTAL INCREASES	--	2,762,202	--	58,006
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(43,006)
B. Program Reductions		--	0	--	(1,014,000)
	TOTAL DECREASES	--	0	--	(1,057,006)
NET CHANGE		--	**2,762,202**	--	**(999,000)**

INDIAN HEALTH SERVICE
Contract Support Costs
Summary of Changes

FY 2019 Annualized CR	717,970,000
Total estimated budget authority	717,970,000
Less Obligations	(717,970,000)
FY 2020 Estimate	855,000,000
Less Obligations	(855,000,000)
Net Change	137,030,000
Less Obligations	(137,030,000)

		FY 2019 Annualized CR Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2019 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2020 Pay Raise CO (9months)	--	n/a	--	0
3	Annualization of FY 2019 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2020 Pay Raise CS (9months)	--	n/a	--	0
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	0
7	Increased Cost of Travel	--	0	--	0
8	Increased Cost of Transportation & Things	--	0	--	0
9	Increased Cost of Printing	--	0	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	0	--	0
11	Increased Cost of Health Care Provided under Contracts & Grants	--	0	--	0
12	Increased Cost of Supplies	--	0	--	0
13	Increased Cost of Medical or other Equipment	--	0	--	0
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	717,970,000	--	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	--	717,970,000	--	0
B. CSC Increase		--	0	--	137,000,000
	TOTAL INCREASES	--	717,970,000	--	137,000,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	0
	TOTAL DECREASES	--	0	--	0
NET CHANGE		--	**717,970,000**	--	**137,000,000**

INDIAN HEALTH SERVICE

FACILITIES

Summary of Changes

FY 2019 Annualized CR	868,704,000
Total budget authority	868,704,000
Less Obligations	(868,704,000)
FY 2020 Estimate	803,026,000
Less Obligations	(803,026,000)
Net Change	(65,678,000)
Less Obligations	65,678,000

		FY 2020 Annualized CR Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2019 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2020 Pay Raise CO (9months)	--	n/a	--	965,000
3	Annualization of FY 2019 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2020 Pay Raise CS (9months)	--	n/a	--	0
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	0
7	Increased Cost of Travel	--	2,761,293	--	57,987
8	Increased Cost of Transportation & Things	--	3,459,770	--	72,655
9	Increased Cost of Printing	--	63,687	--	1,337
10	Increased Cost of Rents, Communications, & Utilities	--	14,666,538	--	307,997
11	Increased Cost of Health Care Provided under Contracts & Grants	--	306,828,221	--	6,443,393
12	Increased Cost of Supplies	--	7,603,776	--	159,679
13	Increased Cost of Medical or other Equipment	--	14,594,699	--	306,489
14	Increased Cost of Land & Structure	--	160,118,069	--	3,362,479
15	Increased Cost of Grants	--	177,491,647	--	3,727,325
16	Increased Cost of Insurance / Indemnities	--	77,886	--	1,636
17	Increased Cost of Interest / Dividends	--	2,475	--	52
18	Increased Cost of Service & Supply Fund	--	0	--	0
19	Population Growth	--	n/a	--	11,254,032
	Subtotal, Built-In	--	687,668,062	--	26,660,061
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	5	7,073,000
	TOTAL INCREASES	--	687,668,062		33,733,061
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(18,317,061)
B. Adjustments		--	0	--	(81,094,000)
	TOTAL DECREASES	--	0	--	(99,411,061)
NET CHANGE		**--**	**687,668,062**	**5**	**(65,678,000)**

INDIAN HEALTH SERVICE
Maintenance & Improvement
Summary of Changes

FY 2019 Annualized CR	167,527,000
Total budget authority	167,527,000
Less Obligations	(167,527,000)
FY 2020 Estimate	168,568,000
Less Obligations	(168,568,000)
Net Change	1,041,000
Less Obligations	(1,041,000)

		FY 2020 Annualized CR Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2019 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2020 Pay Raise CO (9months)	--	n/a	--	0
3	Annualization of FY 2019 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2020 Pay Raise CS (9months)	--	n/a	--	0
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	0
7	Increased Cost of Travel	--	25,735	--	540
8	Increased Cost of Transportation & Things	--	46,076	--	968
9	Increased Cost of Printing	--	2,065	--	43
10	Increased Cost of Rents, Communications, & Utilities	--	173,040	--	3,634
11	Increased Cost of Health Care Provided under Contracts & Grants	--	54,066,383	--	1,135,394
12	Increased Cost of Supplies	--	4,347,428	--	91,296
13	Increased Cost of Medical or other Equipment	--	701,578	--	14,733
14	Increased Cost of Land & Structure	--	2,314,415	--	48,603
15	Increased Cost of Grants	--	47,092,142	--	988,935
16	Increased Cost of Insurance / Indemnities	--	1,951	--	41
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Increased Cost of Service & Supply Fund	--	0	--	0
19	Population Growth	--	0	--	3,015,486
	Subtotal, Built-In	--	108,770,813	--	5,299,673
B. Program Adjustment		--	0	--	0
	TOTAL INCREASES	--	108,770,813	--	5,299,673
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(3,874,673)
B Program Adjustment		--	0	--	(384,000)
	TOTAL DECREASES	--	0	--	(4,258,673)
NET CHANGE		**--**	**108,770,813**	**--**	**1,041,000**

INDIAN HEALTH SERVICE
Sanitation Facilities Construction
Summary of Changes

FY 2019 Annualized CR	192,033,000
Total budget authority	192,033,000
Less Obligations	(192,033,000)
FY 2020 Estimate	193,252,000
Less Obligations	(193,252,000)
Net Change	1,219,000
Less Obligations	(1,219,000)

		FY 2020 Annualized CR Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2019 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2020 Pay Raise CO (9months)	--	n/a	--	0
3	Annualization of FY 2019 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2020 Pay Raise CS (9months)	--	n/a	--	0
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	0
7	Increased Cost of Travel	--	88,207	--	1,852
8	Increased Cost of Transportation & Things	--	811,820	--	17,048
9	Increased Cost of Printing	--	9,283	--	195
10	Increased Cost of Rents, Communications, & Utilities	--	560	--	12
11	Increased Cost of Health Care Provided under Contracts & Grants	--	160,770,139	--	3,376,173
12	Increased Cost of Supplies	--	178,139	--	3,741
13	Increased Cost of Medical or other Equipment	--	18,381	--	386
14	Increased Cost of Land & Structure	--	2,241,182	--	47,065
15	Increased Cost of Grants	--	20,182,342	--	423,829
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Increased Cost of Service & Supply Fund	--	0	--	0
19	Population Growth	--	0	--	3,456,594
	Subtotal, Built-In	--	184,300,052	--	7,326,895
B. Program Adjustment		--	0	--	0
	TOTAL INCREASES	--	184,300,052	--	7,326,895
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(5,782,895)
B. Program Adjustment		--	0	--	(325,000)
	TOTAL DECREASES	--	0	--	(6,107,895)
NET CHANGE		**--**	**184,300,052**	**--**	**1,219,000**

INDIAN HEALTH SERVICE
Health Care Facilities Construction
Summary of Changes

FY 2019 Annualized CR	243,480,000
Total budget authority	243,480,000
Less Obligations	(243,480,000)
FY 2020 Estimate	165,810,000
Less Obligations	(165,810,000)
Net Change	(77,670,000)
Less Obligations	77,670,000

		FY 2020 Annualized CR Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2019 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2020 Pay Raise CO (9months)	--	n/a	--	0
3	Annualization of FY 2019 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2020 Pay Raise CS (9months)	--	n/a		0
5	One Days Pay	--	n/a		0
6	Tribal Pay Cost	--	n/a	--	0
7	Increased Cost of Travel	--	0	--	0
8	Increased Cost of Transportation & Things	--	20,777	--	436
9	Increased Cost of Printing	--	0	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	16,621	--	349
11	Increased Cost of Health Care Provided under Contracts & Grants	--	80,423,819	--	1,688,900
12	Increased Cost of Supplies	--	218,153	--	4,581
13	Increased Cost of Medical or other Equipment	--	7,329,955	--	153,929
14	Increased Cost of Land & Structure	--	155,443,666	--	3,264,317
15	Increased Cost of Grants	--	27,009	--	567
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Increased Cost of Service & Supply Fund	--	0	--	0
19	Population Growth	--	0	--	0
	Subtotal, Built-In	--	243,480,000	--	5,113,080
B. Program Adjustment		--	0	--	0
	TOTAL INCREASES	--	243,480,000	--	5,113,080
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(4,303,080)
B. Program Adjustment		--	0	--	(78,480,000)
	TOTAL DECREASES	--	0	--	(82,783,080)
NET CHANGE		--	**243,480,000**	--	**(77,670,000)**

INDIAN HEALTH SERVICE
Facilities & Environmental Health Support
Summary of Changes

FY 2019 Annualized CR	241,958,000
Total budget authority	241,958,000
Less Obligations	(241,958,000)
FY 2020 Estimate	251,413,000
Less Obligations	(251,413,000)
Net Change	9,455,000
Less Obligations	(9,455,000)

		FY 2020 Annualized CR Base		Change from Base	
		FTE	BA	FTE/Pos	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2019 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2020 Pay Raise CO (9months)	--	n/a	--	965,000
3	Annualization of FY 2019 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2020 Pay Raise CS (9months)	--	n/a	--	0
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	0
7	Increased Cost of Travel	--	2,642,169	--	55,486
8	Increased Cost of Transportation & Things	--	2,361,333	--	49,588
9	Increased Cost of Printing	--	52,339	--	1,099
10	Increased Cost of Rents, Communications, & Utilities	--	14,169,239	--	297,554
11	Increased Cost of Health Care Provided under Contracts & Grants	--	11,395,010	--	239,295
12	Increased Cost of Supplies	--	2,753,848	--	57,831
13	Increased Cost of Medical or other Equipment	--	1,865,265	--	39,171
14	Increased Cost of Land & Structure	--	118,807	--	2,495
15	Increased Cost of Grants	--	91,974,125	--	1,931,457
16	Increased Cost of Insurance / Indemnities	--	75,935	--	1,595
17	Increased Cost of Interest / Dividends	--	2,475	--	52
18	Increased Cost of Service & Supply Fund	--	0	--	0
19	Population Growth	--	n/a	--	4,355,244
	Subtotal, Built-In	--	127,410,545	--	7,995,865
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	5	7,073,000
	TOTAL INCREASES	--	127,410,545	--	15,068,865
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(3,812,865)
B. Program Reduction		--	0	--	(1,801,000)
	TOTAL DECREASES	--	0	--	(5,613,865)
NET CHANGE		**--**	**127,410,545**	**5**	**9,455,000**

INDIAN HEALTH SERVICE
Equipment
Summary of Changes

FY 2019 Annualized CR	23,706,000
Total budget authority	23,706,000
Less Obligations	(23,706,000)
FY 2020 Estimate	23,983,000
Less Obligations	(23,983,000)
Net Change	277,000
Less Obligations	(277,000)

		FY 2020 Annualized CR Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2019 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2020 Pay Raise CO (9months)	--	n/a	--	0
3	Annualization of FY 2019 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2020 Pay Raise CS (9months)	--	n/a	--	0
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	0
7	Increased Cost of Travel	--	5,182	--	109
8	Increased Cost of Transportation & Things	--	219,764	--	4,615
9	Increased Cost of Printing	--	0	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	307,079	--	6,449
11	Increased Cost of Health Care Provided under Contracts & Grants	--	172,869	--	3,630
12	Increased Cost of Supplies	--	106,208	--	2,230
13	Increased Cost of Medical or other Equipment	--	4,679,520	--	98,270
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	18,216,028	--	382,537
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Increased Cost of Service & Supply Fund	--	0	--	0
19	Population Growth	--	0	--	426,708
	Subtotal, Built-In	--	23,706,652	--	924,548
	TOTAL INCREASES	--	23,706,652	--	924,548
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(543,548)
B. Adjustments		--	0	--	(104,000)
	TOTAL DECREASES	--	0	--	(647,548)
NET CHANGE		**--**	**23,706,652**	**--**	**277,000**

INDIAN HEALTH SERVICE
Budget Authority by Activity

(Dollars in Thousands)

	2018 Final		2019 Annualized CR		2020 President's Budget	
	FTE	Amount	FTE	Amount	FTE	Amount
SERVICES						
Hospitals & Health Clinics	5,950	$2,055,128	5,950	$2,054,562	6,011	$2,363,278
Electronic Health Record System (NEW)	0	$0	0	$0	0	$25,000
Dental Health	556	193,283	556	197,013	556	212,370
Mental Health	183	98,900	183	100,682	183	109,825
Alcohol & Substance Abuse	232	224,188	232	228,093	297	246,034
Purchased/Referred Care	0	962,695	0	963,517	0	968,177
Indian Health Care Improvement Fund	0	72,280	0	72,280	0	72,280
Total, Clinical Services	6,921	3,606,474	6,921	3,616,147	7,047	3,996,964
Public Health Nursing	193	84,043	193	85,936	193	92,084
Health Education	17	19,322	17	20,017	0	0
Comm. Health Reps.	3	61,888	3	62,888	3	24,000
Immunization AK	0	2,058	0	2,127	0	2,173
Total, Preventive Health	213	167,311	213	170,968	196	118,257
Urban Health	7	48,533	7	49,315	7	48,771
Indian Health Professions	23	49,363	23	49,363	23	43,612
Tribal Management	0	2,465	0	2,465	0	0
Direct Operations	264	72,338	264	72,338	264	74,131
Self-Governance	12	5,806	12	5,806	12	4,807
Total, Other services	306	178,505	306	179,287	306	171,321
Total, Services	7,440	3,952,290	7,440	3,966,402	7,549	4,286,542
CONTRACT SUPPORT COSTS	0	762,642	0	822,000	0	855,000
FACILITIES						
Maintenance & Improvement	0	167,527	0	167,527	0	168,568
Sanitation Facilities Constr.	119	192,033	119	192,033	119	193,252
Health Care Facs. Constr.	0	243,480	0	243,480	0	165,810
Facil. & Envir. Health Supp.	1,030	240,758	1,030	241,958	1,035	251,413
Equipment	0	23,706	0	23,706	0	23,983
Total, Facilities	1,149	867,504	1,149	868,704	1,154	803,026
SPECIAL DIABETES PROGRAM FOR INDIANS						
SDPI	127	150,000	127	150,000	127	150,000
Total, SDPI	127	150,000	127	150,000	127	150,000
Total IHS	8,716	$5,732,436	8,716	$5,807,106	8,830	$6,094,568

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

Indian Health Service

Authorizing Legislation

(Dollars in Thousands)

	FY 2019		FY 2020	
	Amount Authorized	Amount Appropriated	Amount Authorized	President's Budget
1. Services Appropriation:	3,966,402	3,966,402	4,286,541	4,286,541
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:	717,970	717,970	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:	868,704	868,704	803,026	803,026
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	8,500	8,500
4. Public and Private Collections:	1,193,577	1,193,577	1,193,577	1,193,577
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.				
Unfunded authorizations:	0	0	0	0
Total appropriations:	6,905,153	6,905,153	7,296,644	7,296,644
Total appropriations against Definite authorizations:	6,905,153	6,905,153	7,296,644	7,296,644

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[1]	$3,945,975,000	$4,202,639,000	$4,072,385,000	$3,965,711,000
2020 Congressional Justification	$4,286,541,000	-	-	-

[1]The FY 2019 Appropriation reflects the FY 2019 Continuing Resolution.

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[1]	$822,227,000	$822,227,000	$822,227,000	$717,970,000
2020 Congressional Justification	$855,000,000	-	-	-

[1]The FY 2019 Appropriation reflects the FY 2019 Continuing Resolution.

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[1]	$505,821,000	$882,748,000	$877,504,000	$868,704,000
2020 Congressional Justification	$803,026,000	-	-	-

[1]The FY 2019 Appropriation reflects the FY 2019 Continuing Resolution.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2020 Performance Budget Submission to Congress

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Services

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

(Dollars in Thousands)

	FY 2018	FY 2019	FY 2020	
	Final	Annualized CR	President's Budget	FY 2020 +/- FY 2019
BA	$3,606,474	$3,616,147	$3,996,964	+$380,817
FTE*	6,921	6,921	7,047	+126

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

SUMMARY OF THE BUDGET REQUEST

The FY 2020 Indian Health Service (IHS) Budget submission for Clinical Services of $4.0 billion is $381.0 million above the FY 2019 Annualized CR. Included in the budget is additional funding of $87.0 million for Staffing of New and Replacement Healthcare Facilities, $58.7 million for Current Services, $25.0 million for the Electronic Health Record transition, $25.0 million to prevent and treat Hepatitis C and HIV/AIDS in Indian Country, $20.0 million for a National Community Health Aid Program, $11.5 million to provide direct health care services for six newly federally-recognized Tribes, $8.0 million for an expanded Recruitment and Retention program, and $2 million for Quality and Oversight.

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/AIDS), tuberculosis, and hepatitis; women's and men's health; geriatric health; disease surveillance; and healthcare quality improvement. The Budget proposes an increase of $308.7 million for a total of $2.4 billion for Hospitals and Health Clinics.

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

way. The Budget proposes a new line item in the budget for EHR for an increase of $25.0 million.

- **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. The Budget proposes an increase of $15.4 million for a total of $212.4 million for Dental Health.

- **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. The Budget proposes an increase of $9.1 million for a total of $109.8 million for Mental Health.

- **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. The Budget proposes an increase of $17.9 million for a total of $246.0 million for Alcohol and Substance Abuse.

- **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 Budget proposes an increase of $4.7 million for a total of $968.2 million for Purchased/Referred Care.

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[1] in service areas that are rural, isolated, and underserved.

[1] 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."

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.

OUTPUTS/OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2020 Target +/-FY 2019 Target
28 Unintentional Injury Rates: Age-Adjusted Unintentional injuries mortality rate in AI/AN population (Outcome)	FY 2008: 94.5 (Target Not In Place)	TBD	TBD	Maintain
71 Childhood Weight Control: Proportion of children, ages 2-5 years with a BMI at or above the 95th percentile. IHS-All (Outcome)	FY 2018: 21.9% Target: 22.6 % (Target Exceeded)	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 2018	FY 2019	FY 2020	
	Final	Annualized CR	Request	FY 2020 +/- FY 2019
BA	$2,055,128	$2,054,562	$2,363,278	+$308,716
FTE*	5,950	5,950	6,011	+61

* 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 2020 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 and Tribes primarily serve small, rural populations with primary medical care and community-health services, relying on the private sector for much of the secondary and most of the tertiary medical care needs. Some IHS and Tribal hospitals provide secondary medical services such as ophthalmology, orthopedics, infectious disease, emergency medicine, radiology, general and gynecological surgery, and anesthesia.

The IHS system of care is unique in that personal health care services are integrated with community health services. The program includes public/community health programs targeting health conditions disproportionately affecting AI/ANs such as diabetes, maternal and child health, and communicable diseases including influenza, human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS), and hepatitis. The health status of AI/ANs has improved significantly in the past 60 years since IHS's inception. However, AI/ANs 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.[1]

More than 60 percent of the H&HC budget is transferred under P.L. 93-638 contracts or compacts to Tribal governments or Tribal organizations that design and manage the delivery of individual and community health services through 22 hospitals, 280 health centers, 62 health stations, 134 Alaska village clinics, and 6 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

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

level. The federal system consists of 25 hospitals (23 hospitals have emergency departments), 50 health centers, 26 health stations, and 2 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.

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

The Quality Framework implementation continued through FY 2019. The Quality Framework explicitly set the goal of establishing the Office for Quality to lead all quality and safety work for IHS and report to the Deputy Director for Quality Health Care. In FY 2018, IHS identified a budget for the Office enabling initial critical staffing, training resources, and analytic software procurement to support data-driven decision making. The Agency elevated and institutionalized the goals and objectives included in the Quality Framework in the new Strategic Plan that will guide quality improvement and patient safety efforts over the next several years.

The Office for Quality will be established in FY 2019 at IHS Headquarters to lead all quality and patient safety work including oversight of national policy, 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.

The quality and safety of care at federally operated facilities is a top IHS priority. To provide oversight of IHS facilities, 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 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/. IHS uses existing facility governance structures and processes to address performance improvement.

The IHS is modernizing 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. In early 2018, IHS completed credentialing and privileging software implementation for its federally operated sites

in all IHS Areas. The new software system provides a centralized electronic database and standardization of credentialing data. IHS 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.

IHS uses standardized hospital Governing Board (GB) Bylaws for inpatient acute care hospitals, a change implemented in 2018. Bylaws must now include the following, at a minimum:

1. Frequency of formal governing board meetings: At least twice per year, but may meet more often if desired/necessary to meet the needs of the service unit.
2. Membership of the GB: The minimum number of GB members is determined by the Chair (Area Director) and ensures adequate representation of disciplines to carry out the required activities. All GB members have a vote and the majority of voting members must represent the Area Office and may also include similar representation from Service Units.
3. Due to the inherent federal functions of governing federal facilities, members of the Governing Board must be IHS federal employees/officers.
4. Tribal consultation is encouraged through Chief Executive Officer (CEO) communications with Tribal Leadership, and Tribal representatives may be invited to open forums or town hall meetings in order to provide input.
5. Meeting Agendas: At a minimum, GB meeting agendas must include the following elements:
    - Quality of Care – including quality improvement and quality assurance/compliance
    - Patient Safety
    - Hospital/Facility Operations

These five primary components ensure a baseline of standards IHS-wide while maintaining maximum flexibility for the Areas and Service Units to amend their respective bylaws based upon needs specific to their locations and service populations.

In 2018, all IHS hospitals were aligned under a single source of accreditation to ensure a standardized approach and consistent standards across the system. To support this activity and ensure sustainment, IHS developed an acquisition plan to contract with a single accreditation organization for surveys and accreditation technical assistance at all IHS direct service hospitals. This achieves economy of scale and a uniform knowledge base of accreditation standards, best practices for quality and safety, and cross-agency support for accreditation readiness activities. The contract was awarded to The Joint Commission on September 29, 2017, for accreditation of all IHS direct service hospitals. Similarly, a contract was concurrently awarded to the Accreditation Association for Ambulatory Health Care to provide accreditation services to IHS direct service ambulatory health centers.

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. The instrument was finalized in March 2017, and the first phase of pilot testing of survey administration using electronic tablets (to facilitate data collection and reporting) is complete. Continued piloting and expansion of the number of facilities implementing this tool will continue throughout FY 2019.

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. This standard was incorporated into a measure for the Quality Accountability Dashboard so that it can be monitored routinely and improved.

In 2018, IHS evaluated and determined that the Patient Safety Event Reporting System, WebCident, required replacement to improve the interface. In July 2018, IHS released a Request for Proposals for an adverse event reporting system. In August 2018, a technical expert panel reviewed and recommended a system for selection and a contract was awarded in December 2018. In 2019, IHS will implement the adverse events system across the IHS system.

In 2018, 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.

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.

In 2018, the IPC program 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 IPC program also implemented a national reporting system for the 21 PCMH measures in collaboration with the IHS Office of Information Technology. In 2018, IHS implemented a web based collaborative learning environment to support quality improvement and PCMH information dissemination and knowledge exchange. As of the end of FY 2018, 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.

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 a multi-disciplinary workgroup, nursing is co-leading the formulation of a comprehensive agency-wide Infection Control Policy that will establish the national framework

for infection control programs in IHS. The development of this policy focuses on several core infection control technical content, including: hand hygiene, blood borne pathogen exposure, and isolation precautions. The development of the draft policy is proceeding toward a national comment period and will be ultimately published in the Indian Health Manual, the IHS national policy repository.

Adverse event reporting is the foundation of efforts to expand knowledge of issues in patient safety and to provide learning opportunities. The December 2018 acquisition of a commercial-off-the shelf adverse event reporting system to replace the current internally developed system will assist IHS to better identify risks and develop prevention strategies to increase patient safety. The system will be available for all federal IHS employees 24 hours a day, 7 days a week to report incidents and will be utilized at the national, regional, and local levels to investigate incidents.

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.

Trauma Care – Unintentional Injury is the leading cause of death and disability among the AI/AN population under age 45, and AI/AN trauma death rates are 2.4 times higher than U.S. all races rates (data years 2007-2009).[2] IHS hospitals are frequently the nearest emergency medical facility that can receive patients with traumatic injuries from emergency medical services providers (Paramedics, EMTs). Of the 23 IHS emergency departments (EDs), 52 percent are more than 50 miles from the nearest designated trauma center at any level. According to the FY 2017 IHS emergency department memo, there were 364,495 direct outpatient ED visits and 14,386 direct inpatient ED visits for IHS facilities. Recruitment and retention of competent and proficient staff for EDs at certain facilities posed a significant challenge to continuity of emergency services in FY 2018. A coordinated effort to address this challenge across all levels aims to improve recruitment and retention activities.

Trauma Center designation is determined by state and local municipalities based on unique criteria such as: trauma readiness, resources available, policies, patient care, and performance improvement. Currently, out of 23 IHS hospitals with an ED, only one is designated a Level III Trauma Center (provides prompt assessment, resuscitation, surgery, intensive care, and stabilization of injured patients and emergency operations).

Adequate staffing levels and capabilities, as well as state of the art equipment, are essential for quality care. Emergency medicine physicians, RNs, Advanced Practice Providers, and other highly trained staff are essential for crisis and disaster management to improve patient outcomes.

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

HIV/AIDS Program – AI/AN people face significant health disparities in rates of sexually transmitted infections including HIV. From 2005 to 2014, the Centers of Disease Control and Prevention (CDC) reported a 63 percent increase in HIV rates among gay and bisexual AI/AN men alone, while the overall HIV rate for all AI/AN increased by 19 percent. Racial and ethnic differences in HIV/AIDS survival from 2006-2011 showed that AI/ANs had the lowest survival rate after an AIDS diagnosis of any race.[3] HIV has affected nearly all communities served by the IHS; current statistics indicate many communities reported at least one patient with an HIV diagnosis.

The HIV/AIDS Program goal is to prevent new HIV infections and ensure access to quality health services for AI/ANs living with HIV/AIDS. IHS increased overall prenatal HIV screening to 87 percent in FY 2016 – a 15 percent increase over FY 2006 data. In FY 2016, IHS included HIV screening of 13-64 year-olds in its nationally reportable quality of care metrics. This 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 access to care in remote areas, the IHS HIV/AIDS Program provides technical support to IHS, tribal, and urban Indian health sites on screening and treatment, and the use of tele-health. The HIV/AIDS Program goal is to ensure access to quality health services for AI/ANs living with HIV/AIDS and those at risk of contracting HIV and commonly co-occurring infections.

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/ANs 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.

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 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 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. 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

3 https://www.cdc.gov/hiv/group/racialethnic/aian/index.html
4 https://www.ncbi.nlm.nih.gov/pubmed/?term=Edlin+Toward+amore+accurate+estimate

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 estimates cost of treatment for 40,000 current HCV patients at approximately $310 million.

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,[5] more than 4 in 5 AI/AN women (84.3 percent) have 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.

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 focuses on domestic and sexual violence prevention, advocacy, and coordinated community responses, as well as providing forensic healthcare services to victims of domestic and sexual violence. In FY 2017, the IHS issued 26 new awards to participate in the DVPP. In May of 2018, IHS initiated a Tribal Consultation and an Urban Confer regarding behavioral health initiatives and the distribution of funding for the DVPP program. Over 250 comments and recommendations were received and a summary was provided in a letter to Tribes. The National Tribal Advisory Committee on Behavioral Health is reviewing the responses and will provide recommendations to the IHS Director.

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. 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.

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

FUNDING HISTORY

Fiscal Year	Amount	DVPP
2016	$1,857,225,000	($8,967,278)
2017	$1,935,178,000	($12,967,278)
2018	$2,055,128,000	($8,967,278)
2019 Annualized CR	$2,054,562,000	($8,967,278)
2020 President's Budget	$2,363,278,000	($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 federally inherent functions and is therefore retained by IHS to perform the basic operational services of the Agency.

BUDGET REQUEST

The FY 2020 budget submission for Hospitals and Health Clinics of $2.4 billion is $308.7 million above the FY 2019 Annualized CR.

FY 2019 Base Funding of $2.1 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 2020 Funding Increase of $308.7 million includes:

1. Current Services: +$42.9 million for current services including:

   - Pay Costs +$2.1 million – to fund pay increases for federal and Tribal employees, of whom approximately 90 percent work at the service unit level providing health care and related services.

   - Inflation +$15.8 million – to fund inflationary costs of providing health care services.

   - Population Growth +$25.0 million – to fund the additional services need arising from the growing AI/AN population. The growth rate is projected to be 1.8 percent in CY 2020 based on state births and deaths data.

2. Staffing for New Facilities +$71.8 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
Cherokee Nation Regional Health Center (JV), Tahlequah, OK	$64,931,000	506
Yakutat Tlingit Tribe Health Center (JV), Yakutat, AK	$1,485,000	9
Ysleta Del Sur Health Center (JV), El Paso, TX	$5,346,000	46
Grand Total:	**$71,762,000**	**561**

3. Program Adjustment +$141.0 million – to increase funding for direct patient care services, including hospitals and health clinics. The budget proposes to prioritize direct services while redirecting/reducing funding for other activities.

4. Ending Hepatitis C and HIV/AIDS +$25.0 million - to establish the Ending the HIV Epidemic: A Plan for America and Eliminating Hepatitis C in Indian Country. This funding will aim to diagnose all individuals with HIV as early as possible after infection, treat the infection rapidly and effectively to achieve sustained viral suppression, protect individuals at risk of HIV using proven prevention approaches, and respond rapidly to growing HIV clusters to prevent new HIV infections. The goal of the Ending the HIV Epidemic Initiativeis to reduce new infections in the United States by 75 percent in the next five years and by 90 percent in the next 10 years.

   As part of the Ending the HIV Epedemic Initiative, IHS would provide funding for medication to treat Hepatitis C (HCV) and screening to reduce new HIV infections. Resources would also provide case management services for AI/AN patients in I/T/U facilities, and a portion of the funds would be used for data collection, clinical documentation, surveillance, and evaluation to determine the effectiveness and impact of this funding. This Budget includes:

   $7 million: to implement four strategies in response to the HIV Epidemic. The four strategies include Diagnosing, Treating, Protecting, and Responding to the HIV Epidemic. IHS will address the strategies by:

   A. Diagnosing AI/AN people with HIV as early as possible after infection and connecting them to immediate treatment by expanding screening and sexual health history screening efficacy;
   B. Treating HIV infections rapidly and effectively to achieve sustained virologic response by enhancing and expanding capacity at I/T/U clinics;
   C. Protecting people at risk for HIV by using Pre-Exposure Prophylaxis (or PrEP) and addressing injection drug use, and increasing syringe service programs in tribal communities; and
   D. Responding rapidly to detect and characterize HIV clusters in Indian Country by training a boots-on-the-ground workforce of culturally competent public health professionals interacting with tribal communities.

   These HIV funds will also be used to develop educational toolkits and outreach to educate AI/AN community stakeholders on the Ending HIV Epidemic Initiative, its

mission, goals, strategies, and activities. Finally, the Budget would provide cooperative agreements to the network of Tribal Epidemiology Centers (TECs) to reduce new HIV infections, improve HIV-related health outcomes, and to reduce HIV-related health disparities among AI/AN people. The goals of this proposal will be accomplished by supporting innovation, collaboration, and the integration of best practices, effective strategies, and promising emerging models in response to HIV among minority communities.

$18.0 million: for the prevention and treatment of HCV, which will be modeled after the successful outcomes-driven work done by the Cherokee Nation and the Northwest Portland Area Tribes. In 2015, the Cherokee Nation became the first tribe in the nation to launch a HCV elimination project. Over 600 patients are either currently being treated for HCV or have been cured. The Portland Area HCV ECHO was launched in January 2017, following a clinical training with providers. Between January and August of 2017, the Portland Area's ECHO, in collaboration with the Northwest Portland Area Indian Health Board, reviewed 70 HCV patient cases from a variety of clinics in the Portland, Billings and Great Plains Areas.[6]

AI/AN people are disproportionately affected by and face greater disparities from HCV infection. National data reveal AI/ANs experience more than double the national HCV-related mortality rate and have the highest rate of acute HCV.[7] AI/AN people also have the largest increase in liver and intrahepatic bile duct cancer (which is associated with chronic HCV infection) compared to any other race/ethnicity.[8] Estimates of HCV patients in the IHS user population range as high as 120,000.[9]

This funding will support the *Ending HIV Epidemic Initiative* by testing for HIV/AIDS, as Hepatitis C prevention and treatment services also help reduce active transmission of HIV/AIDS. The Health Resources and Services Administration estimates about 25 percent of people living with HIV also have Hepatitis C, and people who are co-infected are more likely to have life-threatening complications from Hepatitis C.

The National Viral Hepatitis Action Plan, 2017-2020, identifies four national goals to be achieved by 2020:

- Prevent New Viral Infections;
- Reduce Deaths and Improve the Health of People Living with Viral Hepatitis;
- Reduce Viral Hepatitis Health Disparities; and
- Coordinate, Monitor, and Report on implementation of Viral Hepatitis Activities.

Funding would support the following activities identified under each goal:

Goal 1: Prevent New Viral Hepatitis Infections

[6] J.Leston, Clinical Program Coordinator, HIV/HCV Program, Northwest Portland Area Indian Health Board (in review for publication)
[7] https://www.cdc.gov/hepatitis/statistics/2016surveillance/index.htm
[8] Ryerson, A. B., Eheman, C. R., Altekruse, S. F., Ward, J. W., Jemal, A., Sherman, R. L., ... & Anderson, R. N. (2016). Annual Report to the Nation on the Status of Cancer, 1975-2012, featuring the increasing incidence of liver cancer. *Cancer*, *122*(9), 1312-1337
[9] https://www.ncbi.nlm.nih.gov/pubmed/?term=Edlin+Toward+amore+accurate+estimate

AI/ANs had the highest percentages of diagnosed HIV infections due to injection drug use and the highest opioid overdose deaths in 2015, which has made many communities vulnerable to outbreaks of HIV and viral hepatitis among people who inject drugs (PWID). Federal funds can now be used to support a Syringe Services Programs (SSPs). IHS will partner with the Centers for Disease Control and Prevention (CDC) to support SSPs for Tribes experiencing or at risk for significant increases in viral hepatitis infections or an HIV outbreak due to injection drug use

Goal 2: Reduce Deaths and Improve the Health of People Living with Viral Hepatitis

The CDC and the United States Preventive Services Task Force sent a clear signal to health care professionals and the public that screening for HCV is both effective and necessary. Increased funds could support development of necessary case management models incorporating initial testing and diagnosis, linkage to care, access to care, treatment and/or cure. These models can be used to track progress in the proportion of patients who are identified and at various steps in care, and to identify and overcome gaps. Funding could also provide training on recommendations to expand the number of people who should receive screening, help diagnose, and link people into care and treatment, and prevent advanced disease and death. IHS Project Extension for Community Healthcare Outcomes (ECHO) can support these activities.

Goal 3: Reduce Viral Hepatitis Health Disparities

The high cost of viral hepatitis therapy limits access to lifesaving medications. In the case of HCV, the course of treatment is a one-time expense with most people requiring 12 weeks of treatment. Due to the extremely high initial price of the new curative HCV therapies, many insurers have imposed access restrictions such as having a fibrosis score of F3-F4 (moderate fibrosis or cirrhosis), being abstinent from illicit drugs and alcohol for a certain length of time or being treated by a liver specialist. The Budget would support medication procurement and medication management for HCV.

Goal 4: Coordinate, monitor, and report on implementation of viral hepatitis activities

Cascades and continua of care are models that illustrate the sequential steps people living with viral hepatitis go through. From initial testing and diagnosis, linkage to care, access to care, treatment and/or cure, these models can be used to track progress in the proportion of patients who are identified and at various steps in care, and to identify and overcome gaps. In the United States, these care models have been well studied for HIV and HCV. The Budget will support enhancements to the data infrastructure to track patients through the HCV cascade, support clinical decision-making tools, and provide HCV surveillance.

There is an urgent need to diagnose and treat patients with HCV, especially those who are asymptomatic and in late stage disease. Previously, the high cost of drugs has led IHS to depend on third party payers to contain costs, adding barriers to accessing drugs. Nationwide, thousands of patients with HCV have not received treatment or have failed treatment under the earlier generation of far less effective HCV treatments. In FY 2019, IHS included three HCV treatment drugs to the National Core Formulary to address patient needs within AI/AN communities. Follow-up of historical and current patients with diagnosed HCV requires a strong effort to ensure that all patients are treated before the onset of life threatening or fatal HCV related liver damage.

The HHS National Viral Hepatitis Strategic Plan has identified AI/ANs as a priority population, but IHS resources have not specifically targeted HCV. HCV services can support linkages to recovery and treatment programs, and reduce active transmission of HCV among persons who inject drugs. HCV treatment is also aligned with the Secretary's priority to respond to the opioid epidemic, as HCV services can support linkages to recovery and treatment programs and reduce active transmission of HCV among persons who inject drugs.

5. National Community Health Aide Program (CHAP) +$20.0 million – to establish the evidence-based National Community Health Aide Program, which will provide a network of health aides trained to support other health professionals while providing direct health care, health promotion, and disease prevention services. The program will increase access to direct health services, including inpatient and outpatient visits and will include 55 FTEs to staff the program. The proposed funding level also 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 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.

   The funding would allow for this community-based, culturally responsive, and efficient model of health care to be expanded nationally, to the lower 48 states, consistent with the 2010 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 proposed increase of $20 million would be utilized as follows:

   - $5 million: Development of a robust training center network through the utilization of Tribal Colleges and Universities. The training center network would consist of partnerships with and funding for Tribal Colleges and Universities to serve as regional training centers to train behavioral, community, and dental health aides.
   - $5 million: Establishment, operation, and management of CHAP certification boards to ensure compliance the IHCIA to certify individuals under the national CHAP.
   - $10 million: Provide funding to Tribes to support the expansion of CHAP. The proposed increase will establish a new program that would be contracted and compacted by Tribes to establish their own CHAPs after receiving training and certification as described above.

6. New Tribes +$11.5 million – to fund direct health care services for the six Tribes federally recognized on January 30, 2018. The Tribes are as follows:
   - Chickahominy Indian Tribe
   - Chickahominy Indian Tribe - Eastern Division
   - Monacan Indian Nation
   - Nansemond Indian Tribe
   - Upper Mattaponi Tribe

- Rappahannock Tribe

After federal recognition, new tribes are eligible for funds and services within the IHS. Per House Resolution 984, "On or after the date of enactment of this Act, the tribe and tribal members shall be eligible for all services and benefits provided by the Federal Government to federally recognized Indian tribes without regard to the existence of a reservation for the tribe." Additional funding is requested so that the concomitant increase in healthcare service demand does not impact or diminish the funding available for care of existing direct service Tribes.

7. Recruitment and Retention +$8.0 million - for the recruitment and retention of medical personnel for IHS facilities. The additional funds will be used in support of a range of recruitment and retention strategies aimed to enhance and support the mission of the IHS. Initiatives include housing subsidies, Title-38 pay compensation, increased IHS Loan Repayment and Scholarship awards, supplemental loan repayment. Funds will also support the expansion of IHS Recruitment and Outreach activities. This funding level will support $2 million for housing subsidies, $2 million for Title 38 pay compensation, $1.8 million for IHS loan repayments and scholarship awards, and $2.2 million for supplemental loan repayment programs.

   The successful recruitment and retention of employees is a high priority for the IHS. IHS proposes to fund its existing housing subsidy and Title 38 pay authorities to provide competitive employment packages for qualified healthcare professionals and increase the IHS competitive stance in the healthcare labor market.

   For those civilian health professionals that are assigned or accept staff quarters, a housing subsidy would be offered equivalent to the amount charged by General Services Administration. Health professionals not assigned to staff quarters would be offered housing subsidies based on a mileage rate of the nearest location where housing is available as determined by the agency. The determined rates would be level for health professions staff regardless of pay grade. IHS leadership would determine and publish a listing of remote sites eligible to receive a housing subsidy. The program would target critical positions based on IHS vacancy data. The housing subsidy would be provided to civilian employees as a supplemental housing allowance.

   IHS has the delegated authority to use Title 38, Chapter 74, for compensation purposes, including IHS developed Title 38 pay tables. IHS currently has nine IHS Title 38 pay tables but can develop more, or increase current pay tables as long as additional funds are available. By providing more competitive pay, IHS vacancy and turnover rates may be reduced.

8. Quality and Oversight +$2.0 million – to support the IHS vision for quality, based on IHS's mission to raise the physical, mental, social, and spiritual health of AI/ANs to the highest level.

   The quality oversight function of the IHS is to ensure compliance with relevant federal regulations, accreditation organization standards, and professional organization standards. Investments in innovations and quality improvement will improve patient outcomes and patient experience of care, reduce all cause harm and improve population health for AI/AN communities in support of the Secretary's priorities, in particular value-based care. Value based care is driven by improving patient experience care including quality of

care and improving population health of the communities served to reduce the per capita cost of health care. IHS provides an integrated and patient centered model of care in primarily rural and impoverished communities in partnership with Tribal leadership. For example, in 2016, IHS established a policy for all IHS federally-operated ambulatory care facilities to implement the PCMH model of care and obtain designation by either national accreditation organizations or CMS approved state based agencies. Currently, in IHS, 60 percent of health center based ambulatory care and 8 percent of hospital based ambulatory care is designed as PCMH.

These funds will be focused on quality assurance to obtain and maintain compliance with relevant Federal regulations, accreditation organization standards, and healthcare professional standards; improved quality and innovation capability to enhance improve patient outcomes, patient experience of care; and improved population health; and patient safety and clinical risk management to reduce all cause harm.

OUTPUTS/OUTCOMES

Measure	**Year and Most Recent Result / Target for Recent Result / (Summary of Result)**	**FY 2019 Target**	**FY 2020 Target**	**FY 2020 Target +/-FY 2019 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 2017: 99 % 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 In Place)	86.3 years	TBD	N/A
45 Hospital admissions per 100,000 service population for long-term complications of diabetes (Efficiency)	FY 2016: 58.1 Target: 56.0 (Target Not Met)	TBD	TBD	Maintain
55 Nephropathy Assessed (Outcome)	FY 2018: 44.2% Target: 34 % (Target Exceeded)	34 %	48.1%	+14.1%
56 Retinopathy Exam (Outcome)	FY 2018: 49.2% Target: 49.7 % (Target Not Met)	49.7 %	53.5%	+3.8%
57 Pap Smear Rates (Outcome)	FY 2018: 36.0% Target: 35.9 % (Target Exceeded)	35.9 %	39.2%	+3.3%

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2020 Target +/-FY 2019 Target
58 Mammogram Rates (Outcome)	FY 2018: 42.6% Target: 42 % (Target Exceeded)	Discontinued	Discontinued	N/A
59 Colorectal Cancer Screening Rates (Outcome)	FY 2018: 31.9% Target: 32.6 % (Target Not Met)	32.6 %	34.7%	+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 (measles, mumps, rubella); 3 or 4 Hib (Haemophilus influenzae type b); 3 HepB (hepatitis B); 1 Varicella (chicken pox); 4 Pneumococcal conjugate. (Outcome)	FY 2018: 42.2% Target: 45.6 % (Target Not Met)	45.6 %	45.9%	+0.3%
67 Influenza Vaccination Rates among children 6 months to 17 years (Outcome)	FY 2018: 24.0% Target: 20.6 % (Target Exceeded)	20.6 %	26.1%	+5.5%
68 Influenza vaccination rates among adults 18 years and older (Outcome)	FY 2018: 23.3% Target: 18.8 % (Target Exceeded)	18.8 %	25.4%	+6.6%
69 Adult Composite Immunization (Output)	FY 2018: 54.9% Target: 54.9% (Baseline)	54.9%	59.7%	+4.8%
70 Statin Therapy for the Prevention and Treatment of Cardiovascular Disease among American Indians and Alaska Natives (Outcome)	FY 2018: 32.8% Target: 26.6 % (Target Exceeded)	26.6 %	35.7%	+9.1%
72 Tobacco Cessation Intervention (Outcome)	FY 2018: 28.9% Target: 27.5 % (Target Exceeded)	27.5 %	31.4%	+3.9%

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2020 Target +/-FY 2019 Target
73 HIV Screening Ever (Outcome)	FY 2018: 26.1% Target: 17.3 % (Target Exceeded)	17.3 %	28.4%	+11.1%
74 Breastfeeding Rates (Outcome)	FY 2018: 40.1% Target: 39.0 % (Target Exceeded)	39 %	43.6%	+4.6%
75 Controlling High Blood Pressure - MH (Outcome)	FY 2018: 48.4% Target: 42.3 % (Target Exceeded)	42.3 %	52.6%	+10.3%
81 IPV/DV Screening (Outcome)	FY 2018: 38.1% Target: 41.6 % (Target Not Met)	41.6 %	41.5%	-0.1%
87 Mammogram Rates: Proportion of eligible women who have had mammography screening within the previous two years. (Output)	FY 2019: Result Expected Jan 31, 2020 Target: Set Baseline (Pending)	Set Baseline	TBD	N/A

GRANTS AWARDS - H&HC funds support the Healthy Lifestyles in Youth Project,[10] 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 2018 Final	FY 2019 Annualized CR	FY 2020 Request
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

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

Hospital and Health Clinics

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2018 Final			FY 2019 Estimated			FY 2020 Estimated			FY '20 +/- FY '19
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$7,266	$352,940	$360,206	$7,266	$352,782	$360,047	$8,357	$405,790	$414,148	$54,100
Albuquerque	51,277	32,334	83,611	51,274	32,320	83,594	58,979	37,176	96,155	12,561
Bemidji	23,046	86,312	109,358	23,045	86,273	109,318	26,508	99,236	125,744	16,426
Billings	52,599	15,672	68,271	52,596	15,665	68,261	60,499	18,019	78,518	10,257
California	5,630	74,287	79,917	5,630	74,254	79,883	6,476	85,411	91,887	12,003
Great Plains	139,091	41,736	180,827	139,084	41,718	180,802	159,983	47,986	207,969	27,167
Nashville	13,478	67,251	80,729	13,477	67,221	80,698	15,502	77,322	92,824	12,126
Navajo	185,475	74,150	259,625	185,466	74,117	259,583	213,334	85,254	298,588	39,005
Oklahoma	114,205	267,999	382,205	114,200	267,879	382,079	131,359	308,130	439,490	57,411
Phoenix	113,488	78,368	191,856	113,482	78,333	191,815	130,534	90,103	220,637	28,822
Portland	25,845	56,463	82,307	25,843	56,437	82,281	29,726	64,918	94,644	12,363
Tucson	2,296	20,002	22,298	2,296	19,993	22,289	2,641	22,997	25,638	3,349
Headquarters	153,919	0	153,919	153,911	0	153,911	177,037	0	177,037	23,126
Total, H&HC	**$887,614**	**$1,167,514**	**$2,055,128**	**$887,571**	**$1,166,991**	**$2,054,562**	**$1,020,936**	**$1,342,342**	**$2,363,278**	**+$308,716**

Note: FY 2019 through 2020 are estimates.

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

HOSPITALS AND HEALTH CLINICS

Tribal Epidemiology Centers

(Dollars in Thousands)

	FY 2018	FY 2019	FY 2020	
	Final	Annualized CR	President's Budget	FY 2020 +/- FY 2019
BA	$2,055,128	$2,054,562	$2,363,278	+$308,716
Epi Centers	*$4,443*	*$4,433*	*$4,433*	-

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 2020 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 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 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 award cycle, all 12 TECs were awarded an annual average of $338,675 (beginning FY 2016). The next 5-year competitive award cycle will encompass FYs 2021-2026 and is projected at similar funding levels for each TEC.

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

PROGRAM ACCOMPLISHMENTS

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 to designate the TECs as public health authorities. To ensure the security of the agency data access, data sharing agreements are required before TECs access IHS-generated data sets.

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.

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.

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 quality of care and develop recommendations for the targeting of services needed by the populations served.

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*
2016	*$4,433,361*
2017	*$4,433,361*
2018	*$4,433,361*
2019Annualized CR	*$4,433,361*
2020 President's Budget	*$4,433,361*

*Funded under the H&HC budget.

BUDGET REQUEST

The FY 2020 budget submission for the TECs under Hospitals and Health Clinics is $4,433,361, the same as the FY 2019 Annualized CR. 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. The table below identifies the twelve TECs and their respective locations.

Tribal Epidemiology Centers and Locations		
1	Alaska Native Tribal Health Consortium	Anchorage, AK
2	Albuquerque American Indian Health Board	Albuquerque, NM
3	Great Lakes Inter-Tribal Council	Lac du Flambeau, WI
4	Inter-Tribal Council of Arizona	Phoenix, AZ
5	Montana/Wyoming Tribal Leaders Council	Billings, MT
6	Navajo Nation Division of Health	Window Rock, AZ
7	Northern Plains – Great Plains Area	Rapid City, SD
8	Northwest Portland Area Indian Health Board	Portland, OR
9	Oklahoma City Area Inter-Tribal Health Board	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 2019 Target**	**FY 2020 Target**	**FY 2020 Target +/-FY 2019 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 2017: 2,943Target: 850[1] (Target Exceeded)	850	1897	+1,047

[1]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 2017: 210 Target: 89 (Target Exceeded)	89	89	Maintain

New measures adopted by Tribal Epidemiology Centers Consortium during mid-FY 2016

GRANTS AWARDS

(whole dollars)	FY 2018 Operating	FY 2019 Annualized CR	FY 2020 Request
Number of Awards	12	12	12
Average Award	$338,675	$338,675	$338,675
Range of Awards	$265,250 -$412,000	$265,250 -$412,000	$265,250 -$412,000

* 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 2018	FY 2019	FY 2020	
	Final	Annualized CR	President's Budget	FY 2020 +/- FY 2019
BA	$2,055,128	$2,054,562	$2,363,278	+$308,716
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 2020 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) 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. 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 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.

The HIT Program is dedicated to providing the most innovative, effective, cost-efficient, and secure HIT system in the federal government. The HIT program is comprised of 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) **HITSS** is an enterprise health information system that underlies the clinical, practice management and revenue cycle business processes at I/T/U facilities across the

country. The IHS 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 pursuit of expanding capabilities, the HITSS Program Management Office (PMO) continued the deployment of new health information sharing and patient engagement features, collectively called the RPMS Network, throughout FY 2018 and began its planning efforts for the IHS implementation of the IT requirements for the Medicare Access & Children's Health Insurance Program (Reauthorization Act (MACRA) of 2015) and other quality improvement initiatives.

2) **NPIRS** is an enterprise-wide data warehouse and business intelligence environment that produces reports required by statute and regulation and provides a broad range of clinical and administrative information, and associated analytical tools, to managers at all levels of the Indian Health system. This investment is evolving to add rigor to the analytic platform, 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.

3) **IOAT** program consists of six IT investments to provide the technical infrastructure for federal and some tribal healthcare facilities and is the foundation upon which all health IT services are delivered. These investments are: IT Management Standard Investment, Data Center and Cloud Standard Investment, Network Standard Investment, Platform Standard Investment, Delivery Standard Investment, End User Standard Investment, and Application Standard Investment. The IOAT program includes a highly available and secure wide area network which includes locations with unique telecommunication challenges, a national e-mail and collaboration capability that is designed specifically to support health care communication and data sharing, enterprise application services and supporting hardware including servers and end-user devices. The IT infrastructure incorporates government and industry standards for the collection, processing, storage, and transmission of information and is poised to respond to new and pioneering opportunities.

4) **IT Security and Compliance** is an enterprise-wide IT Security Program that creates information security policy, secures centralized resources, and provides cybersecurity training for employees and contractors.

5) **IT Management** investment is an enterprise-wide program that supports IT Management, Capital Planning, Strategic Planning, Enterprise Architecture, IT Finance, and IT Vendor Management activities in support of the two Mission Delivery IT investments. This program serves to promote compliance with federal law and mandates and to improve efficiency and effectiveness of all IHS HIT investments.

PROGRAM ACCOMPLISHMENTS

FY 2018 Accomplishments and Progress to Date

People

- 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.

- Continued deployment of the new health information sharing and patient engagement capabilities in support of improving how we deliver services. Resource and Patient Management System (RPMS) Network accomplishments include:

    - RPMS Direct Messaging: Over 20,000 messages were exchanged between *patients, providers, administrators, and message agents through a*pproximately 13,771 unique direct e-mail addresses.
    - Personal Health Record (PHR): PHR implementation is underway with approximately 11,000 PHR users. *Fifty-six percent of these registered PHR users were verified/linked to their IHS Medical Record. The remaining 44 percent are registered but not yet verified/linked.*
    - Master Patient Index/Health Information Exchange: *Completed onboarding 160 of the 173 requesting sites. Additional sites continue to be onboarded as agreements are established.*

- In response to issues identified by field and program staff, OIT significantly reduced 4,750 active RPMS/RPMS EHR service desk tickets by 80 percent and closed over 4,400 tickets with approximately 350 remaining open.

- Provided a total of 278 HIT training courses to 5,483 I/T/U users as of June 2018. This included 107 classroom/satellite sessions with 1,196 participants and 171 eLearning/eLearning hands-on sessions with 4,287 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 1,200+ registered users.

- In support of Purchased/Referred Care (PRC) Program Reform, the OIT consistently provided RPMS practice management training to I/T/U users and worked closely with Office of Resource Access and Partnership to keep PRC software maintained and up-to-date.

Partnerships

- On September 12 2018, HHS awarded a contract to Emerging Sun, LLC, with subcontractors Pistis, LLC and Regenstrief Institute, for an IHS HIT Modernization Research Project. This contract is sponsored by the Department of Health and Human Services (HHS) Office of the Chief Technology Officer (OCTO), and was planned in close cooperation with IHS Senior Staff and OIT. The HHS Modernization Kickoff Meeting was held on October 9-12, 2018 with IHS, HHS, and the companies that will be engaged in the HHS Modernization efforts: Emerging Sun, Pistis, and Regenstrief Institute.

- The Information Systems Advisory Committee (ISAC) held one semi-annual meeting in March and the September meeting was rescheduled by ISAC for November in Albuquerque.

The meeting was well attended with 27 I/T/U participants, both in person and by teleconference. The discussion focused on several IHS IT initiatives, including but not limited to, IHS HIT modernization efforts, ISAC Charter revisions, IHS Strategic Plan update, the IT Service Catalog, and the IT Human Capital Work Plan, and updates to the ISAC IT priorities.

- The OIT conducted 15 Tribal Consultation and Urban Confer sessions on the draft IT Service Catalog, generating considerable tribal participation with over approximately 125 participants. The IT Service Catalog was completed in September 2018.

- The IHS Chief Information Officer (CIO) began reporting on the IHS's monthly "All Tribal and Urban Indian Organization Leaders" conference calls to share IHS IT/HITSS information. Reports have been well received.

- Developed and implemented the Quarterly National Chief Information Officer Newsletter to promote outreach and education of HIT and IT for IHS dissemination to I/T/U.

- Collaboration with tribal health programs and other federal agencies is key to the success of the HIT Program. IHS worked closely with the Office of the National Coordinator for HIT, Centers for Medicare and Medicaid Services, Agency for Healthcare Research and Quality, the Department of Veteran's Affairs (VA), and other federal entities on IT initiatives to ensure that the direction of its HIT systems are consistent with other federal agencies.

- Collaborating with the Open Source Electronic Health Record Alliance to facilitate making IHS HIT innovations and advances available to the broader public.

Quality

Health Information Technology

- Modernizing 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. Planning for system changes required to support implementation of Medicare Access and CHIP Reauthorization Act (MACRA). Participated in the IHS MACRA Working Group in providing Headquarters/field staff with information, webinars, and a quality initiative boot camp on the Quality Payment Program and MACRA requirements.

- Continued the successful use of a predictable, quarterly release schedule for the IHS EHR system software applications, to improve the efficiency of the development and release processes and to continuously demonstrate value for end-users.

- Completed the development and release of more than 80 software updates, including 4 versions, 69 patches, and 6 terminology content releases to date.

- Completed the base year of consolidated software development contract achieving: code bases consolidated onto a single platform; standardized methodology approaches in place; flattened reporting and reduced contract meetings (1 contractor vs. 5); homogenized work streams (1 point of contact for project management/development assignments vs. 5); and knowledge silos being broken down in a shared work environment resulting in faster

turnaround time and a more easily navigable process of remediating software defects, patch releases, software enhancement and user support.

- Established collaboration, development and test environments accessible by a geographically dispersed team. Collaboration tools include Azure, Visual Studio Team Services (VSTS), and SharePoint.

- Implemented cloud development environments (Azure and VSTS) to support the journey towards agile and a DevOps methodology.

- Continued implementation of a VA-developed Bar Code Medication Administration (BCMA) solution, which is designed to prevent medication errors in healthcare settings and improve the quality and safety of medication administration, across the Indian health system. The overall goals of BCMA are to improve accuracy, prevent errors, and generate online records of medication administration.

- Implementation of the Emergency Department (ED) Whiteboard. Established electronic tracking of patients that is used in places throughout the ED and is site configurable depending on where the site places the screen. This replaces the antiquated, manual process of tracking patients on a whiteboard in the emergency room, thereby avoiding mistakes that could lead to legal and medical risks and patient safety issues.

- Created a report to track results of the RPMS Suicide Risk Assessment, which was previously 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 Substance Abuse and Suicide Prevention Program (SASP).

- Moved the Clinical Care Document Audit logs to reduce local database growth. This reduced the amount of time a site has to spend monitoring the system, purging the logs, or increasing the space to accommodate the logs.

- Improved usability by providing the user with hover help for the mappings between SNOMED and ICD conditional map options in EHR, which reduces the workload on coders/billers and increases coding/billing output.

- Developed and implemented Phase 1 of the New Medicare Card initiative facilitating the documentation in RPMS of newly issued Medicare Beneficiary ID numbers.

- Projects supporting field driven Quality Improvement (QI), updates in evidence-base, emerging public health issues, reporting, 2015 CEHRT include:
  - Hep C evidence-based decision support tools management tools – development, field testing, and reminder files delivered to open source community.
  - Pregnancy intention/repro life plan evidence-based decision support tools - development, implementation, formal QI study, national poster presentation, documentation, deployment guide, knowledge transfer to area Clinical Application Coordinators (CACs), reminder files delivered to open source community.
  - Sexual Orientation / Gender Identity (SOGI) requirements for EHR – evidence-based, engagement with stakeholders including IHS- LGBTQ Two Spirit workgroup (federal/tribal employees and non-employee community members). SOGI evidence-

based training development and presentations (numerous)– evidence-based collaboration between IHS and IHS-LGBTQ Two Spirit workgroup.
  - Nursing care plan documentation tools – terminology and workflow.
  - Tobacco care planning (pharmacy) – terminology and workflow.
  - Forensic codes – collaboration with forensic consultants to develop evidence-based, clinically relevant SNOMED content including submission to National Library of Medicine (NLM), to properly document forensic care.
  - New quality measurements – extensive information system and evidence-base analysis to identify additional measurements needed to support opioid care, behavioral health, inpatient care, chronic care model.
  - Patient Wait Times requirements and interim solutions identified.

National Patient Information Reporting System

- Completed initial deployment of the new Integrated Data Collection System (IDCS), which will improve the quality, effectiveness, and utility of GPRA reporting. Supported quality improvement initiatives for the Great Plains Area.

- Implemented a new system 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.

- Created and enhanced the Data Warehouse Export System (BDW) extract – extensive analysis to improve data extraction for business intelligence (BI).

- Began new Personal Health Record (PHR) 'Always On' Environment; expanded and stabilized the HIE 'Always On' Environment; conducted a Disaster Recovery (DR) exercise for HIE, Direct Messaging and MPI.

- Made Behavioral Health (BH) portal upgrades; developed a new security model for BH data.

- Supported requests to supply data for multiple OIG Reports.

- Provided opioid use disorders (OUD) and opioid information for Headquarters and Congress; began pattern analysis of disparate data related to opioid use.

- Provided information for level of need funded calculation metrics and analytics.

- Developed GIS mapping including community based poverty levels for Division of Program Statistics (DPS).

- Provided data for inpatient, outpatient and emergency department (ED) memos.

- Deployed National Data Quality Reporting Tool and Reports; developed enhancements to the IPC Measures Dashboards including working with RPMS iCare mapping; provided Dental report ad hoc support.

- Developed and implemented a strategy for Business Intelligence Enterprise reporting. Configured and installed the Qlik BI software within the enterprise System Development

Life Cycle environments. Developed a Center of Excellence (COE) framework to support BI delivery standards and reuse across the agency.

- Developed Division of Oral Health Clinical Efficiency and Effectiveness Indicators.

Health Information Technology

- Continued planning for the deployment of systems changes needed in support of the proposed Meaningful Use (MU) 3 initiative. Challenges to this initiative include diminution of the MU incentive funding, together with inflationary costs that will constrain the ability of the HIT investments to maintain current services or to enhance systems.

- Participated in the "New Medicare Card" project team to address impacted RPMS applications and provided information/outreach to IHS facilities to assist in preparing for the new Medicare Beneficiary Identifier.

Infrastructure, Office Automation, and Telecommunications (IOAT)

- Network Standard Investment: In support of bandwidth modernization, implemented network circuit upgrades to provide additional bandwidth at over 50 IHS hospital and clinics to improve access to the HIT and administrative applications essential to support daily operations. Upgrades ensure IHS is positioned to meet future bandwidth needs, simplifies the process to add bandwidth as growth is needed, and reduces costs.

- Data Center and Cloud Standard Investment: In support of the OMB Data Center Optimization Initiative (DCOI), implemented a high-density blade server environment and upgraded Storage Area Network to improve IHS Headquarters data center hosting capabilities of HIT, infrastructure and administrative applications.

- Delivery Standard Investment: Implemented a new Microsoft Active Directory domain to support secured centralized authentication of IHS HIT applications.

- Delivery Standard Investment: Implemented the Information Technology Service Management (ITSM) project to consolidate and standardize ITSM governance, processes and tools. Engaged a contractor who has begun IT process data collection.

- Network Standard Investment: Initiated work on the IHS Enterprise Infrastructure Solutions (EIS) contract (GSA Networx replacement) to ensure all items on the Networx contract are transitioned smoothly to the EIS contract. The IHS is required to take on a much larger role with the EIS contract which requires cross-organization involvement and to enhance service options available on contract and lower overall costs.

- Network Standard Investment: Continue to work through HHS Trusted Internet Connection (TIC) changes to provide segmentation between non-Federal networks and IHS through a TIC, control access to IHS network resources on an as-needed basis only, and have only IHS controlled networks on the IHS wide area network to create a defined network security boundary.

- Security and Compliance Standard Investment: Initiated an IT Access Control (ITAC) replacement project aimed at utilizing a commercial product to eliminate the overhead of

maintaining an in-house application, provide system integration for automation, add efficiency and enforce security standards, and ensure IHS meets requirements for IT security.

Cybersecurity

- The IHS Cybersecurity Program was selected as one of 50 organizations (and people within them) to win a CSO Magazine's CS050 award for developing and implementing security initiatives that drive business value. The IHS was selected due to the quality of our cybersecurity program and security initiatives that demonstrate outstanding business value and thought leadership.

- Software Engineering Systems and Support (SESS) Vulnerability Management: The SESS Team started coordinating the mitigation of findings from the CIRST Weekly Vulnerabilities Report in February of 2018. The initial report contained a total of 794 findings for both the SESS project and OIT. Through July 27, 2018, 1,017 were mitigated, along with 749 new findings being discovered for a total of 362 current findings for all projects including OIT.

- Continuous Diagnostics and Mitigation efforts are underway 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.

- Enterprise Patch Management efforts are ever present through deployment of critical Windows security patches to systems that remain unpatched the 1st Tuesday of the following month that the patch is released. This will secure IHS IT systems to the highest possible levels.

- Performed nine system security assessments resulting in "Authorizations to Operate." To comply with HHS policy, all weaknesses from security assessments are captured and reported to HHS on a monthly basis.

- Implemented a comprehensive "Plan of Action and Milestones" process. All weaknesses from previous assessments and audits are now formally tracked and updated. Quarterly reviews are now occurring which requires staff to provide remediation updates to their reported weaknesses.

Capital Planning and Investment Control

- Effective implementation of the Federal IT Acquisition Reform Act (FITARA) is critical for IHS to demonstrate good stewardship of the funding we have been entrusted with, and to enable IHS to effectively negotiate for increased funding necessary to continue to improve its capabilities and service delivery to all IHS customers. The HHS CIO delegated authority related to FITARA to the IHS CIO, who subsequently implemented the following IT resource acquisition process changes Agency-wide:

- Implemented IT acquisition control reforms in the Unified Financial Management System (iProcurement) to route all IT Category approvals through OIT to comply with FITARA governance requirements.
- Established an enterprise-wide IT Approved Equipment/Software List with examples and correct Object Class Codes.
- Created IHS Enterprise contracts to combine buying power to lower operating costs, including the IHS Enterprise Qlik Business Intelligence system, and the IHS Enterprise MD Staffing Provider Credentialing system.

Policies and Procedures

- Completed the following approved and published Indian Health Manual (IHM) issuances:
  - Part 8 Chapter 1, “Chief Information Officer”
  - Part 8, Chapter 17, “Agency-Issued Mobile Devices Including Cellular Telephones, Smartphones, and Tablets”
  - Part 8, Chapter 23, “Resource and Patient Management System Network”
  - Administrative Delegation #52, "Security of Information Technology Systems"
  - Administrative Delegation #54, “Operating Division Chief Information Officer (CIO) Delegation of Authority, FY 2017”

- Work is underway to develop the new Part 10, “Cybersecurity,” a major policy change that will improve the security posture of the Agency.

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

Through continued maintenance and enhancement of the IHS HIT suite, the agency Quality Framework initiatives has foundational data to generate baselines and adapt performance metrics.

Some of this data has supported the recognition that the agency and patients are experiencing progressive health improvements in patient diabetic populations.

Immediate Priorities and Challenges

The IHS HIT Program 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. Virtually any 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[1]
2016	$182,149,000
2017	$182,149,000
2018	$182,149,000
2019 Annualized CR	$182,149,000
2020 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 federally inherent functions and is therefore retained by the IHS to perform the basic operational services of the Agency.

BUDGET REQUEST

The FY 2020 budget submission for Health Information Technology of $182.1 million is the same as the FY 2019 Annualized CR.

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

[1]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.

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 2019 Target	FY 2020 Target	FY 2020 Target +/-FY 2019 Target
HIT-1 OMB IT Dashboard - All IHS Major Investments will Maintain a score of 4/5 or greater (Outcome)	FY 2018: 4.0 Target: 4.0[2] (Target Met)	4.0	4.0	Maintain
HIT-2 HHS CIO Work plan - The IHS will score 90% or greater on the annual scoring of the HHS CIO Workplan (Outcome)	FY 2017: 83% Target: Not Defined[3] (Target Not In Place)	Achieved more than expected	Achieved more than expected	Maintain

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

[2] >= out of 5 for all investments

[3] Achieved more than expected.

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

(Dollars in Thousands)

	FY 2018	FY 2019	FY 2020	
	Final	Annualized CR	President's Budget	+/- FY 2019 President's Budget
BA	$0	$0	$25,000	+$25,000
FTE*	0	0	32	+32

* 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 2020 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) Program 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. Within the IHS HIT program, the IHS EHR 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.

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.

- Infrastructure, Office Automation, and Telecommunications Contract (IOAT) Support – The Headquarters IOAT contract provides a significant number of IT contract staff to operate and maintain critical IT services. Additional contract staff are required to support an EHR transition and perform the necessary IT infrastructure upgrades.

- IT Service Management (ITSM) Tool - This tool helps IHS to achieve a strategic goal of being the "Partner of Choice" for health IT services by improving the efficiency, effective use, and availability of ITSM practices and IT services which results in improved health care delivery and quality, reduced duplicative costs, enhanced access to care, reduced medical errors, and modernized administrative functions.

- Network Upgrades - Significant improvements are required to the current network infrastructure to support an EHR enhancement. Network bandwidth must be upgraded and aging equipment must be replaced to provide reliable and secure access for the new EHR solution.

FUNDING HISTORY

Fiscal Year	Amount
2016	$0
2017	$0
2018	$0
2019 Annualized CR	$0
2020 President's Budget	$25,000,000

BUDGET REQUEST

The FY 2020 budget submission for the Electronic Health Record System of $25 million is $25 million above the FY 2019 Annualized CR. These funds would 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 transformation.

- Electronic Health Record System 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 Veteran's 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 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.

This funding will support 32 FTEs. FTEs funded may include: IT Specialist (these positions include help desk, policy, planning, security, and development staff and Health Information Management, lab, pharmacy, imaging, nursing and provider consultants), Supervisory IT Specialist (manage teams and programs), Program Managers (training and field support), Budget

Analysts (manage spend plans and funding resources), Contracting Officer Representatives (oversee contract management), and Enterprise Architects (conduct enterprise technology analysis, design, planning, and implementation).

These staff will enable IHS to deploy an EHR across the 12 areas, 537 sites, and replace the 400+ instances of the current version of RPMS.

OUTPUTS/OUTCOMES

As a new initiative, Outputs/Outcomes will be determined.

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 2018	FY 2019	FY 2020	
	Final	Annualized CR	President's Budget	FY 2020 +/- FY 2019
BA	$193,283	$197,013	$212,370	+$15,357
FTE*	556	556	556	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 2020 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.

The demand for dental treatment remains high due to the high incidence of dental caries in AI/AN children. Over 80 percent of AI/AN children ages 6-9 and 13-15 years suffer from dental caries, while less than 50 percent of the U.S. population in the same age cohort have experienced cavities.[1,2] In addition to this disparity in prevalence, there is a significant disparity in severity of dental disease. AI/AN children ages 2-5 years exhibit an average of four decayed teeth, while the same age group in the U.S. population averages one decayed tooth.[3] A continuing emphasis on community oral health promotion/disease prevention is essential in order to address the current high prevalence, reduce the severity of oral disease and improve the oral health of AI/AN people. Prevention activities improve health and reduce the amount and cost of subsequent dental care. The DHP measures performance in part through the delivery of preventive services. The DHP maintains data and tracks three key program objectives:

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

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.

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.[4] 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.[5] In the 13-15 year-old age 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.[6] 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.[7]

PROGRAM ACCOMPLISHMENTS

In 2017, the DHP convened the first-ever oral health strategic planning meeting, with over 60 internal and external stakeholders representing all facets of public health dentistry focused upon mapping the future course of the IHS DHP. As a result of this meeting, a dental tribal advisory committee charter was created. The dental tribal advisory committee will work in partnership with the DHP to implement the future oral health strategic plan.

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 a greater chance of tooth decay in permanent teeth.[8] 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

[4] Indian Health Service. The 2010 Indian Health Service Oral Health Survey of American Indian and Alaska Native Preschool Children. Rockville, MD: U.S. Department of Health and Human Services. Indian Health Service, 2014.
[5] Phipps KR, Ricks TL, Blahut P. The Oral Health of 6-9 year old American Indian and Alaska Native children compared to the general U.S. population and Healthy People 2020 targets. Indian Health Service data brief. Rockville, MD: Indian Health Service 2014.
[6] 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.
[7] 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.
[8] 1. US Department of Health and Human Services, National Institute of Dental and Craniofacial Research, US Public Health Service. Oral Health in America: Report of the US Surgeon General. NIH publication no. 00-213. Washington, DC: DHHS, NIDCR, USPHS; 2000

children.[9] 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. By the end of this initiative, the IHS had increased access to dental care for AI/AN children under 71 months by 7.9 percent and significantly increased prevention and early intervention efforts (sealants increased by 65.0 percent, the number of children receiving fluoride varnish increased by 68.2 percent, and the number of therapeutic fillings increased by 161 percent), resulting in a net decrease of dental caries prevalence from 54.9 percent in 2010 to 52.6 percent in 2014, and an even more dramatic decrease in dental caries experience from 33.4 percent to 27.1 percent in 1-2 year-olds, one of the largest decreases in caries experience evident in dental literature over such a short time span.[10] To support this initiative, the IHS conducted a nationwide surveillance of 1-5 year-old AI/AN children through two coordinated efforts of 8,451 children in 2010 and 11,873 in 2014 – the largest oral health surveillance sample size ever of this age group in the AI/AN population.[11] While the national initiative has since ended, the IHS DHP continues to promote evidence-based best practices in ECC primary and secondary prevention including early access to dental services, dental sealants in primary and permanent teeth, fluoride varnish applications, and secondary prevention tactics such as interim therapeutic restorations and silver ion antimicrobials aimed at reducing the spread of dental caries once it has begun. In March 2017, the IHS was the first US government agency to develop a national silver ion antimicrobial (SIA) clinical guideline. The use of SIAs in IHS and tribal dental programs is a promising practice that could stop or arrest tooth decay in a significant number of AI/AN children.

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

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

[9] Indian Health Service. The 2010 Indian Health Service. The 2010 Indian Health Service Oral Health Survey of American Indian and Alaska Native Preschool Children. Rockville, MD: U.S. Department of Health and Human Services, Indian Health Service, 2013. Available at http://www.ihs.gov/doh .
[10] Ricks TL, Phipps KR, Bruerd BB. The Indian Health Service Early Childhood Caries Collaborative: A Five-year Summary. Ped Dent 2015, 37;3: 275-80.
[11] Phipps KR and Ricks TL. The Oral Health of American Indian and Alaska Native Children aged 1-5 years; results of the 2014 IHS oral health survey. Indian Health Service data brief. Rockville, MD: Indian Health Service. 2015. Available at http://www.ihs.gov/doh .

- 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.

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. The access to care goal in FY 2017, was 29.7 percent and the performance was 29.5 percent. While this measure was not met, it was a significant improvement from FY 2016 and represented the highest access rate in the IHS since dental access first began being measured in the 1990's. 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 our system, according to the IHS Dental Directory.[12] In 2017, there were 2,895,571 AI/AN in the U.S., according to the most recent user population estimate.[13] That means that in the IHS system we have 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[14] serving a population of 325,719,178,[15] 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 either sealants or topical fluorides. New annual targets were set for these two objectives as of July 1, 2013. In FY 2017, 31.9 percent of 1-15 year-old children received topical fluoride, an increase of 0.8 percent from FY 2016, and surpassing the annual goal of 29.9 percent. In FY 2017, 18.5 percent of 2-15 year-old children received dental sealants, an increase of 0.4 percent from FY 2016, and surpassing the annual goal of 16.6 percent.

[12] Indian Health Service, Department of Health and Human Services. IHS Dental Directory Report. www.ihs.gov/doh, accessed 13 January 2018.
[13] Indian Health Service, Department of Health and Human Services. User Population Estimates – FY 2017 Final, Revised 12/27/17.
[14] 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.
[15] U.S. Census Bureau. Population Estimates, July 1, 2017. https://www.census.gov/quickfacts/fact/table/US/PST045217, accessed 13 January 2018.

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. Through an annual continuous surveillance program, the DHP monitors disease burden and progress across all age groups, a process that began in its current form in 2010 with a combination of community-based, school-based, and clinic-based surveillance methodologies. In 2017, the DHP surveyed AI/AN children 6-9 years of age, following up on surveillance conducted in 2011-2012. While this age group continues to suffer disproportionately from dental disease – 86 percent of 6-9 year-old AI/AN children have tooth decay compared to 56 percent of the U.S. population and 6-9 year-old AI/AN children had three times the rate of untreated decay as the U.S. white children – this survey showed, for the first time, a significant decrease in dental disease in this age group.

Specifically, compared to a similar oral health survey conducted in 1999, AI/AN children 6-9 years of age had a decrease of 5 percent in tooth decay overall and a 17 percent decrease in tooth decay in permanent teeth, while untreated decay dropped from 73 percent in 1999 to just 47 percent in 2017. These changes mark the most significant decline in dental disease ever measured on a national scale in the DHP.[16] In 2018, the DHP will once again survey 0-5 year-old AI/AN children, following up on surveys conducted in 2010 and 2014.

The DHP has also made significant improvements in the way dental services are delivered. Through the implementation of an electronic dental record, over 90 percent of IHS and tribal dental programs have been transformed to an electronic system that will improve the quality and delivery of dental services. 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. 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. 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. 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 3 years, an Oral Maxillofacial Surgeon, an endodontist, two 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 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 251 in FY 2018. Between 2017 and 2018, a total of 74,287 hours of CDE were awarded, an estimated value of up to $14.8 million ($200/hour). In addition, through a concentrated effort to train alternative dental workforce

[16] 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: Indian Health Service. 2017.

models, in 2018 the CDE Program trained 101 dental assistants to perform periodontal and preventive dentistry functions similar to a dental hygienist, and trained 147 dental assistants to perform expanded restorative functions such as filling teeth to complement dentist treatment. These two 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 14.0 percent.

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. 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.

FUNDING HISTORY

Fiscal Year	Amount
2016	$178,286,000
2017	$182,597,000
2018	$193,283,000
2019 Annualized CR	$197,013,000
2020 President's Budget	$212,370,000

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

BUDGET REQUEST

The FY 2020 budget submission for Dental Health of $212.4 million is $15.4 million above the FY 2019 Annualized CR.

FY 2019 Base Funding of $197.0 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 2020 Funding Increase of $15.4 million, a net increase, includes:

- Current Services: +$3.5 million for current services including:
    - Pay Costs +$343,000 - to fund pay increases for federal and tribal employees, of whom approximately 90 percent are working at the service unit level providing health care and related services.
    - Inflation +$1.4 million - to fund inflationary costs of providing health care services.

- Population Growth +$1.8 million - to fund the additional services need arising from the growing AI/AN population. The growth rate is projected to be 1.8 percent in CY 2020 based on state births and deaths data.

- Staffing for New Facilities +$4.8 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
Cherokee Nation Regional Health Center (JV), Tahlequah, OK	$3,155,000	37
Yakutat Tlingit Tribe Health Center (JV), Yakutat, AK	$1,116,000	3
Ysleta Del Sur Health Center (JV), El Paso, TX	$570,000	5
Grand Total:	**$4,841,000**	**45**

Program Adjustment +$7.0 million - to increase funding for direct patient care services, including dental services. The budget proposes to prioritize direct services while redirecting/reducing funding for other activities.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2020 Target +/-FY 2019 Target
61 Topical Fluorides (Outcome)	FY 2018: 32.9% Target: 30.0 % (Target Exceeded)	30.0 %	34.5%	+4.5%
62 Access to Dental Services (Outcome)	FY 2018: 28.3% Target: 27.2 % (Target Exceeded)	27.2 %	29.7%	+2.5%
63 Dental Sealants (Outcome)	FY 2018: 16.4% Target: 16.0 % (Target Exceeded)	16.0 %	17.2%	+1.2%

GRANTS AWARDS

The purpose of the 5 grant awards is to support the Dental Preventive and Clinical Support Centers program (also known as Dental Support Centers or DSCs). The 5 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 2018 Final	FY 2019 Annualized CR	FY 2020 Request
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 SERVICES	FY 2018 Final			FY 2019 Estimated			FY 2020 Estimated			FY '20 +/- FY '19
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$339	$34,129	$34,469	$348	$34,652	$35,000	$375	$37,353	$37,728	$2,728
Albuquerque	4,742	3,897	8,639	4,861	3,957	8,818	5,240	4,265	9,505	687
Bemidji	2,023	2,461	4,484	2,074	2,498	4,572	2,235	2,693	4,929	356
Billings	5,746	1,774	7,520	5,890	1,801	7,691	6,349	1,942	8,291	600
California	376	1,864	2,240	386	1,893	2,278	416	2,040	2,456	178
Great Plains	10,159	7,577	17,736	10,414	7,693	18,107	11,226	8,292	19,518	1,411
Nashville	719	6,207	6,926	737	6,302	7,039	794	6,793	7,588	549
Navajo	24,842	8,594	33,436	25,465	8,726	34,191	27,450	9,406	36,856	2,665
Oklahoma	9,441	33,550	42,991	9,678	34,063	43,742	10,433	36,719	47,151	3,410
Phoenix	8,576	8,788	17,364	8,791	8,922	17,713	9,476	9,618	19,094	1,381
Portland	4,313	3,585	7,899	4,422	3,640	8,062	4,766	3,924	8,691	628
Tucson	38	2,059	2,096	39	2,090	2,129	42	2,253	2,295	166
Headquarters	7,483	0	7,483	7,671	0	7,671	8,269	0	8,269	598
Total, Dental	**$78,798**	**$114,485**	**$193,283**	**$80,775**	**$116,238**	**$197,013**	**$87,072**	**$125,298**	**$212,370**	**+$15,357**

Note: FY 2019 through 2020 are estimates.

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

(Dollars in Thousands)

	FY 2018	FY 2019	FY 2020	
	Final	Annualized CR	President's Budget	FY 2020 +/- FY 2019
BA	$98,900	$100,682	$109,825	+$9,143
FTE*	183	183	183	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 2020 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 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.

PROGRAM ACCOMPLISHMENTS

Specific focus areas that meet the Agency's priority relating to People, Partnerships, and Quality for the IHS MH/SS program are:

Suicide Prevention: In 2016, the suicide rate for AI/AN adolescents and young adult 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.[1] 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

[1] 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.

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.[2]

The IHS utilizes a suicide surveillance reporting tool to document incidents of suicide in a standardized and systematic fashion. The suicide surveillance tool captures data related to a specific incident of suicide through 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 2018, tribal communities submitted 2,438 completed Suicide Report Forms.

Zero Suicide Initiative: In FY 2015, IHS launched the Zero Suicide Initiative in partnership with the Substance Abuse and Mental Health Services Administration (SAMHSA), an approach developed by the Education Developmental Center's (EDC) Suicide Prevention Resource Center (SPRC). The Zero Suicide model aims to transform health systems to significantly reduce suicides for those individuals under IHS care by promoting a comprehensive approach. The initiative involves all facets of the healthcare system and includes educating healthcare providers on screening for suicide, conducting suicide risk assessments, and ensuring the infrastructure exists to support evidence-based suicide care.

Eight projects, five tribal and three federal facilities, were funded at $400,000 each to implement the Zero Suicide Model within their healthcare system November 15, 2017. 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. Each project has established a Zero Suicide Policy and developed data collection plans to enhance surveillance and analysis capabilities. As an example, sites participating in the Zero Suicide Initiative have reported a total of 216,717 outpatient contacts. In addition, IHS contracted with EDC's SPRC and held two AI/AN Zero Suicide Academies with 20 IHS, tribal, and urban Indian organizations in attendance.

As mentioned above, in FY 2017, IHS received $3.6 million to fund pilot sites to implement the Zero Suicide model. IHS funded 8 IHS and tribal sites to participate in its first cohort of the Zero Suicide Initiative. These projects will operate on a three year funding cycle through FY 2020, dependent on appropriations. In May of 2018, IHS initiated a Tribal Consultation and an Urban Confer regarding behavioral health initiatives and the distribution of funding for the Zero Suicide program. Over 250 comments and recommendations were received and a letter summarizing the comments and recommendations was provided to tribes. The National Tribal Advisory Committee on Behavioral Health is reviewing the comments and recommendations and will provide recommendations to the Indian Health Service Director.

Trauma-Informed Care: 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.

[2] 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

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.

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 will continue to support seven new sites established in FY 2018, alongside the previous ten sites to develop a quality improvement model. 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 2016, IHS contracted 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 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.

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 (BH2I), which is on a three-year funding cycle through FY 2020. In FY 2018, 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 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 was to formalize integration across the system, develop care teams, strengthen infrastructure, and enhance clinical processes including increased depression screenings in primary care clinics. The contractor has also developed an evaluation of the BH2I 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.

Reflective of the Agency priority to raise the mental health of the AI/AN population, IHS reports the percent of AI/AN adults over the age of 18 screened for depression using a standardized screening assessment for depression. In addition, in FY 2017, this same measure was reported for youth ages 12-17 and baseline data indicated 27.6 percent of eligible youth were screened for depression. For FY 2018, 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 2018, the TBHCE provided more than 3,473 hours of telebehavioral health services across 3,794 patient visits. Additionally, the TBCHE hosts a robust weekly, tele-education schedule designed to meet the specific training needs of IHS, tribal, and urban Indian health care providers. In FY 2018, the TBHCE awarded 2,304 hours of CE/CEU credits across 80 webinars. Additionally, TBHCE now has three online courses with CE/CEU available that were accessed for a total of 97 hours of training and 62 hours of CE/CEU. The TBHCE also developed and supports the online IHS Essential Training on Pain and Addiction. In FY 2018, 254 I/T/U providers completed this five-hour training. Additionally, 740 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.

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

FUNDING HISTORY

Fiscal Year	Amount
2016	$82,100,000
2017	$94,080,000
2018	$98,900,000
2019 Annualized CR	$100,682,000
2020 President's Budget	$109,825,000

BUDGET REQUEST

The FY 2020 budget submission for Mental Health of $109.8 million is $9.1 million above the FY 2019 Annualized CR.

FY 2019 Base Funding of $100.7 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 2020 Funding Increase of $9.1 million includes:

- Current Services: +$1.8 million for current services including:
    - Pay Costs +$54,000 – to fund pay increases for federal and tribal employees, of whom approximately 90 percent are working at the service unit level providing health care and related services.
    - Inflation +$838,000 – to fund inflationary costs of providing health care services.
    - Population Growth +$908,000 – to fund the additional services need arising from the growing AI/AN population. The growth rate is projected to be 1.8 percent in CY 2020 based on state birth and death data.
- Staffing for New Facilities +$2.8 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**
Cherokee Nation Regional Health Center (JV), Tahlequah, OK	$2,137,000	19
Yakutat Tlingit Tribe Health Center (JV), Yakutat, AK	$272,000	2
Ysleta Del Sur Health Center (JV), El Paso, TX	$345,000	3
Grand Total:	**$2,754,000**	**24**

Program Adjustment +$4.6 million - to increase funding for direct patient care services, including mental health services. The budget proposes to prioritize direct services while redirecting/reducing funding for other activities.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2020 Target +/-FY 2019 Target
29 Suicide Surveillance: Increase the incidence of suicidal behavior reporting by health care (or mental health) professionals (Outcome)	FY 2018: 2,449 completed reporting forms Target: 2,561 completed reporting forms (Target Not Met but Improved)	2,586 completed reporting forms	Discontinued	N/A
65 Proportion of American Indian and Alaska Native adults 18 and over who are screened for depression. (Outcome)	FY 2018: 43.3 % Target: 42.2 % (Target Exceeded)	42.2 %	45.7 %	+3.5 %
85 Depression Screening ages 12-17. (Outcome)	FY 2018: 36.0 % Target: 27.6 % (Target Exceeded)	27.6 %	38.0 %	+10.4 %
MH-1 Increase Tele-behavioral health encounters nationally among American Indians and Alaska Natives (Output)	FY 2018: 13,204 Target: 11,600 (Target Exceeded)	13,600	14,900	+1,300
MH-2 Suicide Screen and Assessment (Outcome)	FY 2020: Result Expected Oct.1, 2021 Target: Set Baseline (Pending)	Not Defined	Set Baseline	N/A

GRANTS AWARDS

The proposed FY 2020 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 2018 Final	FY 2019 Annualized CR	FY 2020 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 2018 Final			FY 2019 Estimated			FY 2020 Estimated			FY '20 +/- FY '19
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$71	$12,626	$12,697	$73	$12,758	$12,832	$115	$9,577	$9,693	-$3,139
Albuquerque	1,697	2,825	4,522	1,746	2,855	4,601	2,759	2,143	4,902	301
Bemidji	313	2,140	2,453	322	2,163	2,485	510	1,623	2,133	-352
Billings	2,501	1,368	3,868	2,573	1,382	3,955	4,067	1,037	5,104	1,149
California	108	2,261	2,369	111	2,285	2,396	176	1,715	1,891	-505
Great Plains	6,849	2,727	9,575	7,047	2,755	9,803	11,137	2,068	13,206	3,403
Nashville	312	2,475	2,787	321	2,501	2,822	507	1,877	2,385	-437
Navajo	8,676	7,116	15,792	8,928	7,191	16,119	14,109	5,397	19,507	3,388
Oklahoma	3,008	13,596	16,604	3,095	13,739	16,834	4,891	10,313	15,204	-1,630
Phoenix	3,223	6,095	9,318	3,317	6,159	9,476	5,242	4,623	9,865	389
Portland	478	3,966	4,444	492	4,008	4,500	778	3,008	3,786	-714
Tucson	11	1,591	1,602	11	1,607	1,619	18	1,206	1,225	-394
Headquarters	12,868	0	12,868	13,242	0	13,242	20,927	0	20,927	7,686
Total, Mental	**$40,116**	**$58,784**	**$98,900**	**$41,279**	**$59,402**	**$100,682**	**$65,236**	**$44,590**	**$109,826**	**+$9,144**

Note: FY 2019 through 2020 are estimates.

Note: FY 2020 Total of $109,826 is different from total listed above, by one, due to rounding.

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

ALCOHOL AND SUBSTANCE ABUSE

(Dollars in Thousands)

	FY 2018	FY 2019	FY 2020	
	Final	Annualized CR	President's Budget	FY 2020 +/- FY 2019
BA	$224,188	$228,093	$246,034	+$17,941
FTE*	232	232	297	+65

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

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

FY 2020 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 behavioral health status of AI/AN communities to the highest possible level through a comprehensive array of preventive, educational, and treatment services that are community-driven and culturally competent. The ASAP addresses the Agency's priorities of People, Partnerships, and Quality through these collaborative activities, and works to integrate substance abuse treatment into primary care. For instance, the Substance Abuse and Suicide Prevention Program provides community developed and delivered prevention and intervention resources 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. The age-adjusted AI/AN drug-related death rate is 4.1 deaths per 100,000 population for the three-year period 1979-1981, as compared to the AI/AN death rate of 22.7 in 2007-2009. This is an increase of 454 percent since drug-related death rates were first introduced for AI/AN populations in 1979. The 2007-2009 AI/AN rate is 1.8 times greater than the U.S. all races rate of 12.6 for 2008.[1] The Centers for Disease Control and Prevention (CDC) reported that AI/ANs had the highest drug overdose death rates in 2015 and the largest percentage increase in the number of deaths over time from 1999-2015 compared to other racial and ethnic groups. During that time, deaths rose more than 500 percent among AI/ANs. In addition, because of 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]

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

[2] https://www.cdc.gov/mmwr/volumes/66/ss/pdfs/ss6619.pdf

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. Baseline data for the new SBIRT screening measure was established in FY 2017, and resulted in 3.0 percent of the patients ages 9 through 75 years of age being screened. In FY 2018, the target for this measure increased to 8.9 percent and was exceeded. IHS continues to provide annual national training on SBIRT including guidelines for improved clinical documentation in the electronic health record. In FY 2019, 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. In FY 2018, a new data reporting for clinical measures including the SBIRT utilizes the Integrated Data Collection System Data Mart (IDCS DM). This new reporting system IDCS is expected to improve data collection methods across IHS.

Medication Assisted Treatment (MAT): In FY 2018, IHS has also expanded the National Core Formulary to include MAT therapies that requires IHS Federal facilities to stock and dispense these medications subsequent to a legal prescription. To address access to recovery services in remote and rural IHS locations and villages, the IHS released an Internet Eligible Controlled Substance Prescriber Designation Policy to expand MAT tele-medicine models. The IHS has collaborated with the American College of Obstetrics and Gynecology (ACOG) and the American Academy of Pediatrics (AAP) to develop clinical recommendations focused on the prevention and management of Neonatal Opioid Withdrawal Syndrome (NOWS). The key features of these guidelines are to improve screening of women of childbearing age for substance use disorders, improve referral to MAT, and early engagement of women in prenatal care as well as specific recommendations for the medical management of infants born with gestational exposure to opioids. Release of this guidance was completed in FY 2019. Additionally, the IHS created and released an IHS guideline on appropriate management of acute dental pain in FY 2018.

Proper Opioid Prescriber Training: IHS provided four sessions of its mandatory five-hour training course for providers on proper opioid prescribing. In FY 2018, 254 new clinicians

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

completed this course. The mandate also includes an additional refresher training after three years. In FY 2018, 740 clinicians completed the Essential Training on Pain and Addiction Refresher course.

In FY 2018, buprenorphine and suboxone became part of the IHS Core Formulary. Buprenorphine and suboxone are common medications used to treat opioid misuse disorder. With these added to the Core Formulary, all IHS facilities with pharmacies have these medications readily available for their patients.

In FY 2018, IHS provided Pain Skills Intensive trainings in the Portland Area and the Oklahoma 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 39 clinicians attended these trainings. In FY 2019, IHS will provide four Pain Skill Intensive trainings covering five IHS Areas.

In FY 2018, IHS provided three webinars that addressed pain management, opioids, and opioid misuse with a total of 144 attendees.

- Pain Management & Opioids in Indian Country for Staff and Community Members
- IHS Clinical Rounds: Best Practices in Pain Management and Safe Opioid Prescribing in Indian Country for Non-Prescribing Clinicians
- Harm Reduction Treatment (HaRT) for Substance Use: Meeting People Where They're At

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 2018, 197 IHS, tribal, and urban clinicians participated in this ECHO. The ECHO continues in FY 2019.

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 Southern California facility, Desert Sage, opened in FY 2017. 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 2018 the number of YRTCs in operation 18 months or longer increased from 10 to 11 and 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 will produce 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 Veteran's 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.

The IHS has created a broad harm reduction strategy that includes increasing access to naloxone for trained first responders in tribal communities. The IHS signed a memorandum of agreement with the BIA in 2015. The agreement allows IHS to provide BIA Law Enforcement Officers (LEO) with training and naloxone rescue kits for responding to incidents of opioid overdose. This partnership has put naloxone in the hands LEOs, who are often the first responders to incidents of opioid overdose in tribal communities. The IHS trained 301 BIA LEOs and 23 other tribal Police Department officers and certified 48 of them as naloxone trainers.

ASA Grant and Federal Award Programs

Substance Abuse and Suicide Prevention Program (SASP): The SASP is a nationally-coordinated $31.975 million program providing funds for culturally appropriate substance use and suicide prevention programming in AI/AN communities. The program funds 175 projects. In May of 2018, IHS initiated a Tribal Consultation and an Urban Confer regarding behavioral health initiatives and the distribution of funding for the SASP program. Over 250 comments and recommendations were received and a letter summarizing the comments and recommendations was provided to tribes. The National Tribal Advisory Committee on Behavioral Health is reviewing the comments and recommendations and will provide recommendations to the Indian Health Service 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 12 through 75 years of age. In FY 2017, 68 percent of eligible patients were screened for risky alcohol use.

The SASP program is currently in its third year of implementation. In the second year, 99 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 as preliminary data tracking for SASP program activities. Successful outcomes during the second year of the program include expanded behavioral health services offered through 1,325 partnerships including schools, courts and local law enforcement. Project accomplishments include

62 percent of the SASP projects hosting a successful prevention education community event, 47 percent expanding staff knowledge through training, and 48 percent reported documentation of a system change. In addition, among projects supported, a high percentage of projects have integrated traditional healing into care, extended service hours, provision of follow-up care, new counseling and case management services. The SASP program has increased the number of tribes, 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 site has been able to expand detoxification services to 90 beds; 65 for males and 25 for females; increase coordination and transportation with the Emergency Department; and establish 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.

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.

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

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

FUNDING HISTORY

Fiscal Year	Amount	SASP	Gen I
2016	$205,305,000	($15,475,000)	($10,000,000)
2017	$218,353,000	($15,475,000)	($16,500,000)
2018	$224,188,000	($15,475,000)	($16,500,000)
2019 Annualized CR	$228,093,000	($15,475,000)	($16,500,000)
2020 President's Budget	$246,034,000	($15,475,000)	($16,500,000)

BUDGET REQUEST

The FY 2020 budget submission for Alcohol & Substance Abuse of $246.0 million is $17.9 million above the FY 2019 Annualized CR.

FY 2019 Base Funding of $228.1 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 2020 Funding Increase of $17.9 million includes:

- Current Services +$4.3 million for current services including:
    - Pay Costs +$41,000 – to fund pay increases for federal and tribal employees, of whom approximately 90 percent are working at the service unit level providing health care and related services.
    - Inflation +$2.2 million – to fund inflationary costs of providing health care services.
    - Population Growth +$2.0 million - to fund the additional services need arising from the growing AI/AN population. The growth rate is projected to be 1.8 percent in CY 2020 based on state births and deaths data.
- Staffing for New Facilities +$7.6 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**	**Tribal Positions**
Cherokee Nation Regional Health Center (JV), Tahlequah, OK	$781,000	7
Northern California Youth Regional Treatment Center, Davis, CA	$6,696,000	65
Ysleta Del Sur Health Center (JV), El Paso, TX	$135,000	1
Grand Total:	**$7,612,000**	**73**

Program Adjustments

- Program Adjustment +$7.4 million - to increase funding for direct patient care services, including alcohol and substance abuse services. The budget proposes to prioritize direct services while redirecting/reducing funding for other activities.

- Transfer of former-NIAAA programs to the OUIHP -$1,368,547 – please refer to the Urban Program narrative.

OUTPUTS / OUTCOMES

Measure	**Year and Most Recent Result / Target for Recent Result / (Summary of Result)**	**FY 2019 Target**	**FY 2020 Target**	**FY 2020 Target +/-FY 2019 Target**
10 YRTC Improvement/Accreditation: Accreditation rate for Youth Regional Treatment Centers (in operation 18 months or more). (Outcome)	FY 2018: 100 % Target: 100 % (Target Met)	100%	100%	Maintain
80 Universal Alcohol Screening (Outcome)	FY 2018: 40.9% Target: 37.0 % (Target Exceeded)	37.0 %	42.4%	+5.4%
82 Screening, Brief Intervention, and Referral to Treatment (SBIRT) (Outcome)	FY 2018: 11.8% Target: 8.9% (Target Exceeded)	8.9%	12.2%	+3.3%

GRANTS AWARDS

(whole dollars)	FY 2018 Final	FY 2019 Annualized CR	FY 2020 Request
Number of Awards	143	178	178
Average Award	$150,000	$150,000	$168,800
Range of Awards	n/a	n/a	n/a

AREA ALLOCATION

Alcohol and Substance Abuse

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2018 Final			FY 2019 Estimated			FY 2020 Estimated			FY '20 +/- FY '19
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$574	$33,175	$33,749	$575	$34,000	$34,575	$620	$36,675	$37,294	$2,720
Albuquerque	2,709	9,866	12,575	2,710	10,112	12,821	2,923	10,907	13,830	1,008
Bemidji	1,724	8,682	10,406	1,725	8,898	10,623	1,860	9,598	11,458	836
Billings	460	11,173	11,633	460	11,451	11,911	496	12,351	12,848	937
California	3,050	14,424	17,474	3,051	14,783	17,834	3,291	15,946	19,237	1,403
Great Plains	3,456	10,984	14,440	3,457	11,257	14,715	3,729	12,143	15,872	1,157
Nashville	2,813	6,506	9,318	2,814	6,668	9,481	3,035	7,192	10,227	746
Navajo	1,565	18,903	20,469	1,566	19,374	20,940	1,689	20,898	22,587	1,647
Oklahoma	4,004	12,785	16,789	4,006	13,103	17,109	4,321	14,134	18,455	1,346
Phoenix	6,637	11,036	17,673	6,639	11,311	17,950	7,161	12,201	19,362	1,412
Portland	1,867	15,022	16,890	1,868	15,396	17,265	2,015	16,607	18,622	1,358
Tucson	48	3,231	3,280	48	3,312	3,360	52	3,572	3,625	264
Headquarters	39,493	0	39,493	39,509	0	39,509	42,617	0	42,617	3,108
Total, ASA	**$68,400**	**$155,788**	**$224,188**	**$68,428**	**$159,665**	**$228,093**	**$73,811**	**$172,223**	**$246,034**	**+$17,941**

Note: FY 2019 through 2020 are estimates.

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

(Dollars in thousands)

	FY 2018	FY 2019	FY 2020	
	Final	Annualized CR	President's Budget	FY 2019 +/- FY 2020
BA	$962,695	963,517	$968,177	+4,660
FTE*	--		--	--

* 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."[1] In 1934, Congress provided the specific authority to enter into medical services contracts for American Indians and Alaska Natives.[2] These, among other authorities[3] established the basis for the Indian Health Service (IHS) and the Purchased/Referred Care (PRC) Program.[4]

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

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;

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

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

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

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

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.[5] 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. 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). 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.

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.[6]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 and is available to IHS and tribally-managed PRC programs annually on a first come basis.

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

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

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

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 program funding increases have allowed some of the IHS and Tribally-managed PRC programs to approve referrals in priority categories other than Medical Priority I (life or limb), including some preventive care services, thus increasing access to patient care services. In FY 2018, 92 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 2018, PRC programs denied and deferred an estimated $676,848,215 for an estimated 163,058 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 2018, all high cost cases submitted for reimbursement from the CHEF were 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
2016	$862,639,000	$51,500,000	$914,139,000
2017	$875,830,000	$53,000,000	$928,830,000
2018	$909,695,000	$53,000,000	$962,695,000
2019 Annualized CR	$912,017,000	$51,500,000	$963,517,000
2020 President's Budget	$916,677,000	$51,500,000	$968,177,000

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.

BUDGET REQUEST

The FY 2020 budget submission for Purchased/Referred Care of $968.2 million is $4.7 million above the FY 2019 Annualized CR level.

The FY 2019 Annualized CR base funding will provide for the following approximate services:

- 31,976 Inpatient admissions
- 708,164 Outpatient visits
- 41,161 Patient travel trips

The FY 2020 funding increase of $4.7 million would provide the following additional estimated services:

- 147 Inpatient admissions
- 3,521 Outpatient visits
- 189 Patient travel trips

FY 2020 Funding Increase of $4.7 million includes:

- Current Services +$4,660 million for current services includes:

    - Inflation +$2,544– to fund inflationary costs of providing health care services

    - Population Growth +$2,116- to fund the additional services need arising from the growing AI/AN population. The growth rate is projected to be 1.8 percent in CY 2020 based on state births and deaths data.

Performance Impact

Since 2011, the GAO has published four reports on the PRC program.[7] The IHS PRC Workgroup has reviewed the recommendations and the Agency is implementing a majority of the GAO

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

recommendations, including the capitated rate rule described above and many programmatic and policy improvements. In addition, the program has identified several risk categories and is working to ensure proper policies and procedures are in place to maintain programmatic consistency across all Areas. These ongoing activities continue to be monitored by PRC staff at the IHS Area office and Headquarters level.

In its 14-57 GAO report, the GAO recommended the PRC program change its IHS GPRA measure into two measures by modifying the IHS' claims data system to track:

(1) by an established timeframe for payment specific to authorized IHS referrals[8]
(2) by an established timeframe for payment specific to authorized self-referrals[9]

In the FY 2018 Budget, IHS adopted the GAO recommendation in recognition of the differences in payment processes for these two types of authorized referrals using CY 2017 data for a baseline. The number of days to medical claims payment is based on medical industry standards for a Preferred Provider Organization.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2020 Target +/-FY 2019 Target
PRC-2 Track IHS PRC referrals (Outcome)	FY 2018: 71.0 days Target: 60.0 days (Target Not Met)	60.0 days	60.0 days	Maintain
PRC-3 Track PRC self-referrals (Outcome)	FY 2018: 68.0 days Target: 45.0 days (Target Not Met)	45.0 days	45.0 days	Maintain

GRANT AWARDS. This program does not fund grant awards.

[8]As defined by the GAO, IHS referrals are "cases in which an IHS-funded provider refers a patient for care to an external provider."

[9]As defined by the GAO, self-referrals are "typically emergency situations where the patient receives services from external providers without first obtaining a referral from an IHS funded provider."

AREA ALLOCATION

Purchased/Referred Care

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2018 Final			FY 2019 Estimated			FY 2020 Estimated			FY '20 +/- FY '19
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$0	$93,509	$93,509	$0	$97,106	$97,106	$0	$97,575	$97,575	$470
Albuquerque	29,188	17,427	46,616	27,822	18,098	45,920	27,957	18,185	46,142	222
Bemidji	15,045	50,636	65,681	14,341	52,583	66,924	14,410	52,838	67,248	324
Billings	47,428	19,783	67,211	45,208	20,544	65,751	45,427	20,643	66,069	318
California	788	51,644	52,432	752	53,630	54,382	755	53,890	54,645	263
Great Plains	73,070	21,896	94,966	69,649	22,738	92,387	69,986	22,848	92,834	447
Nashville	6,679	32,445	39,124	6,366	33,693	40,059	6,397	33,856	40,253	194
Navajo	62,683	42,596	105,279	59,748	44,234	103,983	60,037	44,448	104,486	503
Oklahoma	49,809	70,152	119,960	47,477	72,850	120,327	47,707	73,202	120,909	582
Phoenix	48,142	30,614	78,756	45,888	31,791	77,679	46,110	31,945	78,055	376
Portland	14,326	87,579	101,905	13,656	90,947	104,603	13,722	91,387	105,109	506
Tucson	303	19,862	20,165	289	20,626	20,915	291	20,726	21,016	101
Headquarters	77,091	0	77,091	73,482	0	73,482	73,837	0	73,837	355
Total, PRC	**$424,553**	**$538,142**	**$962,695**	**$404,677**	**$558,840**	**$963,517**	**$406,634**	**$561,543**	**$968,177**	**+$4,660**

Note: FY 2019 through 2020 are estimates.

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

(Dollars in Thousands)

	FY 2018	FY 2019	FY 2020	
	Final	Annualized CR	President's Budget	+/- FY 2019
BA	$167,311	$170,968	$118,258	-$52,710
FTE*	213	213	196	-17

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

SUMMARY OF THE BUDGET REQUEST

The FY 2020 budget submission for Preventive Health programs of $118.3 million is $57.7 million below the FY 2019 Annualized CR. Included in the budget is $1.6 million for Current Services and $3.4 million for Staffing for New Facilities. 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 critical health care needs. This also includes $24 million for the transition from Community Health Representatives to a National 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. The budget proposes $92.1 million for Public Health Nursing.

- **Health Education** to support the provision of community health, school health, worksite health promotion, and patient education. In order to prioritize health care services and staffing of newly constructed facilities, the Budget discontinues the Health Education program.

- **Community Health Representatives** (CHRs) to help bridge the gap between AI/AN individuals and health care resources through outreach by specially trained indigenous community members. The Budget includes $24.0 million to begin phasing out the program, which will be replaced by a National Community Health Aide Program.

- **Hepatitis B and Haemophilus Immunization Programs (Alaska)** will support the provision of vaccines for preventable diseases, immunization consultation/education, research, and liver disease treatment and management through direct patient care, surveillance, and education for Tribal facilities throughout Alaska. The Immunization Alaska Program budget supports these priorities through direct patient care, surveillance, and educating Alaska Native patients. The Budget proposes $2.2 million for the Hepatitis B and Haemophilus Immunization Programs (Alaska).

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 2018	FY 2019	FY 2020	
	Final	Annualized CR	President's Budget	FY 2020 +/- FY 2019
BA	$84,043	$85,936	$92,084	+$6,148
FTE*	193	193	193	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 2020 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.

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 American Indian/Alaska Native (AI/AN), and through public health education, inspiring AI/AN people to engage in healthy lifestyles and ultimately live longer lives.

PHNs conduct home visiting services for:

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

PHNs perform a community assessment to identify high-risk populations and implement evidenced based interventions to address identified areas. This activity targets fragmentation in services and improves care continuums, including patient safety, and patient services. Interventions are monitored with data collection and evaluated for outcome with an emphasis on producing a good return on investments in terms of service 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 populations focused nurse visiting program which serves the patient and family in the home and in the community. The PHN Program assesses the care 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. 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 2018, the PHN Program sustained efforts to support the IHS's goal to decrease childhood obesity and prevent diabetes by supporting Baby Friendly designation and 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. To assess how the PHN program delivers services, the PHN data mart provides a mechanism to evaluate this evidence-based prevention service of promoting breastfeeding during the nurse home visit. 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 during prenatal, postpartum and newborn encounters by the PHN, 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.

In FY 2015, the PHN Program implemented the Resource to Enhance All Caregivers Health (REACH) program, an evidenced-based program that provides a structured intervention to support caregivers of individuals suffering from dementia. Caregivers supported by the program show improvement in 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 REACH 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 overall goal to implement the REACH service in 50 Tribal communities by 2018 was met in December 2017 and making the service available in 52 communities. Efforts to adapt this intervention to deliver and sustain the program in AI/AN communities is ongoing.

Addressing behavioral health issues, in 2016, the Pine Ridge PHN Mental Health Case Management Program was established to focus on suicide prevention in the local community. This intervention is to improve health outcomes of high risk patients through a community case management model that utilizes the PHN as a case manager. In FY 2018 expand the services in the community, include data collection reports on the PHN Data Mart to report outcome, and in FY 2019, collaborate and replicate this service at the Standing Rock Service Unit PHN Program. In FY 2019, this service will be shared as a best practice resource for the PHN grant program for tribal and urban grant recipients.

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 had: 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 will support the efforts for Relationship Based Care (RBC) as a means of improving quality care and meeting the needs of the AI/AN population. To build, strengthen, and sustain collaborative relationships, RBC is linked to the 2018-2022 IHS Strategic Plan which is to ensure that comprehensive, culturally acceptable personal and public health services are available and accessible to the AI/AN people. Investing in a transformation of the agency'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. This model of care compliments and will build on current patient safety initiatives; specifically the PHN program will begin with staff training efforts in FY 2019, and develop program plans to support this activity.

The PHN program continues to review the delivery of service for safe and quality standards of various accrediting bodies. This activity includes coordinating with 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 2019 to promote quality PHN services are provided in a safe manner. In 2019, 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 engaged in FY 2019 efforts to meet the IHS national target of one hundred percent of IHS ambulatory care facilities achieving PCMH by 2021.

In 2018, the PHN program implemented prevention services to target sexually transmitted infections to improve quality care. This activity was monitored with the use of the PHN data mart tool as a performance measurement in support of practicing population health management. Data and improvement activities will be shared publicly as PHN Program's commitment to quality and included in reports for FY 2019.

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. 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. The Pine Ridge PHN Program initiated a similar PHN Case Management Program in 2016 and serves as a best practice for replication. The program has data to reflect increased home visits for behavioral health follow up and increased coordination and collaboration with the local Behavioral Health Department.

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. In FY 2019, the PHN Documentation Manual will be updated to include PHN electronic health record templates and include information on the PHN data mart reports to improve reporting of outcome.

Beginning in 2018, the PHN accomplishment report will coincide with the fiscal year reporting time and data will be available in December 2018.

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 federally

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

FUNDING HISTORY

Fiscal Year	Amount
2016	$76,623,000
2017	$78,701,000
2018	$84,043,000
2019 Annualized CR	$85,936,000
2020 President's Budget	$92,084,000

BUDGET REQUEST

The FY 2020 budget submission for Public Health Nursing of $92.1 million is $6.1 million above the FY 2019 Annualized CR.

FY 2019 Base Funding of $85.9 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 2020 Funding Increase of $6.1 million includes:

- Current Services: +$1.5 million for current services includes:
    - Pay Costs +$147,000 million to fund pay increases for Federal employees and tribal, of whom approximately 90 percent are working at the service unit level providing health care and related services.
    - Inflation +$636,000 to fund inflationary costs of providing health care services.
    - Population Growth +$1.5 million to fund the additional services need arising from the growing AI/AN population. The growth rate is projected to be 1.8 percent in CY 2020 based on state births and deaths data.
- Staffing for New Facilities +$3.4 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
Cherokee Nation Regional Health Center (JV), Tahlequah, OK	$2,231,000	16
Yakutat Tlingit Tribe Health Center (JV), Yakutat, AK	$596,000	4
Ysleta Del Sur Health Center (JV), El Paso, TX	$604,000	4
Grand Total:	**$3,431,000**	**24**

Program Adjustment +$1.2 million - to increase funding for direct patient care services, including Public Health Nursing. The budget proposes to prioritize direct services while redirecting/reducing funding for other activities.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2020 Target +/-FY 2019 Target
23 Public Health Nursing: Total number of public health activities captured by the PHN data system; emphasis on primary, secondary and tertiary prevention activities to individuals, families and community groups. (Outcome)	FY 2018: 329,980 Target: 381,314 (Target Not Met)	381,314	381,314	Maintain

GRANTS AWARDS

(whole dollars)	FY 2018 Final	FY 2019 Annualized CR	FY 2020 President's Budget
Number of Awards	9	9	9
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 2018 Final			FY 2019 Estimated			FY 2020 Estimated			FY '20 +/- FY '19
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$131	$11,217	$11,348	132	$11,555	$11,687	$141	$12,382	$12,524	$836
Albuquerque	1,827	1,697	3,524	1,841	1,748	3,589	1,973	1,873	3,846	257
Bemidji	32	2,381	2,413	32	2,453	2,485	35	2,629	2,663	178
Billings	1,699	2,729	4,428	1,712	2,812	4,524	1,835	3,013	4,848	324
California	13,269	1,137	1,150	13,375	1,171	1,184	14	1,255	1,269	85
Great Plains	4,784	4,968	9,751	4,822	5,118	9,939	5,166	5,484	10,650	711
Nashville	416	1,729	2,145	420	1,781	2,201	450	1,909	2,358	157
Navajo	8,617	7,687	16,304	8,686	7,919	16,605	9,307	8,485	17,792	1,188
Oklahoma	3,542	12,628	16,169	3,570	13,009	16,579	3,825	13,940	17,765	1,186
Phoenix	4,038	5,202	9,241	4,070	5,360	9,430	4,361	5,743	10,104	675
Portland	620	2,564	3,183	625	2,641	3,266	669	2,830	3,499	234
Tucson	16,594	1,117,893	1,134	17	1,151,656	1,168	18	1,234	1,252	84
Headquarters	3,253	0	3,253	3,278	0	3,278	3,513	0	3,513	235
Total, PHN	**$28,988**	**$55,055**	**$84,043**	**$29,218**	**$56,718**	**$85,936**	**$31,308**	**$60,776**	**$92,084**	**+$6,148**

Note: FY 2019 through 2020 are estimates.

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

(Dollars in Thousands)

	FY 2018	FY 2019	FY 2020	
	Final	Annualized CR	President's Budget	FY 2020 +/- FY 2019
BA	$19,322	$20,017	$0	-$20,017
FTE*	17	17	0	-17

* 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 2020 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.

PROGRAM ACCOMPLISHMENTS

In FY 2018, 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.

The Health Education program targeted the following activities in FY 2018:

- Strengthening management by providing training to I/T/U staff to increase patient education and documentation of education provided through the Basic Tobacco Intervention Skills for Native Communities to increase commercial tobacco cessation.

- Addressing community health priorities by assisting Tribes, health boards, and States to implement Behavioral Risk Factor Surveillance Surveys (BRFSS) and providing anti-bullying health education in schools through the "Courage 2 Care" curriculum.
- Addressing elder fall prevention through Tai Chi classes and evidence-based "Stay Active and Independent for Life" classes that focus on targeting strength, balance and fitness for tribal elders.
- Collaborating with Tribes, health boards, universities, county, state, Indian Health Service programs, and national organizations to increase patient education in the community focusing on cancer prevention and tobacco cessation. Partnerships include the American Lung Association, American Cancer Society, University of Arizona's HealthCare Partnership, Boys and Girls Clubs of America, and Bureau of Indian Education.
- Collaborating with I/T/U Public Health Nursing to increase school-age immunizations, flu vaccinations, and providing Human Papilloma Virus education and immunization through health fairs, back to school fairs, and immunization drives.
- Collaborating with Tribes to increase Colorectal Cancer screening rates as evidenced by the following programs:
    - Turtle Mountain Band of Chippewa Indians Health Education and Turtle Mountain Service Unit-Quentin North Burdick Memorial Health Care Facility Public Health Nursing program were recipients of the North Dakota Colorectal Cancer Screening Achievement Award. Collaborative efforts led to a 10 percent increase in colorectal cancer screening and an 80 percent Tribal member screening rate.
    - Sisseton-Wahpeton Oyate of the Lake Traverse Band Health Education program, in collaboration with the Woodrow Keeble Memorial Health Care Center, national FY 2018 Government Performance and Results Act (GPRA) measure of 32.6 percent was met and were selected for the Great Plains Area Director's "Health and Wellness Award."
- The Wewoka Service Unit increased documented physical activity in youth, decreasing obesity rates in youth from 53 percent to 36 percent of participants diagnosed as obese. The Fort Thompson Service Unit, in collaboration with Public Health Nursing; during GPRA Year 2018, achieved the target rate of 42.3 percent for the proportion of patients with blood pressure less than (<) 140/90current Service Unit measure at 60.9 percent.
- Addressing Sexually Transmitted Disease (STD) prevention through school health education and prevention targeting Human Papilloma Virus education and immunization, providing Rapid HIV Test screening to underserved and high risk Tribal populations, and educating adult Tribal community members about Hepatitis C screening and treatment.
- Providing Digital Storytelling, "train the trainer" workshops to develop I/T/U Public Service Announcements targeting the following prevention programs: domestic violence, intimate partner violence, cancer prevention, diabetes prevention and commercial tobacco abuse.
- Providing Adult Mental Health First Aid "train the trainer" workshops to address suicide prevention.

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.

FUNDING HISTORY

Fiscal Year	Amount
2016	$18,255,000
2017	$18,663,000
2018	$19,322,000
2019 Annualized CR	$20,017,000
2020 President's Budget	$0

BUDGET REQUEST

The FY 2020 budget submission for Health Education of $0 is $20.0 million below the FY 2019 Annualized CR. This would discontinue the program at federal sites and discontinue the funding transferred to Tribes as part of their annual contracts and compacts; however, Tribes may choose to use their own resources to support similar functions. The budget prioritizes funding for direct health care services and staffing of newly constructed facilities.

OUTPUTS / OUTCOMES

Measure	**Year and Most Recent Result / Target for Recent Result / (Summary of Result)**	**FY 2019 Target**	**FY 2020 Target**	**FY 2020 Target +/-FY 2019 Target**
HE-1 Number of visits with Health/Patient Education (Output)	FY 2018: 3,304,225 visits Target: Not defined (Target not in place)	3,305,000 visits	0 visits	3,305,000 visits

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

AREA ALLOCATION

Health Education

(dollars in thousands)

DISCRETIONARY	FY 2018 Final			FY 2019 Estimated			FY 2020 Estimated			FY '20 +/- FY '19
SERVICES	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$31	$2,800	$2,832	$33	$2,901	$2,934	$0	$0	$0	-$2,934
Albuquerque	269	947	1,216	279	981	1,259	0	$0	0	-1,259
Bemidji	55	613	669	57	635	693	0	$0	0	-693
Billings	218	1,034	1,252	226	1,071	1,297	0	$0	0	-1,297
California	29	328	357	30	340	370	0	$0	0	-370
Great Plains	313	1,727	2,040	324	1,789	2,113	0	$0	0	-2,113
Nashville	154	661	815	160	685	844	0	$0	0	-844
Navajo	34	3,076	3,110	36	3,187	3,222	0	$0	0	-3,222
Oklahoma	706	2,258	2,963	731	2,339	3,070	0	$0	0	-3,070
Phoenix	829	1,121	1,950	859	1,161	2,020	0	$0	0	-2,020
Portland	95	903	998	98	936	1,034	0	$0	0	-1,034
Tucson	4	240	244	4	249	253	0	$0	0	-253
Headquarters	876	0	876	907		907	0	$0	0	-907
Total, Hlth Ed	**$3,614**	**$15,709**	**$19,322**	**$3,743**	**$16,274**	**$20,016**	**$0**	**$0**	**$0**	**-$20,016**

Note: FY 2019 through 2020 are estimates.

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

COMMUNITY HEALTH REPRESENTATIVES

(Dollars in Thousands)

	FY 2018	FY 2019	FY 2020	
	Final	Annualized CR	President's Budget	FY 2020 +/- FY 2019
BA	$61,888	$62,888	$24,000	-$38,888
FTE*	3	3	3	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 2020 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.

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.

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 968,046 CHR patient contacts. In addition, CHR reported patient contacts for visits made to patients with chronic diseases was 413,138.

The FY 2018 training target for CHRs was met. IHS trained 606 CHRs in mental health first aide, mental health first aide for youth, basic CHR training, 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 serious mental illness as one of the top three clinical priorities for the Department of Health and Human Services, IHS offered six Mental Health First Aid (MHFA) courses across the Nation. IHS trained more than 100 CHRs in MHFA with the goal that paraprofessionals are able to help individuals during a mental health crisis and learn skills to assist with access to care with anxiety, depression, psychosis, and addictions with competencies in knowing how to help individuals access care before they begin to experience negative outcomes.

FUNDING HISTORY

Fiscal Year	Amount
2016	$58,906,000
2017	$60,325,000
2018	$61,888,000
2019 Annualized CR	$62,888,000
2020 President's Budget	$24,000,000

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

BUDGET REQUEST

The FY 2020 budget submission for Community Health Representatives of $24.0 million is $38.9 million below the FY 2019Annualized CR.

The Budget begins phase out of the CHR program in FY 2020 and will replace the program with a new National Community Health Aide Program (CHAP). The requested funding will allow for a seamless transition to the new National CHAP.

Program Adjustment -$33.9 million -the Budget reforms in-home clinical health care services through nationwide expansion of the evidence-based CHAP and starts to phase out the Community Health Representatives Program.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2020 Target +/-FY 2019 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)	1,317,800 patient contacts	501,600 patient contacts	-816,200 patient contacts
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)	526,881 patient contacts	201,400 patient contacts	-325,481 patient contacts
CHR-3 Number of CHRs Trained (Output)	FY 2018: 606 CHRs Target: 600 CHRs (Target Exceeded)	616 CHRs	235 CHRs	-381 CHRs

GRANTS AWARDS – No grant awards are anticipated for FY 2020.

AREA ALLOCATION

Community Health Representatives

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2018 Final			FY 2019 Estimated			FY 2020 Estimated			FY '20 +/- FY '19
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$32	$4,613	$4,645	32	4,686	4,718	$15	$1,781	$1,796	-$2,923
Albuquerque	25	3,627	3,652	26	3,685	3,711	11	1,400	1,412	-2,299
Bemidji	35	4,985	5,020	36	5,064	5,100	16	1,925	1,941	-3,160
Billings	32	4,613	4,646	33	4,687	4,720	15	1,781	1,796	-2,924
California	15	2,075	2,089	15	2,108	2,123	7	801	808	-1,315
Great Plains	166	7,189	7,355	170	7,304	7,474	75	2,776	2,851	-4,623
Nashville	176	3,293	3,469	181	3,345	3,526	80	1,271	1,351	-2,175
Navajo	50	7,135	7,185	51	7,249	7,300	23	2,755	2,778	-4,522
Oklahoma	66	9,402	9,468	68	9,551	9,619	30	3,630	3,660	-5,959
Phoenix	45	6,474	6,519	47	6,577	6,624	20	2,500	2,520	-4,103
Portland	34	4,850	4,884	35	4,927	4,962	15	1,873	1,888	-3,074
Tucson	14	2,037	2,052	15	2,070	2,085	6	787	793	-1,291
Headquarters	903	0	903	926		926	408	0	408	-518
Total, CHR	**$1,595**	**$60,293**	**$61,888**	**1,634**	**61,253**	**62,887**	**$720**	**$23,280**	**$24,000**	**-$38,888**

Note: FY 2019 through 2020 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 2018	FY 2019	FY 2020	
	Final	Annualized CR	President's Budget	FY 2020 +/- FY 2019
BA	$2,058	$2,127	$2,173	+$46
FTE*	--	--	--	--

* This program is managed by tribal staff. FTE numbers reflect no Federal 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.....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 maintains high vaccine coverage by providing resources, training, and coordination to Tribal facilities throughout Alaska. Regular meetings are held with regional Immunization Coordinators, Clinical Directors, Community Health Aide Program, IHS Immunization Coordinators, and the State of Alaska Immunization Program. The Program works with Tribal public relations to address parental immunization hesitancy and highlight the importance of vaccines.

The Hepatitis B Program and the Hib Program of the Alaska Native Tribal Health Consortium, 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 immunization coverage, and high clinical management coverage of hepatitis B and C in Alaska Natives. The programs' activities support the IHS priorities on quality and partnerships.

PROGRAM ACCOMPLISHMENTS

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

Hepatitis B Program

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

In FY 2018:

- Hepatitis A vaccination coverage met the target, and hepatitis B vaccination coverage exceeded the target. Hepatitis A vaccination coverage was 90 percent (90 percent target) and hepatitis B vaccination coverage was 96 percent (90 percent target).
- At least 71 percent of AI/ANs with chronic hepatitis B (66 percent) or C (74 percent) infection were screened for liver cancer and for liver aminotransferase levels.
- The program maintains its practice of encouraging hepatitis patients to have regular, bi-annual screening.

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

During FY 2018:

- Immunization Coverage for Alaska s age 19-35 months was 76 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 91 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 2017 rate of 80.7 percent.
- Achieved 80 percent Tdap vaccine coverage in all patients 19 years and older who had received Tdap within the past 10 years, achieved 80 percent in 2017. Previous measure tracked Tdap vaccine coverage in Alaska Natives 19-64 years, 83 percent coverage in 2015 and 86 percent in 2016.
- Achieved 90 percent pneumococcal vaccine coverage in patients 65 years and older who received pneumococcal vaccine in the past ever.
- Assisted tribal facilities using the RPMS immunization package or new electronic health record (EHR) in maintaining their interface to share vaccine records with the Alaska State Immunization Information System (SIIS).
    - Provided consultation with numerous facilities that implemented new EHRs on immunization documentation and helped facilitate SIIS interface implementation.

- Assisted Tribal facilities throughout Alaska to implement new State policy and procedures associated with vaccine 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	76%
4:3:1:3:3:1	19-35 months	77%
3 Hib vaccines doses		91%
3 PCV (pneumococcal conjugate vaccine)	19-35 months	93%
1+ HPV	13-17 years female	78%
Pneumococcal vaccine	65+ years	90%
Tdap	19 years and older	80%

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 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 immunization coverage. Regular reporting of immunizations is critical in assuring follow-up with facilities experiencing vaccination administration issues and will continue to be addressed through coordinated efforts by the Hib program, IHS, State, and tribes. Vaccine and immunization coverage are measured as well as consults provided to Tribal partners.

FUNDING HISTORY

Fiscal Year	Amount
2016	$1,950,000
2017	$2,041,000
2018	$2,058,000
2019 Annualized CR	$2,127,000
2020 President's Budget	$2,173,000

TRIBAL SHARES

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

BUDGET REQUEST

The FY 2020 budget submission for Alaska Immunization of $2.2 million is $46,000 above the FY 2019 Annualized CR.

FY 2020 Funding Increase of $46,000 includes:

- Current Services: +$39,000 for current services including:
    - Inflation +$21,000 to cover inflationary costs of providing immunization services in Alaska.

- Population Growth +$18,000 to fund the additional services need arising from the growing AI/AN population. The growth rate is projected to be 1.8 percent in CY 2020 based on state births and deaths data.

- Program Adjustment +$7,000 - to increase funding for direct patient care services, including Hepatitis B and Haemophilus Immunization Programs. The budget proposes to prioritize direct services while redirecting/reducing funding for other activities.

The FY 2020 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 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 three days a week of outpatient clinics 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. Added AK 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 support to regional tribal programs on-site and for many partner locations, including rural and isolated locations, as well as limited printing of media materials. Funding of these activities allows maintenance of current program support of Alaska tribal immunization activities, statewide and national immunization advocacy and technical support, and Area reporting to IHS Headquarters. Statewide Alaska Native immunization coverage rates are reported to IHS Headquarters for infants 3-27 months, 19-35 months, adolescents, older adults, and flu vaccine immunization rates for all ages. In addition, the number of consultations and trainings offered to tribal facilities is also reported.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2020 Target +/-FY 2019 Target
AK-1 Chronic Hepatitis B Patients Screened/Targeted (Output)[1]	FY 2018: 671 Screened Target: 600 Screened (Target Exceeded)	600 Screened	600 Screened	Maintain
AK-2 Chronic Hepatitis C Patients Screened/Targeted (Output)[2]	FY 2018: 1368 Screened Target: 990 Screened (Target Exceeded)	990 Screened	1300 Screened	+310 Screened

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2020 Target +/-FY 2019 Target
AK-3 Other Liver Disease Patients Screened (Output)[3]	FY 2018: 226 Screened Target: 200 Screened (Target Exceeded)	200 Screened	200 Screened	Maintain
AK-4 Hepatitis A vaccination (Output)[4]	FY 2018: 90 % Target: 90 % (Target Met)	90 %	90 %	Maintain
AK-5 Hepatitis B vaccinations (Output)[5]	FY 2018: 96 % Target: 90 % (Target Exceeded)	90 %	90 %	Maintain

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

[1] Hepatitis Program (Known Cases Screened) Sum of known hepatitis B cases FY 2018: 1,006. Decline in hepatitis B cases due to an aging cohort and their deaths; discovery of new cases is rare given hepatitis B vaccinations.
[2] Hepatitis Program (Known Cases Screened) Sum of known hepatitis C cases FY 2018: 2,028. With DAA treatment regimens available screening rates have increased; following treated cases with no/mild fibrosis for 5 years, advanced fibrosis/cirrhosis being followed indefinitely; number of new hepatitis C cases identified increased in this reporting period.
[3] Hepatitis Program (Known Cases Screened) Sum of known other liver disease cases FY 2018: 250. Other liver disease includes autoimmune hepatitis and primary biliary cirrhosis.
[4] 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.
[5] The rates reported herein represent the most recent reporting period. Established target immunization rate for each vaccine is 90%.

GRANTS AWARDS -- The program does not award grants.

AREA ALLOCATION

Immunization Alaska

(dollars in thousands)

DISCRETIONARY	FY 2018 Final			FY 2019 Estimated			FY 2020 Estimated			FY '20 +/- FY '19
SERVICES	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$0	$2,058	$2,058	$0	$2,127	$2,127	$0	$2,173	$2,173	$46
Total, Imm AK	**$0**	**$2,058**	**$2,058**	**$0**	**$2,127**	**$2,127**	**$0**	**$2,173**	**$2,173**	**$46**

Note: FY 2019 through 2020 are estimates.

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

(Dollars in Thousands)

	FY 2018	FY 2019	FY 2020	
	Final	Annualized CR	Request	FY 2020 +/- FY 2019
BA	$48,533	$49,315	$48,771	-$544
FTE*	7	7	7	0

*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 2020 Authorization.....Permanent

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

PROGRAM DESCRIPTION

The Office of Urban Indian Health Programs (OUIHP) was established in 1976 to make health care services more accessible to Urban Indians. The Indian Health Service (IHS) enters into limited, competitive contracts and grants with 40 urban Indian 501(c)(3) non-profit organizations to provide health care and referral services for Urban Indians throughout the United States. Urban Indian Organizations (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. Each UIO is governed by a Board of Directors that must include at least 51 percent Urban Indians. UIOs provide unique access to culturally appropriate and quality health care for Urban Indians.

UIOs provide health care services for approximately 77,400 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. UIO health 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 40 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 a UIO 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 a UIO 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. Refer to the Budget Request section for additional information.

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

- Urban Indian Education and Research Organization Cooperative Agreement: Provides national education and research services for UIOs and OUIHP through a cooperative agreement.
- Albuquerque Indian Dental Clinic: Provides dental services through the Albuquerque Area IHS Dental Program.

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 Area Urban Coordinators 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.

PROGRAM ACCOMPLISHMENTS

IHS released a plan to guide, support, and improve access to high quality health care services for Urban Indians. The OUIHP 2017-2021 Strategic Plan supports health care solutions that fit the diverse circumstances of Urban Indians and their communities.

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 July 1, 2016, to June 30, 2017, the UIO 2017 GPRA cycle accomplishments included:

- 97 percent of the UIOs reported on 20 of the 20 performance measures;
- 20 UIOs reported through the Clinical Reporting System (CRS);
- 11 UIOs reported using 100 percent review of appropriate data source (as opposed to sampling a smaller percentage of records); and
- In FY 2017, UIOs improved performance on 7 of the GPRA measures with comparable FY 2017 data.

The IHS will proceed with plans to have UIOs export data to the IHS data center and assist with the National Patient Reporting System (NPIRS) staff to compare data for the budget formulation

for Urban programs. OUIHP with the assistance of the Office of Information Technology, will continue to provide training and technical assistance to urban programs on accurate and uniform data collection, so as to achieve standardization throughout the system.

Design requirements for the IHS's new centralized performance data mart, Integrated Data Collection System Data Mart (IDCS DM), included 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. At the end of calendar year 2018, the IDCS DM facility level reports have not been completed. IHS expects the facility level reports to be ready in the spring of 2019. Once facility level reports are complete, an aggregate Urban report can be built. Until then, the Urban Indian Health Program cannot provide aggregated measure results.

FUNDING HISTORY

Fiscal Year	Amount
2016	$44,741,000
2017	$47,678,000
2018	$48,533,000
2019 Annualized CR	$49,315,000
2020 President's Budget	$48,771,000

BUDGET REQUEST

The FY 2020 budget submission for the Urban Indian Health program of $48.8 million is $544,000 below the FY 2019 annualized CR level.

FY 2019 Budget Funding of $49.3 million – The base funding provides for the following:

- Improving Urban Indian access to health care to improve health outcomes in urban centers.
- Strengthening programs that serve Urban Indians throughout the United States.
- Enhancing UIO 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 UIO programs and patient centered medical homes for Urban Indians.
- Implementing and utilizing advanced health information technology.
- Expanding access to quality, culturally competent care for Urban Indians through collaboration with other federal agencies.
- Implementing IHCIA authorities specific to UIOs.

FY 2020 Funding includes:

- Current Services: +$876,000 million for current services including:
    - Pay Costs +$20,000 – to fund pay increases for Federal and urban employees.
    - Inflation +$455,000 – to fund inflationary costs of providing health care services.
    - Population Growth +$401,000 – to fund population growth based on CY 2018 births and deaths data.

Program Adjustments

- Program Adjustment -$2.8 million - The budget proposes to prioritize other direct services while redirecting/reducing funding for other activities.

- Transfer of funding for former-NIAAA programs from ASAP to the OUIHP +$1.4 million – In 1978 programs benefitting AI/AN were transferred from NIAAA to IHS under an interagency agreement, and for Urban AI/ANs by statute in 1992, 25 U.S.C. §1660c. In 2017, IHS identified seven remaining former-NIAAA programs for potential transfer to the OUIHP. After review of the seven former-NIAAA programs, IHS determined that five of the programs meet the urban Indian health requirements of the IHCIA, including the UIP definition at 25 U.S.C § 1603(29). See table below. As a result, IHS proposes to transfer the existing funds for these five programs from the Alcohol and Substance Abuse budget line to the Urban Health budget line. Transferring these funds will increase the efficiency of the OUIHP and fully implement the transfer authorized by IHCIA at 25 U.S.C. § 1660c – *Urban NIAAA transferred programs.* This technical adjustment does not impact current programming. There would be no change in the funding level to existing UIOs already funded through the Urban Indian Health budget line. Any future increases would be included in the Urban Indian Health budget line item. The $1.4 million will continue to be used for the same purpose of providing awards to these former NIAAA programs.

Former-NIAAA Program	Location	IHS Area	Amount
American Indian Council on Alcoholism, Inc.	Milwaukee. WI	Bemidji	$104,685
Juel Fairbanks Chemical Dependency Services, Inc.	St. Paul, MN	Bemidji	$278,816
Native Directions, Inc.	Manteca, CA	California	$364,037
Kansas City Indian Center's Morningstar Outreach Program	Kansas City, MO	Oklahoma City	$118,353
Native American Connections	Phoenix, AZ	Phoenix	$502,656
Total			$1,368,547

OUTPUTS / OUTCOMES

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

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2020 Target +/-FY 2019 Target
UIHP-7 Number of AI/ANs served at Urban Indian clinics. (Outcome)	FY 2017: 75,194 Target: 53,408 (Target Exceeded)	54,525	81,350	+26,825
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 June 30, 2019 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 June 30, 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 June 30, 2019 Target: Set Baseline (Pending)	Maintain Baseline	TBD	N/A
UIHP-11 Reduce the proportion of American Indians/Alaska Natives with diagnosed diabetes who have poor glycemic control (A1c >9%) (Outcome)	FY 2019: Result Expected Jan 31, 2020 Target: Set Baseline (Pending)	Set Baseline	TBD	N/A

GRANTS AWARDS - Funding for UIOs for FY 2020 includes both grants and contracts awarded to the programs.

	FY 2018 Final	FY 2019 Annualized CR	FY 2020 Request
Number of Awards	30	30	40
Average Award	$288,962	$291,961	$244,736
Range of Awards	$162,775 - $1,021,175	$164,373 - $1,050,517	$100,000 - $1,000,000

AREA ALLOCATION

Urban Health

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2018 Final			FY 2019 Estimated			FY 2020 Estimated			FY '20 +/- FY '19
	Federal	Urban	Total	Federal	Urban	Total	Federal	Urban	Total	Total
Alaska	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Albuquerque	0	2,891	2,891	0	2,938	2,938	0	2,906	2,906	-32
Bemidji	0	4,372	4,372	0	4,443	4,443	0	4,394	4,394	-49
Billings	0	2,439	2,439	0	2,479	2,479	0	2,451	2,451	-27
California	0	6,681	6,681	0	6,789	6,789	0	6,714	6,714	-75
Great Plains	0	1,634	1,634	0	1,661	1,661	0	1,642	1,642	-18
Nashville	0	974	974	0	990	990	0	979	979	-11
Navajo	0	785	785	0	798	798	0	789	789	-9
Oklahoma	0	2,259	2,259	0	2,295	2,295	0	2,270	2,270	-25
Phoenix	0	2,687	2,687	0	2,730	2,730	0	2,700	2,700	-30
Portland	0	5,921	5,921	0	6,016	6,016	0	5,950	5,950	-66
Tucson	0	554	554	0	563	563	0	557	557	-6
Headquarters	0	17,335	17,335	0	17,614	17,614	0	17,420	17,420	-194
Total, Urban	**$0**	**$48,533**	**$48,533**	**$0**	**$49,315**	**$49,315**	**$0**	**$48,771**	**$48,771**	**-$544**

Note: FY 2019 through 2020 are estimates.

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

INDIAN HEALTH PROFESSIONS

(Dollars in Thousands)

	FY 2018	FY 2019	FY 2020	
	Final	Annualized CR	President's Budget	FY 2020 +/- FY 2019
BA	$49,363	$49,363	$43,612	-$5,751
FTE*	23	23	23	0

*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 2020 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 to recruit and retain health professionals to provide high-quality primary care and clinical preventive services to American Indians and Alaska Natives (AI/AN). The IHP programs also work with IHS, Tribal facilities and 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.
- 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.

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 2018, 73 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 2018, a total of 1,325 health professionals were receiving IHS loan repayment. This included 478 new two-year contracts, 413 one-year extension contracts and 434 health professionals starting the second year of their FY 2017 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 2018, there were 445 “matched unfunded” applicants (including 158 nurses, 6 behavioral health providers, 13 dentists, 73 mid-level providers and 154 pharmacists, among others) and 399 “unmatched unfunded” health professionals (including 20 physicians, 72 behavioral health providers, 27 dentists, 47 mid-level providers and 157 nurses among others). The inability to fund these 844 health professional applicants is a significant challenge for the recruitment efforts of the agency. A more detailed breakout of loan repayment awards in FY 2018 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 2018, there were 787 new online scholarship applications submitted to the IHS Scholarship program. After evaluating the application for completeness and eligibility, a total of 426 of these new scholarship applications were considered eligible for funding. The IHS Scholarship program was able to fund 155 new awards. The IHS Scholarship program also reviewed applications from previously awarded scholars that were continuing their education. A

total of 146 continuation awards were funded in FY 2018. A detailed breakout of scholarships awarded by discipline in FY 2018 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 2018, the Extern Program funded a total of 48 student externs. A breakout of extern awards in FY 2018 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
2016	$48,342,000
2017	$49,345,000
2018	$49,363,000
2019 Annualized CR	$49,363,000
2020 President's Budget	$43,612,000

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

BUDGET REQUEST

The FY 2020 budget submission for the Indian Health Professions program of $43.6 million is -$5.8 million below the FY 2019 Annualized CR level.

FY 2019 Base Funding of $49.4 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 2020 Funding includes:

- Current Services: +$433,000 for current services including:
    - Pay Costs +$17,000 to fund pay increases for Federal employees through these program funds.
    - Non-Medical Inflation +$416,000 to fund inflationary costs.

- Program Adjustment - $6,184,000 - The budget proposes to prioritize other direct services while redirecting/reducing funding for other activities, such as Health Professions.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2020 Target +/-FY 2019 Target
42 Scholarships: Proportion of Health Scholarship recipients placed in Indian health settings within 90 days of graduation. (Outcome)	FY 2018: 73 % Target: 78 % (Target Not Met)	78 %	78 %	Maintain
IHP-1 Number of scholarship awards under section 103 (Output)	FY 2018: 63 Awards Target: 34 Awards (Target Exceeded)	89 Awards	89 Awards	Maintain
IHP-2 Number of scholarship awards under section 104 (Output)	FY 2018: 230 Awards Target: 223 Awards (Target Exceeded)	223 Awards	223 Awards	Maintain
IHP-3 Number of externs under section 105 (Output)	FY 2018: 52 Externs Target: 135 Externs (Target Not Met)	135 Externs	135 Externs	Maintain
IHP-4 Number of new 2 year contract awarded loan repayments under section 108 (Output)	FY 2018: 478 contracts Target: 367 contracts (Target Exceeded)	465 contracts	465 contracts	Maintain
IHP-5 Number of continuing 1 year loan repayment contract extensions under section 108 (Output)	FY 2018: 413 Awards Target: 360 Awards (Target Exceeded)	360 Awards	360 Awards	Maintain
IHP-6 Total number of new awards funded in previous fiscal year under section 108 (Outcome)	FY 2018: 434 awards Target: 360 awards (Target Exceeded)	360 awards	360 awards	Maintain

***** FY 2019 "Targets" include estimates based on complete FY 2015 funding cycle data and additional Loan Repayment Program funding received in the FY 2017 budget.
** The "Number of Loan Repayments – Total" includes New Awards, Contract Extensions and Continuation Awards.

GRANTS AWARDS

The IHP administers three grant programs which fund colleges and universities to train students for health professions: (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.

	FY 2018 Final	FY 2019 Annualized CR	FY 2020 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	$332,715	$337,225	$337,225
Range of Awards	$332,715	$337,225	$337,225
Indians Into Medicine Program (Section 114) – CFDA No. 93.970			
Number of Awards	3	3	3
Average Award	$365,788	$365,788	$365,788
Range of Awards	$198,682 - $700,000	$198,682 - $700,000	$170,000 - $691,837
American Indians Into Psychology Program (Section 217) – CFDA No. 93.970			
Number of Awards	3	3	3
Average Award	$238,359	$240,780	$240,780
Range of Awards	$200,000-$253,000	$240,780	$240,780

Scholarship Program Awards – In FY 2018, students in the following disciplines received IHS Scholarship Program funding:

Section 103 Pre-professional - 31 students				
Pre-Clinical Psychology	9		Pre-Pharmacy	4
Pre-Nursing	13		Pre-Social Work	5
Section 103 Pre-graduate – 32 students				
Pre-Dentistry	5		Pre-Optometry	5
Pre-Medicine	20		Pre-Podiatry	2
Section 104 Health Professions - 230 students				
Counseling Psychology	5		Pharmacy	22
Dentistry	21		Physical Therapy	7
Environmental Engineering	1		Physician Assistant	12
Chemical Dependency	3		Optometry	10
Medical Technology	1		Physician, Allopathic	45
Clinical Psychology	8		Physician, Osteopathic	21
Nurse Practitioner	27		Podiatry	2
Nurse, Associate Degree	1		Public Health Nutritionist	1
Nurse, Baccalaureate Degree	24		Social Work	10
Nurse, Master's Degree	1		Ultrasonography	1
Nurse, Pediatric	1		X-Ray Technology	1
Nurse, Psychiatric	2		Nurse Anesthetist	3

Loan Repayment Program Awards – In FY 2018, the IHS LRP made awards to the following disciplines:

Awards by Profession	Total Awards	New Awards	Contract Extensions	Matched Not Awarded
Behavioral Health	86	49	37	6
Dental*	100	39	61	13
Nurse	182	154	28	158
Optometrists	51	13	38	5
Pharmacists	158	58	100	154
Physician Assistants/ Advanced Practice Nurses	100	54	46	73
Physicians	122	61	61	2
Podiatrists	11	1	10	2
Rehabilitative Services	54	31	23	11
Other Professions	27	18	9	21
TOTAL	**891**	**478**	**413**	**445**

* Includes Dentists and Dental Hygienists.

Other Professions	Total Awards	Matched Not Awarded	By Pay System	Awards
Acupuncturist	1	0	Tribal Employees	537
Certified Professional Coder	0	0	Civil Service	244
Chiropractors	4	0	Commissioned Corps	98
Dietetics/Nutrition	11	14	Urban Health Employees	12
Engineering	1	0		
Health Records	0	0		
Medical Laboratory Scientist	9	5		
Medical Technology	0	2		
Naturopathic Medicine	1	0		
Radiology Technicians	0	0		
Respiratory Therapist	0	0		
Sanitarian	0	0		
TOTAL	**27**	**21**	**Total**	**891**

Extern Program Awards – In FY 2018, the IHS Extern Program funded summer or winter externships for the following Area Offices for a total of 48:

AREA OFFICES	NUMBER OF EXTERNS
ALASKA	1
BEMIDJI	4
BILLINGS	4
CALIFORNIA	0
GREAT PLAINS	8
NASHVILLE	0
NAVAJO	4
OKLAHOMA	22
PHOENIX	3
PORTLAND	0
ALBUQUERQUE	2

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

TRIBAL MANAGEMENT GRANT PROGRAM

(Dollars in Thousands)

	FY 2018	FY 2019	FY 2020	
	Final	Annualized CR	President's Budget	FY 2020 +/- FY 2019
BA	$2,465	$2,465	$0	-$2,465
FTE*	--	--	--	--

*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 2020 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. 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.

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
- 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.

PROGRAM ACCOMPLISHMENTS

Fiscal Year	New Funded Awards	*Cont: 2/3 Year	Total Award
FY 2015	7	7	$1,164,442
FY 2016	16	3	$1,786,683
FY 2017	16	8	$2,235,271
FY 2018	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.
- Provided technical assistance to potential applicants
- 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.

FUNDING HISTORY/REQUEST

Fiscal Year	Amount
2016	$2,442,000
2017	$2,465,000
2018	$2,465,000
2019 Annualized CR	$2,465,000
2020 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 2020 budget submission for the Tribal Management Grant Program of $0 is $2.5 million below the FY 2019 Annualized CR and discontinues the program. The budget prioritizes funding for direct health care services and staffing of newly constructed facilities.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2020 Target +/-FY 2019 Target
TMG-1 Planning Grants (Output)	FY 2018: 0 planning grants Target: 0 planning grants (Target Met)	1 planning grants	0 planning grants	-1
TMG-2 Health Management Structure (HMS) grants (Output)	FY 2018: 27 HMS grants Target: 0 HMS grants (Target Exceeded))	20 HMS grants	0 HMS grants	-20

GRANTS AWARDS

	FY 2018 Final	FY 2019 Annualized CR	FY 2020 President's Budget
Number of Awards[1]	$2,465,000 13 Noncompeting Continuations and 3 New	$2,465,000	$0
Average Award	$90,125	$90,125	$0
Range of Awards	$50,000 - $150,000	$50,000 - $150,000	$0

[1] Includes partial awards

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

(Dollars in Thousands)

	FY 2018	FY 2019	FY 2020	
	Final	Annualized CR	President's Budget	FY 2020 +/- FY 2019
BA	$72,338	$72,338	$74,131	+1,793
FTE*	264	264	264	--

*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 2020 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 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.

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.

In December 2018, the Office of Quality (OQ) was 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. Establishment of the OQ fulfilled a priority objective within the IHS Quality Framework and reflects the input of tribal and urban Indian partners collected through consultation and conferral.

The IHS Quality Framework was mostly implemented by the end of FY 2018 and has transitioned to the IHS Strategic Plan FY 2019-2023 to ensure promotion of quality across the entire agency. The Strategic Plan was published in February 2019 and describes what the agency hopes to achieve over the next five years. Development of the Plan included gathering stakeholder feedback on an ongoing basis. The IHS initiated tribal consultation and urban Indian 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 Indian health care system faces several challenges related to access, quality, management, and operations. This Strategic Plan aims to address these challenges and builds on progress we have made.

To bring quality healthcare expertise and strengthen management, the IHS continues to focus considerable efforts on Human Resource (HR) management. 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. A few specific HR-related accomplishments follow:

- Developed and implemented the IHS-wide Enterprise Workflow Information Tracking System (EWITS) for tracking recruit actions from identification of vacancy to onboarding. The system has created transparency in the process and real time status of classifying and staffing positions for managers and human resources (HR). This transparency allows the agency to identify bottlenecks in order to improve HR processes and increase hiring time efficiency. EWITS also has a reporting capability to capture time-to-hire, workload, health profession hiring, and other efficiency and effectiveness metrics.
- Strengthened the partnership with the Office of the Surgeon General on a First Priority Initiative to give IHS the first priority in selecting applicants to the Commissioned Corps before consideration by other agencies. The Office of Human Resources established a process for engaging, vetting, and supporting applicants through the IHS hiring process and provided a fully vetted candidate to IHS service units in priority areas in the Navajo, Great Plains, and Billings Areas. The process decreased workload for regional HR staff while simultaneously providing a sustained period of superior service and attention to candidates in critical clinical health professions.

- Procured the Security Manager System to support 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 will ensure 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 2018, the IHS also expanded the use of data analysis and visualization tools to enhance reporting and data-driven decisions including several working applications:

- 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. This dashboard democratizes data previously held only in the proprietary accounting and reporting systems, Unified Financial Management System and Financial Business Intelligence System. This tool provides instant access to collections data in a non-technical format. Users are able to quickly sort and compare collections data by parameters such as type, Area, Service Unit, and fiscal year, which eliminates the requirement for a skilled financial analyst to produce custom reporting.

- "Follow the Money" Dashboard – A Qliksense based application developed to provide a first in class reporting tool allowing non-technical users to review funding status and spending data related to Purchased and Referred Care. Building on the 3rd Party Revenue Dashboard technical approach, this tool allows instant access to ten years of spending data by month, location, and object class code, in a simple format accessible by a person without financial expertise. 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.

If resources allow continued investment in these tools, IHS will be able to revolutionize financial reporting across the agency and provide faster, more reliable financial reporting to support high quality patient care and efficient resource utilization while providing significantly improved reporting to stakeholders.

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
2016	$72,338,000
2017	$70,420,000
2018	$72,338,000
2019 Annualized CR	$72,338,000
2020 President's Budget	$74,131,000

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 2020 budget submission for Direct Operations of $74.1 million is $1.8 million above the FY 2019 Annualized CR.

FY 2019 Base Funding of $72.3 million – Funding is for Direct Operations to continue to fund system-wide administrative, management, and oversight priorities at the discretion of the IHS Director that include:

- Continuing vital investments to enhance the IHS' 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 General Accountability Office (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 Purchased/Referred Care (PRC) program.
- 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 claims and maintaining policies and procedures to accurately determine CSC needs in the future.

FY 2020 Funding Increase of $1.8 million, a net increase, includes:

Current Services: +$407,000 for current services including:

- Pay Costs +$92,000 – to fund pay increases for Federal and tribal employees.

- Inflation +$315,000– to fund inflationary costs.

Program Adjustment +$1,386,000

- The funding increase provides expanded administrative oversight of national functions such as: human resoources, financial management and health care facilities planning, as well as advancing the overall Agency-wide mission, priorities and strategic plan.

- The OQ is being implemented currently to lead all quality and patient safety work including oversight of national policy, quality improvement strategies, and monitoring accountability of federally-operated facilities. A funding increase will enable recruitment of additional staff and provide the administrative and operational support necessary for carrying out the functions of the new Headquarters office. These operational funds will complement a proposed increase to the Hospitals and Health Clinics (H&HC) budget line

item that is primarily intended for development, implementation, and monitoring of national quality programmatic initiatives and activities.

- Funds will also be used to strengthen the agency'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 2018 Final	**FY 2019 Annualized CR**	**FY 2020 Request**
Headquarters (73.5%)	$43,153,446	$43,153,446	$54,116,000
Area Offices (12) (26.5%)	$29,184,554	29,184,554	$20,015,000
BA	**$72,338,000**	**$72,338,000**	**$74,131,000**

AREA ALLOCATION

Direct Operations
(dollars in thousands)

DISCRETIONARY SERVICES	FY 2018 Final			FY 2019 Estimated			FY 2020 Estimated			FY '20 +/- FY '19
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$36	$10,376	$10,412	$36	$10,376	$10,412	$37	$10,831	$10,868	$456
Albuquerque	873	684	1,557	873	684	1,557	889	714	1,603	46
Bemidji	1,224	0	1,224	1,224	0	1,224	1,245	0	1,245	22
Billings	1,931	73	2,003	1,931	73	2,003	1,965	76	2,041	38
California	1,299	0	1,299	1,299	0	1,299	1,322	0	1,322	23
Great Plains	2,137	0	2,137	2,137	0	2,137	2,175	0	2,175	38
Nashville	899	1,736	2,635	899	1,736	2,635	915	1,812	2,727	92
Navajo	2,685	0	2,685	2,685	0	2,685	2,733	0	2,733	48
Oklahoma	1,592	3,924	5,516	1,592	3,924	5,516	1,620	4,097	5,717	201
Phoenix	2,329	896	3,225	2,329	896	3,225	2,371	935	3,306	81
Portland	1,677	1,485	3,162	1,677	1,485	3,162	1,707	1,550	3,257	95
Tucson	598	0	598	598	0	598	608	0	608	11
Headquarters	35,886	0	35,886	35,886	0	35,886	36,529	0	36,529	642
Total, Direct Ops	**$53,164**	**$19,174**	**$72,338**	**$53,164**	**$19,174**	**$72,338**	**$54,116**	**$20,015**	**$74,131**	**+$1,793**

Note: FY 2019 through 2020 are estimates.

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

(Dollars in Thousands)

	FY 2018	FY 2019	FY 2020	
	Final	Annualized CR	President's Budget	FY 2020 +/- FY 2019
BA	$5,806	$5,806	$4,807	-$999
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 2020 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 relationship 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.

PROGRAM ACCOMPLISHMENTS

The IHS Tribal Self-Governance Program has grown dramatically since the initial 14 compacts and funding agreements were signed in 1994. In FY 2018, approximately $2.3 billion of the total IHS budget appropriation was transferred to Tribes and Tribal organizations to support 101 ISDEAA self-governance compacts and 127 funding agreements.[1]

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

[1] For FY 2019, the IHS estimates an additional five 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.

The Self-Governance budget engages local tribal resources through several activities:

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

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 to enhance information technology infrastructure and prepare for meaningful use and other federal reporting standards; and
- Collaborating on crosscutting issues and processes including, but not limited to: budget formulation; program management issues; self-determination issues; tribal shares methodologies; and emergency preparedness, response and security.

These services are deployed in accordance with strategic planning, are data driven, and support program integrity through adherence to reporting requirements. The Office of Tribal Self-Governance Funds Management Database supports the delivery of services by improved access to data to evaluate performance and identify areas of process improvement.

FUNDING HISTORY

Fiscal Year	Amount
2016	$5,735,000
2017	$5,786,000
2018	$5,806,000
2019 Annualized CR	$5,806,000
2020 Request	$4,807,000

BUDGET REQUEST

The FY 2020 budget submission for the Tribal Self-Governance Program of $4.8 million is $1.0 below the FY 2019 Annualized CR.

FY 2019 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, continues to fund performance projects, and funds tribal shares needs in IHS Areas and Headquarters for any AI/AN Tribes that have decided to participate in the IHS Tribal Self-Governance program**.**

FY 2020 Funding includes:

- Current Services: +$15,000 for current services including:
    - Inflation +$15,000 – to fund inflationary costs.

- Program Adjustment -$1 million- The budget proposes to prioritize other direct services while redirecting/reducing funding for other activities, such as Self-Governance.

OUTPUTS / OUTCOMES

Measure	**Year and Most Recent Result / Target for Recent Result / (Summary of Result)**	**FY 2019 Target**	**FY 2020 Target**	**FY 2020 Target +/-FY 2019 Target**
TOHP-SP Implement recommendations from Tribes annually to improve the Tribal consultation process and IHS operations. (Output)	FY 2017: 3 recommendations Target: 3 recommendations (Target Met)	3 recommendations	3 recommendations	Maintain

GRANT AWARDS

	FY 2018 Final	FY 2019 Annualized CR	FY 2020 Request
Planning Cooperative Agreements			
Number of Awards	7	5	5
Award Amount	$120,000	$72,000 - 120,000	$120,000
Negotiation Cooperative Agreements			
Number of Awards	2	5	5
Award Amount	$48,000	$48,000	$48,000

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

(Dollars in Thousands)

	FY 2018[1] Final	FY 2019 Annualized CR	FY 2020 President's Budget	FY 2020 +/- FY 2019
Medicare	$248,638	$248,638	$248,638	$0
Medicaid	$807,605	$807,605	$807,605	$0
M/M Total:	**$1,056,243**	**$1,056,243**	**$1,056,243**	**$0**
Private Insurance	$109,272	$109,272	$109,272	$0
VA Reimbursements	$28,062	$28,062	$28,062	$0
TOTAL :	**$1,193,577**	**$1,193,577**	**$1,193,577**	**$0**
FTE 1/	6,569	6,569	6,569	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 collect 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) 2018, $1.193 billion was collected from third party insurers, of which $1.056 billion or 87 percent was Federal M&M collections and $109.272 million was collected from private insurers. The FY 2020 estimates above are based on the FY 2018 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 Priorities which focus on People, Partnerships, Quality, and Resources.

Accreditation - In accordance with IHCIA authorization for collections, the IHS places the highest

[1] FY 2018 Collections are estimates.

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 IHS' priority on quality and ensuring excellence in everything we do to assure a high-performing Indian health system.

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, 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.

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 IHS' priority on resources to secure and effectively manage the assets needed to promote the IHS mission.

Partnerships – IHS is working to develop and enhance partnerships with federal and state agencies. IHS continues to work with CMS and the state Medicaid agencies to identify patients who are eligible to enroll in M&M and the state Children's Health Insurance Programs. 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' 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 one hundred 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 efforts by CMS. This includes increasing awareness, training and implementation of the Quality Payment Program under the Medicare Access and CHIP Reauthorization Act. IHS is working on implementation of the Merit-Based Incentive Payment System and Advanced Alternative Payment Models with the end goal of improving 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.

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 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 IHS' priority on building, strengthening and sustaining collaborative partnerships and relationships that advance the IHS mission.

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 activities focus on IHS' priority on people and the charge to recruit, develop and retain a dedicated, competent, caring workforce collaborating to achieve the IHS mission.

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. This partnership with the VA and implementation of VA reimbursement at IHS sites serve to support the IHS priority to build, strengthen, and sustain collaborative relationships that advance the IHS mission and enable IHS to provide further services to local communities funded with these collections.

- In FY 2018, the IHS HQ hosted several webinars and office hours to train staff on new monitoring tools, VA pharmacy billing, and other topics. The webinars are designed to provide information regarding programs and benefits available to populations within the AI/AN community as well as to share best practices as to how to reach those populations from across the I/T/U system.

- 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.

- As a result of partnership and discussions with CMS on outreach and enrollment opportunities within the IHS, the IHS HQ conducted a pilot project to increase M&M enrollment at six IHS Service Units in four states during the latter part of CY 2016. This project led to the development of a RPMS report that allows a facility to identify patients within their user population that may be eligible for alternate resources. IHS has conducted training and webinars to educate staff on the implementation and effective use of the report. Use of the report has led to increased insurance coverage and increased revenue at several facilities.

  In July 2018, the IHS Office of Resource Access and Partnerships partnered with the Office of Information Technology (OIT) to host a joint Partnership Conference with over 1,600 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, and FY 2018, in four Areas. Over 400 attendees participated in the training, which covered aspects of the entire revenue cycle. In FY 2019, IHS has scheduled seven training sessions across the nation focusing on Third Party Billing and Accounts Management, and Resource patient Management System

(RPMS) Process Training. In addition, IHS is hosting an Accounts Reconciliation Workshop in FY 2019, which will include finance and business office staff from every IHS Area.

- In the final quarter of FY 2018, the IHS completed a draft update of 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. The update will be complete in early FY 2019, and IHS will then develop training materials consistent with the IHS Third Party Internal Controls Policy and a training plan to be implemented in FY 2020.

- Finally, in FY 2020 IHS will update the Third Party Internal Controls Self-Assessment process and collaborate internally on the update of the IHS Debt Management Policy

FY 2019 - 2020 Collections Estimates

***Medicare and Medicaid (M&M)* -- The FY 2020 Budget request includes $1.056 billion which continues the collection estimates for FY 2019.**

***Medicaid* – The FY 2020 budget request totals $807.6 million, the same level as FY 2019.** IHS continues to educate its users on the benefits of increased 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 2020 budget request totals $248.6 million, the same level as FY 2019.** 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 2020 budget request includes $109.3 million, the same level as FY 2019.** 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 2020 budget submission includes $28.1 million, the same level as FY 2019.**

The estimate include collections for Federal and Tribal payments made by the VA. The FY 2020 estimate is based on the FY 2018 actual collections. The estimate includes actual collections received by IHS for Federal programs and the payments made by the VA to Tribal organizations. 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.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2020 Performance Budget Submission to Congress

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Facilities

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

(Dollars in Thousands)

	FY 2018	FY 2019	FY 2020	
	Final	Annualized CR	President's Budget	FY 2020 +/- FY 2019
BA	$867,504	$868,704	$803,026	$-65,678
FTE*	1,192	1,192	1,197	5

*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 2020 budget submission for Facilities of $803.0 million is $65.7 million below the FY 2019 Annualized Continuing Resolution (CR).

Maintenance & Improvement –The budget submission for M&I of $168.6 million is an increase of $1.0 million above the FY 2019 Annualized CR. 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; and
- Ensuring compliance with executive orders and public laws relative to building requirements, e.g., sustainability, energy conservation, seismic, environmental, handicapped accessibility, and security.

Sanitation Facilities Construction –The submission for Sanitation Facilities Construction of $193.3 million is an increase of $1.2 million above the FY 2019 Annualized CR. 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 budget submission for Health Care Facilities Construction of $165.8 million is a decrease of $77.7 million below the FY 2019 Annualized CR. This funding level for the construction of new and replacement healthcare facilities will allow IHS to continue/complete the following projects:

- Bodaway Gap Health Center, The Gap, AZ
- Albuquerque West Health Center, Albuquerque, NM
- Albuquerque Central Health Center, Albuquerque, NM
- New and Replacement Staff Quarters

Facilities and Environmental Health Support (FEHS) – The budget submission for FEHS of $251.4 million is an increase of $9.5 million above the FY 2019 Annualized CR. 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 budget submission for Equipment of $24.0 million is an increase of $277,000 above the FY 2019 Annualized CR. 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 budget submission for Personnel Quarters of $8.5 million is the same as the FY 2019 Annualized CR projection based on FY 2018 collections data. 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 2018	FY 2019	FY 2020	
	Final	Annualized CR	President's Budget	FY 2020 +/- FY 2019
BA	$167,527	$167,527	$168,568	$1,041
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 2020 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 35 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, 2018, is $648.9 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.

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.

[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.

FUNDING HISTORY/REQUEST

Fiscal Year	Amount
2016	$73,614,000
2017	$75,745,000
2018	$167,527,000
2019 Annualized CR	$167,527,000
2020 President's Budget	$168,568,000

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 2020 Budget submission for Maintenance and Improvement program of $168.6 million is $1.0 million above the FY 2019 Annualized CR level.

This level of funding provides for the following allocation categories:

Current Services of +$1.4 million, including:

- Inflation: +$771,000 to fund inflationary costs of providing health care services.

- Population Growth: +$654,000 to fund additional equipment needs arising from the growing AI/AN population. The growth rate is projected to be 1.8 percent in the FY 2020 based on State births and deaths data.

Program Adjustment -$384,000 - The budget proposes to prioritize other direct services while redirecting/reducing funding for other activities, such as Maintenance and Improvement.

- Approximately $81.0 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 $84.6 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 $4.8 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 $648.9 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 2018	FY 2019	FY 2020	
	Final	Annualized CR	President's Budget	FY 2020 +/- FY 2019
BA	$192,033	$192,033	$193,252	$1,219
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 2020 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 provide new and existing homes with first time services such as water wells, onsite waste water systems or connecting homes to community water, and waste water facilities. The universe of need includes upgrading existing water supply and waste disposal facilities.

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. 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. 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.

PROGRAM ACCOMPLISHMENTS

SFC is an integral component of IHS disease prevention activities. IHS has carried out the program since 1959 using funds appropriated for SFC to provide potable water and waste disposal facilities for AI/AN eligible homes and communities. As a result, infant mortality rates and mortality rates for gastroenteritis and other environmentally-related diseases have been reduced by about 80 percent since 1973. Research supported by the Centers for Disease Control and Prevention state populations in regions with lower proportion of homes without 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 SFC Program works collaboratively with Tribes to assure all AI/AN homes and communities are provided with safe and adequate water supply systems and sanitary sewage disposal systems as soon as possible.

In FY 2018, IHS provided service to 22,514 AI/AN homes with an average project duration of 3.5 years. However, at the end of FY 2018 about 7,612, or 1.9 percent of all AI/AN homes were without access to adequate sanitation facilities; and, about 130,153 or approximately 32 percent of AI/AN homes 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 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 for the ten year period (2009 to 2018) has decreased approximately $180 million or 6.4 percent from $2.82 billion to $2.64 billion. Over the same time period the Indian Health Service was appropriated $1.15 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.

[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] 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.

The SFC Program will continue in FY 2019 focusing on improving quality of data reported through the SDS on the sanitation facility needs supporting AI/AN homes and communities. These efforts will ensure the sanitation facilities needs included in SDS are:

- Adequately documented
- Reflect an update of current needs
- Include only sanitation facilities fundable by the SFC program for AI/AN eligible homes and communities and within the intent of the IHCIA consistent with the prescribed Deficiency Levels

Additionally, in FY 2019 the SFC Program will continue to focus on maintaining average construction project duration to less than 4 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
2016	$99,423,000
2017	$101,772,000
2018	$192,033,000
2019 Annualized CR	$192,033,000
2020 President's Budget	$193,252,000

BUDGET REQUEST

The FY 2020 Budget submission for Sanitation Facilities Construction of $193.3 million is an increase of $1.2 million above the FY 2019 Annualized CR level.

FY 2020 funding includes:

Current Services of +$1.5 million, including:

- Inflation +$666,000 to fund inflationary costs of providing health care services.

- Population Growth +$878,000 to fund additional equipment needs arising from the growing AI/AN population. The growth rate is projected to be 1.8 percent in the FY 2020 based on State births and deaths data

Program Adjustment -$325,000 - The budget proposes to prioritize other direct services while redirecting/reducing funding for other activities, such as Facilities and Environment Health Support.

The FY 2020 Budget request of $193.3 – provides funding in the following allocation categories:

- Approximately $127.8 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 $3.0 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 $2.0 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) will 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 $250,000 will be used to incorporate a graphical 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. 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 on Indian 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.

[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.)

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2020 Target +/-FY 2019 Target
35 Number of new or like-new and existing AI/AN homes provided with sanitations facilities. (Outcome)	FY 2018: 22,514 Target: 17,000 (Target Exceeded)	19,478	37,045	+17,567
SFC-E Track average project duration from the Project Memorandum of Agreement (MOA) execution to construction completion. (Outcome)	FY 2018: 3.5 yrs Target: 3.5 yrs (Target Met)	4 yrs	4 yrs	Maintain

GRANT AWARDS – This Program has no grant awards.

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

(Dollars in Thousands)

	FY 2018	FY 2019	FY 2020	
	Final	Annualized CR	President's Budget	FY 2020 +/- FY 2019
BA	$243,480	$243,480	$165,810	-$77,670
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 2020 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 April 2018. 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.

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. With the increase in facility size comes more healthcare providers and exam rooms, dentists and dental chairs, improved imaging systems, and expanded or new health 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. Tribes typically provide land, at no cost to the Federal Government, for the new or replacement health care facility.

In FY 2018 two facilities were completed: The Fort Yuma Health Center in Winterhaven, CA and The Red Tail Hawk Health Center, in the Gila River Indian Community near Chandler, AZ.

The FY 2018 appropriation completed funding for the Rapid City Health Center, Rapid City, SD; the Alamo Health Center, Alamo, NM and contributed funding to the Dilkon Alternative Rural Health Center, Dilkon, AZ; Pueblo Pintado Health Center, Pueblo Pintado, AZ; and Bodaway Gap Health Center, The Gap, AZ.

The FY 2018 appropriation funded planning activities for the Albuquerque West Health Center, Albuquerque, NM; the Albuquerque Central Health Center, Albuquerque, NM; and the Sells Health Center, Sells, AZ

The FY 2018 appropriation also contributed $15.0 million to the IHS SAP (SAP) and $11.5 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.

In FY 2017 the following health organizations entered into a Joint Venture with IHS:
Yakutat Tlingit Tribe for the Yakutat Community Health Center Yakutat, Alaska.

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
2016	$105,048,000
2017	$117,991,000
2018	$243,480,000
2019 Annualized CR	$243,480,000
2020 President's Budget	$165,810,000

BUDGET REQUEST

The FY 2020 Budget submission for Health Care Facilities Construction of $165.8 million is $77.67 million below the FY 2019 Annualized CR level.

FY 2020 Funding of $165.8 million includes:

- Current Services +$810,000, including:
    - Inflation +810,000 – to fund inflationary cost of providing health care services.
- Program Adjustment -$78.5 million - The budget proposes to prioritize other direct services while redirecting/reducing funding for other activities, such as Health Care Facilities Construction.

Bodaway Gap Health Center, The Gap, AZ $60.2 million
These funds will be used to complete construction of the health center Funding for 82 staff quarters located in The Gap, AZ will be prioritized in FY 2021. Bodaway Gap Health Center will be approximately 60,000 GSF. 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 West Health Center, Albuquerque, NM $51.42 million
The 80,400 GSF Albuquerque Indian Health Center, built in 1934, will be replaced by the Albuquerque Health Care System which will be in two locations (West and Central).These funds will be used to design and construct the health center located West of Albuquerque, NM. The West Health Center will be approximately 131,100 GSF. The Health Center will serve a projected user population of 11,500 generating 43,000 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 $44.20 million
The 80,400 GSF Albuquerque Indian Health Center, built in 1934, will be replaced by the Albuquerque Health Care System which will be in two locations (West and Central).These funds will be used to design and construction the health center located in west Albuquerque, NM. The Central Health Center will be approximately 150,600 GSF. 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 $10.00 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 2019 Target**	**FY 2020 Target**	**FY 2020 Target +/-FY 2019 Target**
36 Health Care Facility Construction: Number of health care facilities construction projects completed. (Outcome)	FY 2018: 2 projects Target: 2 projects[1] (Target Met)	1 project	0 project	-1 project
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 2018: 2 Target: 2 (Target Met)	1 project	0 project	-1 project

GRANT AWARDS – Program has no grant awards.

[1]The health care facilities completed in FY 2018 were the Fort Yuma Health Center in Winter Haven, CA and the Red Tail Hawk Health Center south of Phoenix in the Gila River Indian Community, AZ.

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

FACILITIES AND ENVIRONMENTAL HEALTH SUPPORT

(Dollars in Thousands)

	FY 2018	FY 2019	FY 2020	
	Final	Annualized CR	President's Budget	FY 2020 +/- FY 2019
BA	$240,758	$241,958	$251,413	$9,455
FTE*	1,030	1,030	1,035	5

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

(Dollars in Thousands)

	FY 2018	FY 2019	FY 2020	
Detail Breakout of FEHS Activity	Final	Annualized CR	President's Budget	FY 2020 (+/-) FY 2019
BA	$240,758	$241,958	$251,413	$9,455
Facilities Support	*$142,828*	*$143,540*	*$149,149*	$5,609
Environmental Health Support	*$80,822*	*$81,225*	*$084,399*	$3,174
Office of Environmental Health and Engineering Support	*17,108*	*$17,193*	*$17,865*	$672
FTE	1,030	1,030	1,035	5
Facilities Support	*582*	*582*	*587*	*5*
Environmental Health Support	*376*	*376*	*376*	--
Office of Environmental Health and Engineering Support	*72*	*72*	*72*	--

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, 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
2016	$222,610,000
2017	$226,950,000
2018	$240,758,000
2019 Annualized CR	$241,958,000
2020 President's Budget	$251,413,000

BUDGET REQUEST

The FY 2020 Budget request for the Facilities & Environmental Health Support Account of $251.4 million is $9.5 million above the FY 2019 Annualized CR level. Within the funding level provided, $4.2 million will fund Current Services and $7.1 million will support Staffing of New Facilities.

FY 2020 Funding Increase of $9.5 million, a net increase, includes:

Current Services of +$4.2 million, including:

- Pay Costs +$965,000 to fund pay increases for Federal and Tribal employees, of whom approximately 90 percent are working at the service unit level providing health care and related services.

- Inflation +$1.243 million to fund inflationary costs of providing health care services.

- Population Growth: +$1.975 million to fund additional equipment needs arising from the growing AI/AN population. The growth rate is projected to be 1.8 percent in the CY 2020 based on State births and deaths data.

Staffing for New Facilities +$7.1 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
Cherokee Nation Regional Health Center (JV), Tahlequah, OK	$5,203,000	12
Yakutat Tlingit Tribe Health Center (JV), Yakutat, AK	$302,000	2
Northern California Youth Regional Treatment Center, Davis, CA	$741,000	5
Ysleta Del Sur Health Center, (JV), El Paso, TX	$827,000	4
Grand Total:	**$7,073,000**	**23**

Program Adjustment -$1.8 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 Agency's priorities including: (1) people; (2) partnerships; (3) quality; and (4) resources.

The IHS owns approximately 10,376,000 square feet of facilities (totaling 2,152 buildings) and 1,723 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 166 years, with an average age greater than 38 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.

PROGRAM ACCOMPLISHMENTS

In FY 2018, total utility costs were $13.0 million and total utility costs per Gross Square Feet (GSF) were $2.91/GSF. In FY 2020, the total utility cost is expected to be $14.1 million reflecting a 4.0 percent annual increase. The cost per GSF is expected to rise to approximately $3.27/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. IHS placed into service a youth regional treatment center in July 2017 that consumed 63,942 BTU/SF in fiscal year 2018. The average IHS building consumed 135,127 BTU/SF in fiscal year 2018.

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, environmental health technicians, 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 by about 80 percent since 1973. Research supported by the Centers for Disease Control and Prevention state populations in regions with lower proportion of homes and absent of water service, reflect significantly higher hospitalization rates for pneumonia, influenza, and

respiratory syncytial virus.[1] Researchers associate the increasing illnesses with the restricted access to clean water for hand washing and hygiene. The absence of clean water to sanitation facilities for tribal households exacerbate concern for the Indian Health Service Clinical Health Care program; further decreasing the quality of life for 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 staff work collaboratively with tribes to assure all communities and homes are provided with safe water supply and waste disposal systems as soon as possible. Under this program in FY 2018, staff managed and/or provided professional engineering services to construct 482 sanitation projects with a total cost of over $286.0 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 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

[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.

training, technical assistance, and project funding (including cooperative agreements) to enhance the capacity of Tribal communities to address environmental health issues.

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.

The EHS 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 healthcare accreditation, which improves the quality of care. Maintaining accreditation ensures that IHS continues to have access to third-party funding.

PROGRAM ACCOMPLISHMENTS

OEHE staff accomplishments reduce the need for direct healthcare services when environmentally related diseases and injuries are reduced. For example, between 1973 and 2009, unintentional injury deaths for AI/AN people has decreased by 59 percent. 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]

Staff collaborate with IHS and Tribal behavioral health programs in supporting suicide and violence prevention initiatives. Examples include initiatives for training students and teachers on suicide prevention and bullying prevention measures and more recent involvement in efforts supporting prevention of prescription drug overdose.

The IEH Program provides technical assistance and program development support for local healthcare worker safety programs. 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 1.97 injuries/100 employees in 2017.

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, environmental compliance, fire safety, chemical safety, and radiation safety are accessed and recommendations for corrective action are provided.

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

[4] Indian Health Focus: Injuries, 2017 Edition

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 2019 Target	FY 2020 Target	FY 2020 Target +/-FY 2019 Target
EHS-3 Injury Intervention: Occupant protection restraint use (Outcome)	FY 2018: 100 %[5] Target: 100 % (Target Met)	Greater than 64 %	100 %[6]	N/A*
EHS-4 Environmental Surveillance (Outcome)	FY 2018: 100 %[7] Target: 100 % (Target Met)	Less than 5 %	100 %[8]	N/A*

The table is updated to reflect actual program performance measures. In FY 2016, a national baseline was established for EHS-3 and EHS-4 at 64 percent and 5 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). 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. 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 FY 2018 target, 10 of 10 (100 percent) of Areas reported their intervention strategies and some Areas modified their strategies to address identified intervention barriers. In FY 2019, Area programs will conduct final assessments and data collection to compare restraint use against the 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.

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. For the 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

[5] Percent of all participating Area conduct interim assessments.
[6] Percent of all participating Areas distribute model practices and highlight challenges.
[7] Percent of all participating Areas conduct interim assessments.
[8] Percent of all participating Areas distribute model practices and highlight challenges.

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 FY 2018, 10 of 10 (100 percent) of the Areas continued their comprehensive interventions and reported their survey results. In FY 2019, Area programs will conduct final assessments and data collection to compare foodborne illness risk factors against the 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.

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 will be available to the 32 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.

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. 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 2018	FY 2019	FY 2020	
	Final	Annualized CR	President's Budget	FY 2020 +/- FY 2019
BA	$23,706	$23,706	$23,983	$277
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 2020 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 $18.5 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.

FUNDING HISTORY/REQUEST

Fiscal Year	Amount
2016	$22,537,000
2017	$22,966,000
2018	$23,706,000
2019 Annualized CR	$23,706,000
2020 President's Budget	$23,983,000

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.

BUDGET REQUEST

The FY 2020 Budget request for Equipment of $24.0 million is $277,000 above the FY 2019 Annualized CR level.

FY 2020 Funding includes:

Current Services of +$381,000, including:

- Inflation: +$209,000 to fund inflationary costs of providing health care services.

[1] The IHS Facilities appropriation limits total expenditures up to $500,000 for equipment purchased through the TRANSAM Program.

- Population Growth: +$172,000 to fund additional equipment needs arising from the growing AI/AN population. The growth rate is projected to be 1.8 percent in the FY 2020 based on State births and deaths data.

- Program Adjustment -$104,000 – The budget proposes to prioritize other direct services while redirecting/reducing funding for other activities, such as Medical Equipment.

This level of funding provides for the following allocation categories:

- Approximately $18.5 million for new and routine replacement medical equipment to over 1,500 federally and tribally-operated healthcare facilities;
- $5.0 million for new medical equipment in tribally-constructed health care facilities; and
- $500,000 for the TRANSAM program.

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 2018	FY 2019	FY 2020	
	Final	Annualized CR	President's Budget	FY 2020 +/- FY 2019
BA	$8,500	$8,500	$8,500	$0
FTE*	43	43	43	--

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 2020 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.

FUNDING HISTORY/REQUEST

Fiscal Year	Amount
2016	$8,000,000
2017	$8,500,000
2018	$8,500,000
2019 Annualized CR	$8,500,000
2020 President's Budget	$8,500,000

BUDGET REQUEST

The FY 2020 Quarters Return budget submission for Rent Collections of $8.5 million is the same as the FY 2019 Annualized CR level for anticipated rental collections. FY 2018 rent collections were approximately $8 million and are projected to increase to approximately $8.5 to $9.0 million in FY 2020. 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.

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INDIAN HEALTH SERVICE
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Contract Support Costs

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Contract Support Costs: 75-0344-0-1-551
CONTRACT SUPPORT COSTS

(Dollars in Thousands)

	FY 2018	FY 2019	FY 2020	
	Final	Annualized CR[1]	President's Budget	FY 2020 +/- FY 2019
BA	$762,642	$717,970	$855,000	+$137,000
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 2020 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 in October 2016,[2] 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 both Title I contracts and Title V compacts.

[1] The 2019 CR estimate was based on the 2018 estimate for full CSC funding which was $718 million.

[2] *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.

PROGRAM ACCOMPLISHMENTS

- Following is a summary CSC funds for FY 2014 – FY 2019, as of February 2019:

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Appropriations*	$612,483,901	$662,970,000	$686,859,423	$714,642,272	$762,642,272	$762,642,272
Paid to Tribes	($611,150,133)	($639,069,567)	($675,280,831)	($705,343,072)	($753,955,359)	($172,370,006)
Balance*	$1,333,768	$23,900,433	$11,578,592	$9,253,300	$8,686,913	$590,272,266

* 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 in October 2016 and continues to work diligently to implement the policy by providing training and guidance to internal and external customers. The updated policy provides detailed guidance and clarifies the data used to determine each T/TO's estimated CSC need and/or final amount.

- The updated IHS CSC policy implemented in late 2016 includes a provision that provides a simplified calculation of indirect CSC on recurring service unit shares, referred to as the 97/3. After a year of implementing the revised CSC Policy, the IHS has found that in certain instances, 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" – does not conform with the statutory authority of the ISDEAA. On December 21, 2017, after careful review and consideration, the IHS temporarily rescinded this provision until such time that the IHS is able to consult with Tribes on any changes. IHS has reviewed the comments received from the Tribal consultation and is preparing the final decision.

- IHS Headquarters reconciles CSC fund requests on a quarterly basis and allocates funds to each Area office to pay tribes.

- 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 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, deadlines are met, and funding amounts are correctly calculated. 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.

- For FY 2018, IHS paid $3,108,647 for one time direct CSC for pre-award and startup funds for two tribes that assumed new program, functions, services, and activities (PFSAs) or renegotiated their direct or indirect type CSC amount.

- IHS continues to make progress in resolving Contract Disputes Act claims from T/TO for additional CSC funding for prior years. As of February 7, 2019, the IHS has extended settlement offers on 1,571 of the 1,596 claims, with settlement payments of approximately $869 million that has been tentative or confirmed for payment from the Judgment Fund.

FUNDING HISTORY

Fiscal Year	Amount
2016	$717,970,000
2017	$800,000,000
2018[3]	$762,642,000
2019 Annualized CR	$717,970,000
2020 President's Budget	$855,000,000

BUDGET REQUEST

The FY 2020 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 $137 million above the FY 2019 Annualized CR 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 2018 Final			FY 2019 Estimated			FY 2020 Estimated			FY '20 +/- FY '19
SERVICES	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$0	$226,266	$226,266	$0	$213,013	$213,013	$0	$253,668	$253,668	$40,655
Albuquerque	0	18,869	18,869	0	17,764	17,764	0	21,154	21,154	3,390
Bemidji	0	40,391	40,391	0	38,025	38,025	0	45,282	45,282	7,257
Billings	0	14,179	14,179	0	13,349	13,349	0	15,897	15,897	2,548
California	0	63,513	63,513	0	59,792	59,792	0	71,204	71,204	11,412
Great Plains	0	7,254	7,254	0	6,829	6,829	0	8,132	8,132	1,303
Nashville	0	32,877	32,877	0	30,951	30,951	0	36,858	36,858	5,907
Navajo	0	60,212	60,212	0	56,685	56,685	0	67,503	67,503	10,819
Oklahoma	0	115,206	115,206	0	108,458	108,458	0	129,158	129,158	20,700
Phoenix	0	41,820	41,820	0	39,371	39,371	0	46,885	46,885	7,514
Portland	0	58,425	58,425	0	55,003	55,003	0	65,501	65,501	10,498
Tucson	0	24,219	24,219	0	22,800	22,800	0	27,152	27,152	4,352
Headquarters	0	59,412	59,412	0	55,932	55,932	0	66,606	66,606	10,675
Total, CSC	**$0**	**$762,642**	**$762,642**	**$0**	**$717,970**	**$717,970**	**$0**	**$855,000**	**$855,000**	**+$137,030**

Note: FY 2019 through 2020 are estimates.

[3] FY 2018 amount is the final level for CSC.

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Special Diabetes Program for Indians

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
SPECIAL DIABETES PROGRAM FOR INDIANS

(Dollars in Thousands)

	FY 2018	FY 2019	FY 2020	
	Final	Annualized CR	President's Budget	FY 2020 +/- FY 2019
Special Diabetes Program for Indians	$150,000	$150,000	$150,000	$0
Total Special Diabetes Program for Indians	$150,000	$150,000	$150,000	$0
FTE*	127	127	127	0

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

Authorizing Legislation ..... 111 Stat. 574, 1997 Balanced Budget Act (P.L. 105-33), Consolidated Appropriation Act 2001 and amendment to Section 330C (c)(2)(c) Public Health Service Act through Senate Bill 2499 (passed the Senate 12/18/07) to extend funding through FY 2009, the Medicare Improvements for Patients and Providers Act of 2008 (P.L. 110-275) Title III Special Diabetes Program for Indians (SDPI) to extend funding through FY 2011, the H.R. 4994 Medicare and Medicaid Extenders Act of 2010 to extend SDPI funding through FY 2013, the American Taxpayer Relief Act of 2012 (P.L. 112-240) to extend funding through FY 2014, the Protecting Access to Medicare Act of 2014 (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.

FY 2020 Authorization.....Expires September 30, 2019 (FY 2019)

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 2020 would be the 23rd year of the SDPI. SDPI operates with a usual budget of $150 million per year and is currently authorized through September 30, 2019. The IHS Office of Clinical and Preventive Services (OCPS) Division of Diabetes Treatment and Prevention (DDTP) provides leadership, programmatic, administrative, and technical oversight to the SDPI grant program.

The mission of the DDTP is to develop, document, and sustain public health efforts to prevent and control diabetes in American Indians and Alaska Natives (AI/ANs) by promoting collaborative strategies through its extensive diabetes network. The diabetes network consists of a national program office, Area Diabetes Consultants in each of the 12 IHS Areas, and approximately 301 SDPI grants and sub-grants at I/T/U sites across the country.

Target Population: American Indians and Alaska Natives

Diabetes and its complications are major contributors to death and disability in nearly every Tribal community. AI/AN adults have the highest age-adjusted rate of diagnosed diabetes (15.1 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.

Strategy

The SDPI brings Tribes together to work toward a common purpose and share information and lessons learned. The Tribal Leaders Diabetes Committee, established in 1998, reviews information on the SDPI progress and provides recommendations on diabetes-related issues to the IHS Director. Through partnerships with federal agencies, private organizations, and an extensive I/T/U network, DDTP undertook one of the most strategic diabetes treatment and prevention efforts ever attempted in AI/AN communities and demonstrated the ability to design, manage, and measure a complex, long-term project to address this chronic condition. Because of the significant costs associated with treating diabetes, I/T/Us have used best and promising practices for their local SDPI funding to address the primary, secondary, and tertiary prevention of diabetes and its complications.

This collaborative approach supports the strategic planning process necessary to identify the goals and objectives needed to achieve the intended SDPI outcomes. This process aligns with the IHS priorities to renew and strengthen partnerships with Tribes and also to improve access to quality health care.

[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.

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 proven interventions to address the diabetes epidemic.

The Consolidated Appropriations Act of 2001 established statutory authority for SDPI to implement a best practices approach to diabetes treatment and prevention. The SDPI has incorporated these Indian Health Diabetes Best Practices into the SDPI grant application process used throughout AI/AN communities. Grant programs are required to document the use of one 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%
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%

[3] *Available at* https://www.ihs.gov/sdpi/sdpi-community-directed/diabetes-best-practices/

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 8.2 percent in 2017, 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 91 mg/dL in 2017, 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. SDPI supports the development and implementation of the IHS Electronic Health Record, and the IHS Diabetes Management System in all 12 IHS Areas.

Facilities associated with SDPI programs participate in the annual IHS Diabetes Care and Outcomes Audit. The Diabetes Audit is the cornerstone of the IHS DDTP diabetes care surveillance system, tracking annual performance on diabetes care and health outcome measures. Data collection for the Diabetes Audit follows a standardized protocol to ensure statistical integrity and comparability of measures over time. The 2017 Diabetes Audit included a review of 124,822 patient charts at 333 I/T/U health facilities. The Diabetes Audit enables IHS and the SDPI programs to monitor and evaluate yearly performance at the local, regional, and national levels. DDTP provides Diabetes Audit training through online and webinar formats. DDTP receives evaluations on all trainings provided to guide improvements for future sessions.

Key Performance/Accomplishments

Annual SDPI assessments have shown significant improvements in diabetes clinical care and community services provided over time when compared to the baseline SDPI assessment in 1997 (see table above titled "Diabetes treatment and prevention services available to AI/AN individuals").

Ongoing efforts to improve blood glucose, blood pressure, and cholesterol values will continue to reduce the risk for microvascular, as well as macrovascular complications (see "Outputs/Outcomes" table below).

[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.

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 September 30, 2019, under P.L. 115-123— Bipartisan Budget Act of 2018. The FY 2020 budget proposes to extend funding for two years through FY 2021, at $150 million each year. The distribution of funding is shown in the grant tables that follow.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2019 Target	FY 2020 Target	FY 2020 Target +/-FY 2019 Target
52 Good Glycemic Control (Outcome)	FY 2018: 36.8% Target: 36.2 % (Target Exceeded)	Discontinued	Discontinued	N/A
53 Controlled BP <140/90 (Outcome)	FY 2018: 55.6% Target: 52.3 % (Target Exceeded)	52.3 %	60.5%	+8.2%

54 Statin Therapy to Reduce Cardiovascular Disease Risk in Patients with Diabetes (Intermediate Outcome)	FY 2018: 47.4% Target: 37.5 % (Target Exceeded)	37.5 %	51.6%	+14.1%
86 Reduce the proportion of American Indians/Alaska Natives with diagnosed diabetes who have poor glycemic control (A1c >9%). (Outcome)	FY 2019: Result Expected Jan 31, 2020 Target: Set Baseline (Pending)	Set Baseline	TBD	N/A

GRANTS AWARDS

The SDPI provides grants for diabetes treatment and prevention services to IHS, Tribal and Urban Indian health programs in 35 states. The SDPI grant programs provide local diabetes treatment and prevention services based on community needs.

(whole dollars)	FY 2018 Final	FY 2019 Annualized CR	FY 2020 Request
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 2020 State/Formula Grants

CFDA No. 92.237 / Special Diabetes Program for Indians Grant Programs by State and FY 2020 Annual Financial Assistance Awards					
State	State Name	FY 18 Total # Grant Programs	FY 2018 Final	FY 2019 Annualized CR	FY 2020 Request*
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	28,913,564	28,913,564
CA	California	39	9,740,219	9,740,219	9,740,219
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

CFDA No. 92.237 / Special Diabetes Program for Indians Grant Programs by State and FY 2020 Annual Financial Assistance Awards					
State	State Name	FY 18 Total # Grant Programs	FY 2018 Final	FY 2019 Annualized CR	FY 2020 Request*
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	12,615,849	12,615,849
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	6,014,473	6,014,473	6,014,473
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*	**253**	**$114,124,998**	**$114,124,998**	**$114,124,998**

*This is the number of tribes that are primary grantees or sub-grantees.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2020 Performance Budget Submission to Congress

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Drug Budget

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Drug Control Budget
FY 2020

	Budget Authority (in Millions)		
	FY 2018 Final	**FY 2019 CR**	**FY 2020 President's Budget**
Drug Resources by Function			
Prevention	24.540	24.771	25.837
Treatment	88.516	89.963	96.878
Total Drug Resources by Function	**$113.056**	**$114.734**	**$122.715**
Drug Resources by Decision Unit			
Alcohol and Substance Abuse	109.481	111.130	118.715
Urban Indian Health Program	3.575	3.604	4.000
Total Drug Resources by Decision Unit	**$113.056**	**$114.734**	**$122.715**
Drug Resources Personnel Summary			
Total FTEs (direct only)	171	171	171
Drug Resources as a Percent of Budget			
Agency Budget	$ 6,934.513	$ 6,905.153	$7,296.644
Drug Resources Percentage	1.63%	1.66%	1.68%

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 2020, IHS requests $122.7 million for its drug control activities, an increase of $7.9 million above the FY 2019 annualized CR level.

Alcohol and Substance Abuse
FY 2020 Request: $118.7 million
(Increase of $8.0 million above the FY 2019 Annualized CR)

In FY 2020, 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 addresses public health and public safety challenges. IHS is also working with Federal partners to implement ONDCP's Prescription Drug Misuse Prevention Plan, "*Epidemic: Responding to America's Prescription Drug Abuse Crisis*."

The Prescription Drug Misuse Prevention Plan expands upon the Administration's *Strategy* which offers a valuable opportunity for IHS to advance its mission by strengthening existing programs to control and reduce substance use and eliminate its deleterious effects on the health and safety of AI/AN patients and communities.

In FY 2020, IHS will continue to serve AI/ANs impacted by substance use disorders and dependence through its Youth Regional Treatment Centers (YRTCs) and other IHS, Tribal, and Urban Indian operated substance use disorder treatment and prevention programs. In addition to those direct services, the IHS Substance Abuse and Suicide Prevention (SASP), 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. The strategic goal is to support Tribal 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.

Youth Regional Treatment Center Aftercare Pilot Project - IHS currently funds thirteen YRTCs to provide a range of clinical services rooted in a culturally relevant, holistic model of care. These services include clinical evaluation, substance use education, group, individual and family psychotherapy, art therapy, adventure-based counseling, life skills, medication management or monitoring, evidence-based/practice-based treatment, aftercare relapse prevention, and limited post-treatment follow-up services. Once AI/AN youth are discharged home, they are faced with leaving a structured treatment environment to return home where little work has occurred with their families and often times, aftercare services are limited.

In December 2017, IHS established a pilot project to fill this gap in services and provide a continuum of care for AI/AN youth after they are discharged home from YRTCs. The goal of the pilot project is to promote integration of cultural practices with evidence based treatment in aftercare services for AI/AN youth. IHS funds two YRTCs, Desert Sage and the Healing Lodge of the 7 Nations to participate in the pilot project over the next three years.

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 youth adults and preventing further progression by recognizing and responding to the sequel of the abuse. IHS promotes expanded health care services, such as mental and behavioral health treatment and prevention, by providing training on substance use disorders to

IHS, Tribal, and 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.

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.

In FY 2020, the IHS budget request for its drug control activities supports the Office of National Drug Control Policy's funding priorities.

The IHS established a multi-disciplinary workgroup to focus on Prescription Drug Abuse in Indian Country in 2012. In March 2017, the IHS chartered this workgroup to form the IHS National Committee on Heroin, Opioids, and Pain Efforts (HOPE). The HOPE Committee is comprised of 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.

The IHS implemented the "Chronic Non-Cancer Pain Management Policy" to promote appropriate pain management as a primary prevention tool. 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. 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. The policy also establishes requirements for Federal pharmacists to query PDMPs prior to dispensing controlled substance prescriptions ordered by external prescribers and for Federal pharmacies to report controlled substance dispensing data to state PDMPs. The IHS will create an automated process to ensure compliance with PDMP reporting requirements in FY 2019. Additionally, the IHS will improve pain management through the creation and release of an IHS guideline on appropriate management of acute dental pain.

[1] ONDCP. Integrating Treatment into Healthcare. *Available at* http://www.whitehouse.gov/ondcp/integrating-treatment-and-healthcare.

The IHS developed a robust training requirement to support opioid policy implementation. The "IHS Essential Training in Pain and Addictions" is a mandatory training course for all Federal prescribers, contractors, residents and trainees who prescribe controlled substances and spend at least 50 percent of their time in a clinical setting. The purpose of this training is to assure that providers have the knowledge needed to appropriately and effectively prescribe controlled substance medications. The IHS has reformatted this training to include on-demand content for new IHS prescribers entering the healthcare system and has created a refresher training course to update prescribers on emerging chronic pain treatments as well as highlight key agency policies and requirements. In FY 2019, IHS will conduct a national evaluation of the "IHS Essential Training in Pain and Addictions" to determine changes and outcomes associated with the mandatory trainings. Findings from this evaluation are expected to guide efforts to revise and update trainings. The IHS will continue to revise and improve these trainings as well as develop mechanisms to track training completion by discipline. The IHS created and delivered a 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 has been offered in three IHS Areas with additional sessions planned in FY 2019. 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 is committed to workforce development and hosts weekly continuing education on pain and addiction as well as consultation on complex cases to further train primary care clinicians to provide these specialty services. Consultation is offered through virtual clinics hosted by the University of New Mexico to connect primary care clinicians with expert teams to share knowledge and elevate the level of specialty care available to patients. 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.

The IHS is supporting improved access to prevention, treatment, and recovery support services. For example, the IHS has increased workforce capacity in treatment and recovery and has trained IHS providers to obtain Drug Addiction Treatment Act (DATA) waivers to treat opioid use disorders. The IHS has also developed an intensive Trauma Informed Care curriculum for health systems to create trauma responsive organizations that incorporate a holistic approach to recovery and healing. Additionally, the IHS has developed and released a comprehensive Medication Assisted Treatment (MAT) resource that includes best and promising practices to support a holistic approach to recovery for patients diagnosed with opioid use disorder. To address access to tele-medicine for MAT services in remote IHS locations and villages, the IHS has created an Internet Eligible Controlled Substance Prescriber Designation policy. In FY 2018 the IHS collaborated with the American College of Obstetrics and Gynecology (ACOG) and the American Academy of Pediatrics (AAP) to develop and release two guidelines focused on the prevention and management of Neonatal Opioid Withdrawal Syndrome (NOWS). The key features of these guidelines are to improve screening of women of childbearing age for substance use disorders, improve referral to MAT, and early engagement of women in prenatal care as well as specific recommendations for the medical management of infants born with gestational exposure to opioids. Finally, the IHS will evaluate mechanisms to increase access to controlled substance disposal services for unused and unwanted medications in FY 2018.

The IHS is increasing access to naloxone for trained first responders in tribal communities. 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. This partnership has put naloxone in the hands of law enforcement officers, who are often the first responders to incidents of opioid overdose in Tribal communities. The IHS trained 321 BIA LEOs as well as certified 48 BIA LEOs as naloxone trainers. 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 anticipates release of the agency policy surrounding 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 in FY 2018. These efforts have resulted in a 143 percent increase in naloxone procurement across IHS facilities that utilize the Prime Vendor.

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.

Urban Indian Health Program – Alcohol and Substance Abuse Title V Grants
FY 2020 Request: $4.0 million
(Increase of $400,000 above the FY 2019 Annualized CR)

Urban Indian Organizations (UIOs) are resources to both tribal and urban communities. UIOs that offer inpatient and outpatient substance use disorder treatment have become reliable referral sites for Tribes. In FY 2020, IHS is proposing $4.0 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.

[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.

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.

UIO emphasis on integrating behavioral health, health education, health promotion and disease prevention into primary care offered within a culturally appropriate framework, leads to positive outcomes for urban AI/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 treatment. While male AI/ANs can encounter wait times for treatment admission up to six months, treatment options for youths, 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. The existing UIOs have operated culturally appropriate initiatives to reduce health risk factors. UIOs continued efforts to target behavioral or lifestyle changes offer the best hope for impacting the major health challenges of the urban AI/AN population.

Fetal alcohol spectrum disorders 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 includes 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 a 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.

PERFORMANCE

Information regarding the performance of the drug control efforts of IHS are based on agency GPRAMA documents and other information that measure the agency’s contribution to the *Strategy.*

[3] Ibid.

In FY 2020, the IHS will begin to 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.

FY 2019 Changes (no change): IHS will continue to serve AI/ANs impacted by substance abuse and dependence through its YRTCs and other IHS, Tribal, and Urban Indian operated substance abuse treatment and prevention programs.

The table and accompanying text below represent highlights of IHS achievements during FY 2017, 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 2018 Target**	**FY 2018 Achieved**
» Universal alcohol screening	37%	40.9%
» 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	39,658	38,262
Report on number of SUD services in primary care clinics	113,497	133,210

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 12 through 75 years of age. The final FY 2018 new universal alcohol screening target of 37 percent was met with final results achieving 40 percent screened.

In FY 2017, IHS implemented the Screening, Brief Intervention, and Referral to Treatment (SBIRT) measure. SBIRT is an effective screening tool in identifying risky alcohol use and will have a far-reaching positive impact on the overall health of AI/AN communities. The FY 2018 target for the SBIRT screening of 8.9 percent was exceeded with the final result of 11.8 percent of patients 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 208, 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 2018 number of SUD encounters provided in emergency department was 32,262 while SUD encounters provided in primary care clinics totaled 133,210. 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 2018 SUD intervention services provided across all IHS clinics was 703,669 encounters.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2020 Performance Budget Submission to Congress

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Supplemental Tables

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FY 2020 BUDGET SUBMISSION
INDIAN HEALTH SERVICE
OBJECT CLASSIFICATION
(Dollars in Thousands)

Object Class	FY 2018 Final	FY 2019 Annualized CR	FY 2020 Pres. Budget	FY 2020 +/- FY 2019
DIRECT OBLIGATIONS				
Personnel Compensation:				
Full-Time Permanent(11.0)……	468,891	470,407	483,558	13,151
Other than Full-Time Permanent(11.3)……	19,019	19,082	19,259	177
Other Personnel Comp.(11.5)……	68,763	68,999	69,639	640
Military Personnel Comp (11.7)……	75,890	76,087	79,436	3,349
Special Personal Services Payments (11.8)……	384	385	389	4
Subtotal, Personnel Compensation...…	632,947	634,960	652,281	17,321
Civilian Personnel Benefits(12.1)……	184,680	185,285	196,966	11,681
Military Personnel Benefits (12.2)	32,122	32,210	33,628	1,418
Benefits to Former Personnel(13.0)……	11,871	11,913	12,023	110
Subtotal, Pay Costs……	**861,620**	**864,368**	**894,898**	**30,530**
Travel(21.0)……	32,009	32,117	34,074	1,957
Transportation of Things(22.0)……	8,936	8,959	9,106	147
Rental Payments to GSA(23.1)……	13,588	13,636	13,860	224
Rental Payments to Others(23.2)……	18,382	18,393	18,696	303
Communications, Utilities and Miscellaneous Charges(23.3……	11,812	11,853	12,090	237
Printing and Reproduction(24.0)……	208	209	212	3
Other Contractual Services:				
Advisory and Assistance Services(25.1)……	5,510	5,530	5,621	91
Other Services(25.2)……	533,040	533,518	570,224	36,706
Purchases from Govt. Accts.(25.3)……	72,777	73,035	74,234	1,199
Operation and Maintenance of Facilities(25.4)….	24,684	24,691	25,098	407
Research and Development Contracts(25.5)…….	0	0	0	0
Medical Care(25.6)……	258,352	259,274	263,530	4,256
Operation and Maintenance of Equipment(25.7)..	17,257	17,315	17,599	284
Subsistence and Support of Persons(25.8)……	4,859	4,878	4,958	80
Subtotal, Other Contractual Current.....…	**916,479**	**918,241**	**961,264**	**43,023**
Supplies and Materials(26.0)……	90,041	90,344	113,469	23,125
Equipment (31.0)……	8,640	8,660	9,518	858
Land & Structures (32.0)……	2,001	2,001	2,034	33
Investments & Loans (33.0)……	0	2	2	0
Grants, Subsidies, & Contributions (41.0)……	2,845,977	2,856,186	3,010,065	153,879
Insurance Claims & Indemnities (42.0)……	10,010	10,046	10,187	141
Interest & Dividends (43.0)……	91	91	92	1
**Subtotal Non-Pay Costs.....…… **	**3,958,174**	**3,970,738**	**4,194,669**	**223,931**
Total, Direct Obligations……	**4,819,794**	**4,835,106**	**5,089,567**	**254,461**

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

Object Class	2018 Final	FY 2019 Annualized CR	FY 2020 Pres. Budget	Increase or Decrease
Personnel Compensation:				
Full-Time Permanent (11.0)	468,891	470,407	483,558	13,151
Other than Full-Time Permanent (11.3)	19,019	19,082	19,259	177
Other Personnel Comp. (11.5)	68,763	68,999	69,639	640
Military Personnel Comp. (11.7)	75,890	76,087	79,436	3,349
Special Personnel Services Payments (11.8)	384	385	389	4
Subtotal, Personnel Compensation	616,337	634,960	652,281	17,321
Civilian Personnel Benefits (12.1)	184,680	185,285	196,966	11,681
Military Personnel Benefits (12.2)	32,122	32,210	33,628	1,418
Benefits to Former Personnel (13.0)	11,871	11,913	12,023	110
Total, Pay Costs	**839,072**	**864,368**	**894,898**	**30,530**
Travel (21.0)	32,009	32,117	34,074	1,957
Transportation of Things (22.0)	8,936	8,959	9,106	147
Rental Payments to Others (23.2)	18,382	18,393	18,696	303
Communications, Utilities & Misc. Charges (23.3)	11,812	11,853	12,090	237
Printing and Reproduction (24.0)	208	209	212	3
Other Contractual Services:				
Advisory and Assistance Services (25.1)	5,510	5,530	5,621	91
Other Services (25.2)	533,040	533,518	570,224	36,706
Purchases from Govt. Accts. (25.3)	72,777	73,035	74,234	1,199
Operation and Maintenance of Facilities (25.4)	24,684	24,691	25,098	407
Operation and Maintenance of Equipment (25.7)	17,257	17,315	17,599	284
Subsistence and Support of Persons (25.8)	4,859	4,878	4,958	80
Subtotal, Other Contractual	330,316	658,967	697,734	38,767
Supplies and Materials (26.0)	90,041	90,344	113,469	23,125
Total, Non-Pay Costs	**479,067**	**820,842**	**885,381**	**64,539**
Total Salaries & Expenses	1,318,139	1,685,210	1,780,279	95,069
Direct FTE	8,589	8,589	8,703	114

INDIAN HEALTH SERVICE
Detail of Full-Time Equivalents (FTE)

	FY 2018 Final	FY 2019 Annualized CR	FY 2020 PB
Headquarters 1/			
Sub-Total, Headquarters	448	448	492
Area Offices			
Alaska Area Office	361	361	361
Albuquerque Area Office	1,026	1,026	1,026
Bemidji Area Office	555	555	555
Billings Area Office	996	996	996
California Area Office	144	144	214
Great Plains Area Office	2,226	2,226	2,226
Nashville Area Office	202	202	202
Navajo Area Office	4,199	4,199	4,199
Oklahoma City Area Office	1,717	1,717	1,717
Phoenix Area Office	2,566	2,566	2,566
Portland Area Office	504	504	504
Tucson Area Office	320	320	320
Sub-Total, Area Offices	14,816	14,816	14,886
Trust Funds (Gift)	21	21	21
TOTAL FTES	15,285	15,285	15,399

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 2018 Final	FY 2019 Annualized CR	FY 2020 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 2020 Congressional Justification
Programs Proposed for Discontinuation

Two programs within the Indian Health Service budget have been proposed for elimination: Health Education and the Tribal Management Grants.

Health Education: The FY 2019 Annualized CR amount for Health Education is $20,017,000, with the program discontinued in FY 2020. The rationale for discontinuing this program is to prioritize funding for clinical services and staffing costs of new and replacement health care facilities to provide health care to American Indians and Alaska Natives (AI/AN). This program has played a role in IHS's approach to Native American health care, but direct health care services are a priority.

Tribal Management Grant Program: The FY 2019 Annualized CR amount for the Tribal Management Grant Program is $2,465,000, with the program discontinued in FY 2020. The rationale for discontinuing this program is 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 2017 (Actual)	CY 2018 (Estimates)	BY* 2019 (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.)*

Not Applicable

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

Not Applicable

INDIAN HEALTH SERVICE
Summary of Reimbursements, Assessments, and Purchases
FY 2019 Estimate

Agreement Type		FY 2018 Actuals	FY 2019 Estimate
	Reimbursement for Services Purchased within HHS		
SSF-PSC	Service & Supply Fund (SSF) - Program Support Center (PSC)	10,268,860	10,698,681
SSF-NonPSC	Office Business Management Transformation (OBMT)	42,800	44,340
SSF-NonPSC	Offices of Human Resources (OHR) - e.g. Enterprise Services, Operations	6,111,514	6,111,514
SSF-NonPSC	Office of Enterprise Application Development (OEAD) - OCIO	5,292,588	4,318,639
SSF-NonPSC	Information Technology Infrastructure & Operations (ITIO) - OCIO	3,695,716	3,180,021
SSF-NonPSC	Office of IT Strategy, Policy & Governance (OSPG) - OCIO	600,893	623,709
SSF-NonPSC	Office of Information Security (OIS) - OCIO	2,643,829	3,069,221
SSF-NonPSC	Equal Employment Opportunity Compliance & Operations (EEOCO)	613,623	420,960
SSF-NonPSC	Office Security & Strategic Information (OSSI)	4,109,435	4,109,435
	Subtotal SSF Non-PSC	23,110,398	21,877,839
SSF-NonASA	Acquisition Integration Modernization (AIM)	239,000	358,000
SSF-NonASA	Category Management	231,000	231,000
SSF-NonASA	Commissioned Corps Force Management (CCFM)	8,157,000	8,391,071
SSF-NonASA	Departmental Contract Information System (DCIS)	429,000	424,000
SSF-NonASA	Departmental Ethics Program - OGC (moved from Joint Funding Agreement)	431,000	447,000
SSF-NonASA	Web Media (Formerly Web Communications)	5,478,000	5,563,000
SSF-NonASA	Web Crawler	19,000	19,000
SSF-NonASA	Freedom of Information Act (Request and Appeal)	16,000	17,000
SSF-NonASA	Grants.gov System	48,000	37,301
SSF-NonASA	Grants Solutions Center of Excellence-Support & System Services	434,000	418,000
SSF-NonASA	HHS Broadcast Studio (moved from Joint Funding Agreement)	35,000	59,000
SSF-NonASA	Consolidated Acquisition System (HCAS) Operations & Maintenance (O&M)	2,610,000	3,243,000
SSF-NonASA	Media Monitoring & Analysis (moved from Joint Funding Agreement)	84,000	97,000
SSF-NonASA	Office of General Counsel (OGC) Claims	190,000	259,000
SSF-NonASA	Office of Program Audit Coordination (Formerly Audit Resolution)	602,000	655,000
SSF-NonASA	Small Business Center (Formerly Small Business Consolidation)	800,000	1,000,000
SSF-NonASA	Strategic Planning System	26,250	26,250
SSF-NonASA	Tracking Accountability Government Grants System (TAGGS)	304,000	262,000
SSF-NonASA	National Security Adjudications	175,000	37,000
SSF-NonASA	Unified Financial Management System (UFMS) O&M / Pass-Thru	8,269,000	8,831,000
SSF-NonASA	UFMS (Governance)	1,173,000	1,242,000
SSF-NonASA	UFMS (CFRS, FBIS/OBIEE)	2,135,000	2,242,000
	Subtotal SSF Non-Assistant Secretary Administration (ASA)	31,885,250	33,858,622
	Subtotal - Purchased within HHS through SSF	**65,264,508**	**66,435,142**
	Joint Funding Agreement (JFA) Assessments		
JFA	Chief Financial Officer (CFO) Financial Statement Audit	652,613	712,670
JFA	DATA Act	416,662	56,173
JFA	Interdepartmental Council on Native American Affairs	80,000	80,000
JFA	Office of Global Health Affairs	20,000	20,000
JFA	National Clinical Care Commission	22,800	90,000
JFA	Regional Health Administrators	308,010	308,010
	Subtotal - JFA Assessments	**1,500,085**	**1,266,853**
	Government-wide Administrative Functions (GAF)		
IAA	Federal Employment Services (USAJOBS)	101,792	88,254
IAA	Dept. of Homeland & Security (DHS) - HQ, Dallas & Seattle	156,927	154,398
IAA	General Services Administration (GSA) Fleet (Non-OPS)	10,039	6,677
IAA	GSA - HQ & Seattle FIT Loan	1,190,224	1,476,990
IAA	GSA - HQ, Dallas & Seattle Rent	4,878,539	4,870,931
IAA	HHS Federal Audit Clearinghouse (FAC)	2,936	3,490
IAA	National Archives & Records Admin (NARA)	12,000	15,000
IAA	National Institute of Health - Health Services Research Library	676,608	619,171
IAA	Office of General Counsel (OGC) - Legal Services	1,702,516	1,550,364
IAA	Office of Personnel Management (OPM) - Credit Monitoring	132,251	132,251
IAA	Office of Personnel Management (OPM) - Investigations	596,536	665,444
IAA	Radio Frequency Spectrum	152,940	154,102
IAA	Unified Communications (UC) Services	905,618	321,600
	Subtotal - GAF Interagency Agreements (IAA)	**10,518,926**	**10,058,672**
	Grand Total	77,283,519	77,760,667

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2020 Performance Budget Submission to Congress

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Significant Items in Committee Reports

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INDIAN HEALTH SERVICE
FY 2020 CONGRESSIONAL JUSTIFICATION
House Report 115-765
Significant Items

Accreditation Emergencies. - 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. Funds allocated to a facility to address compliance issues shall 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). (p.79-80).

Action taken or to be taken:

In FY 2018, IHS implemented several efforts to strengthen the delivery of high quality health care at IHS direct service facilities. The FY 2019 target is to maintain 100 percent accreditation and/or certification at IHS-operated hospitals and outpatient clinics.
IHS is working with The Joint Commission for accreditation, training, and education services to strengthen quality and patient safety.

Indian Health Care Improvement Act. - It has been over eight 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 is aware of the work being done by the IHS in consultation with Tribes to re-evaluate the existing formula for calculating the level of need funded. The Service is expected to combine this calculation with other existing resource deficiency metrics to estimate a total amount necessary for fully funding existing health services, and report to the Committee no later than 180 days after enactment of this Act. (p. 80).

Action taken or to be taken:

IHS appreciates the Committee's interest in the Indian Health Care Improvement Act.
A comprehensive plan, including dollar amounts would require significantly more time than the 90 days allotted in the report, as well as dedicated resources (e.g., necessary funding for a health economist and a team of researchers).

Maternal and Child Health. - The Committee is aware the Indian Health Service Chief Medical Officer (CMO) has established the hiring of a national maternal/child health coordinator as a top priority for the Office of Clinical and Preventive Services. In addition, the CMO has also appointed a Chief Clinical Consultant for Obstetrics and Gynecology for issues related to maternal health. Within 90 days of enactment of this Act, the Indian Health Service shall report on its progress to hire a permanent Maternal and Child Health Coordinator at Headquarters with experience working as a health care provider on maternal and child health issues. (p. 80).

Action taken or to be taken:

The position has not yet been filled; however, the IHS Chief Medical Officer has established the hiring of a national maternal/child health coordinator as a top priority for the IHS Headquarters Office of Clinical and Preventive Services.

INDIAN HEALTH SERVICE
FY 2020 CONGRESSIONAL JUSTIFICATION
Senate Report 115-267
Significant Items

Village Built Clinics. - The Committee has provided additional resources for village built clinics [VBCs] leasing costs. The Service testified before the Committee that these resources are now 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 mandates payment of leasing costs when Tribal facilities are used to operate IHS programs. The agency indicated that these costs may grow exponentially over time. While the Committee has not included proposed language in the budget request to overturn this decision it is concerned with the budgetary impacts of this case moving forward. Within 90 days of enactment of this act, the Service shall submit a report which indicates the current number of Tribes pursuing 105(l) leasing arrangements, where these Tribes are located by State, the associated costs, and proposals for addressing this issue in the budget beyond simply overturning a court decision. The Committee believes these costs should be included separately in the budget request from those funds needed for village built clinics. (p. 91).

Action taken or to be taken:

The 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 for administration and delivery of health care services. 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 carrying out the health programs. Since the first proposals were received in FY 2017, the IHS has seen a steady increase in costs and proposals.

GIMC - The Committee remains concerned about deficiencies identified at Gallup Indian Medical Center [GIMC] in New Mexico by the Centers for Medicare and Medicaid Services [CMS], including Emergency Medical Treatment and Labor Act [EMTALA] violations and a lack of compliance with the Medicare Conditions of Participation related to governing body, quality assurance and performance improvement and infection control that were identified in a May 2018 survey. It is imperative that the Service take all needed steps to come under compliance and ensure that GIMC does not lose access to third party reimbursements, which account for the majority of the facility's funding. In addition to the report directed by the fiscal year 2018 Consolidated Appropriations Act (Public Law 115–141) regarding GIMC accreditation, the Service is also directed to provide a supplemental report to the Committee within 90 days of enactment that details all actions taken to address the deficiencies identified by CMS and a list of any outstanding recommendations that require future action by GIMC or the Service to implement. The Service is expected to include its corrective action plans submitted to CMS as part of this report. (p. 91).

Action taken or to be taken:

Report submitted to Congress August 27, 2018.

Alcohol and Substance Abuse. - the bill continues 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 Committees 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 .92).

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 directs 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 IHS to employ the full spectrum of medication assisted treatments for alcohol and opioid use disorders, including non-narcotic treatment options that are less subject to diversion combined with counseling services. (p. 92).

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. With the additional funding, the Gallup site has been able to expand detoxification services to 90 beds; 65 for males and 25 for females; increase coordination and transportation with the Emergency Department; and establish 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.

For medication assisted treatments (MAT), to address the shortage of specialists who can prescribe MAT, IHS is training its current workforce to provide these specialty services.

- Number of facilities providing onsite MAT= 9

From FY 2013 to FY 2016, IHS increased buprenorphine prescriptions, a common medication used to treat opioid use disorder, by 30 percent. IHS, in partnership with SAMHSA, provides in-person and virtual training for providers to obtain their DATA waiver to prescribe MAT.

70 IHS and tribal physicians were trained over the last two years.

- 33 DATA waived providers.

IHS, in partnership with the University of New Mexico, provides weekly continuing education on pain and addiction as well as consultation on complex cases to further train primary care clinicians to provide these specialty services. This model is called Project ECHO.

IHS has seen an increase in the number of buprenorphine being prescribed across all IHS areas - a positive example that IHS in increasing MAT services.

Consultation is offered through virtual clinics hosted by the University of New Mexico to connect primary care clinicians with expert teams to share knowledge and elevate the level of specialty care available to patients.

Opioid Grants. -To better combat the opioid epidemic, the Committee has included an increase of $10,000,000 and instructs the Service, in coordination with the Assistant Secretary for Mental Health and Substance Abuse, to use the additional funds provided above the fiscal year 2018 level to create a Special Behavioral Health Pilot Program modeled after the Special Diabetes Program for Indians. This Special Behavioral Health Pilot Program for Indians should support the development, documentation, and sharing of more locally-designed and culturally appropriate prevention and treatment interventions for mental health and substance use disorders in Tribal and urban Indian communities, The Director of the Indian Health Service, 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. 92).

Action taken or to be taken:
IHS is currently discussing the best mechanism to distribute opioid related funding through a pilot program. In the immediate future, tribal consultation and urban confer will be initiated to discuss funding mechanisms and/or funding formulas with tribal partners. 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.

Quality of Care. - The Committee finds that structural reforms are needed at the Indian Health Service, and directs IHS to work with the Committee to improve access to care and quality of services. The Committee also directs Indian Health Service to establish measurements for tracking the improvement of patient health, rather than defining increased funding alone as a metric for measuring improvements. (p.93).

Action taken or to be taken:

Throughout CY 2018 IHS diligently pursued implementation of the Quality Framework, achieving many accomplishments.

- The National Accountability Dashboard for Quality and associated web-based dashboard reporting tool were developed and rolled out for quarterly publication on the IHS website.

- Patient Wait Time standards were developed and published as an IHS policy (average routine primary care < 28 days, average urgent care < 48 hours).
- IHS Credentialing and Privileging software implemented for use by all IHS federal healthcare facilities
- Accreditation contracts were awarded to The Joint Commission (for hospitals) and the Accreditation Association for Ambulatory Health Care (AAAHC, for health centers) to standardize processes and increase access to accreditation readiness resources.
- Rosebud Hospital successfully completed its Systems Improvement Agreement (SIA) with Centers for Medicare and Medicaid Services (CMS), restoring their participation in the Medicare Program.
- Pine Ridge Hospital did not successfully complete its SIA with CMS, while the hospital has not achieved CMS certification it has made progress to that goal. The hospital has re-opened its surgical and obstetrics services and continues work with Joint Commission Resources to implement improvements to achieve CMS certification and accreditation.
- The agency Adverse Event Reporting System software will be awarded by the end of December 2018. The workgroup identified the requirements prior to the announcement for the contract.

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. 93).

Action taken or to be taken:

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2020 Performance Budget Submission to Congress

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Operating Division-Specific Requirements

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Department of Health & Human Services
Indian Health Service
Number of Service Units and Facilities
Operated by IHS and Tribes, October 1, 2017

Type of Facility	TOTAL	IHS Total	TRIBAL Total	Title I [a]	Title V [b]	Other [c]
Service Units	168	54	114			
Hospitals	48	25	22	2	20	0
Ambulatory	560	78	482	132	343	7
Health Centers	335	50	280	98	181	1
School Health Centers	8	2	6	0	6	0
Health Stations	83	26	62	29	33	0
Alaska Village Clinics	134	0	134	5	123	6

[a] Operated under P.L. 93-638, Self Determination Contracts

[b] Operated under P.L. 106-260, Tribal Self-Governance Amendment of 2000

[c] Operated by a local government, not a tribe, for some Alaska Native villages through a standard procurement contract or also to denote certain Navajo Area contractors

Indian Health Service
Summary of Inpatient Admissions and Outpatient Visits
Federal and Tribal
FY 2017 Data

Direct Care Admissions

	IHS	Tribal	TOTAL
TOTAL	**14,798**	**23,925**	**38,723**
Alaska	*	11,335	11,335
Albuquerque	459	*	459
Bemidji	72	*	72
Billings	665	*	665
California	*	*	0
Great Plains	2,506	*	2,506
Nashville	*	1,175	1,175
Navajo	6,359	4,764	11,123
Oklahoma	1,265	6,542	7,807
Phoenix	3,472	512	3,984
Portland	*	*	0
Tucson	*	241	241

* No direct inpatient facilities in FY 2017

Direct Care Outpatient Visits

	IHS	Tribal	TOTAL
TOTAL	**4,918,509**	**8,892,662**	**13,811,171**
Alaska	**	1,880,013	1,880,013
Albuquerque	479,271	133,610	612,881
Bemidji	271,497	638,047	909,544
Billings	403,730	166,464	570,194
California	**	621,643	621,643
Great Plains	890,042	137,320	1,027,362
Nashville	22,954	539,536	562,490
Navajo	1,094,939	857,647	1,952,586
Oklahoma	691,691	2,341,255	3,032,946
Phoenix	787,967	635,385	1,423,352
Portland	276,418	637,455	913,873
Tucson		304,287	304,287

** No IHS facilities in FY 2017

INDIAN HEALTH SERVICE
Immunization Expenditures[1]

	FY 2016 Estimate	FY 2017 Estimate	FY 2018 Estimate	FY 2019 Estimate	FY 2020 Estimate	Increase or Decrease
Infants, <2 yrs	$30,855,296	$18,234,078	$18,370,977	$17,637,372	$16,999,814	-$637,558
Adolescents, 13-17 yrs	$11,551,407	$14,184,614	$14,416,586	$14,539,873	$14,751,715	+$211,842
HPV vaccine, Female 19-26 yrs	$2,654,568	$7,116,136	$3,365,850	$1,888,480	$2,234,867	+$346,387
HPV Vaccine, Males 19-21 yrs	$3,136,902	$5,339,282	$3,617,239	$3,007,340	$3,471,040	+$463,700
Tdap, 19+ yrs	$1,399,293	$4,369,742	$4,986,405	$5,642,763	$6,881,091	+$1,238,328
Hepatitis B for diabetics, 19-59 yrs	$4,870,146	$5,400,839	$3,458,933	$5,001,855	$2,596,434	-$2,405,421
Influenza, 19yrs+	$29,542,047	$25,539,057	$25,865,678	$26,722,962	$26,869,430	+$146,468
Zoster vaccine, 60yrs	$558,050	$598,728	$634,156	$749,722	$600,430	-$149,292
Pneumococcal (PPSV23), 65yrs+	$179,359	$270,111	$826,614	$1,263,179	$367,796	-$895,383
Pneumococcal (PCV13), 65yrs+	$4,410,552	$4,790,620	$5,105,479	$6,107,426	$6,676,690	+$569,264
Monitoring	$122,565	$127,100	$132,057	$137,207	$138,579	+$1,372
TOTAL	$89,280,185	$85,970,307	$80,780,034	$82,698,180	$81,587,886	-$1,110,294

The Indian Health Service (IHS) patient care data system does not calculate itemized costs for the treatment of various conditions. Because the cost of vaccines for infants and adolescents < 19 years of age is covered by the Vaccines for Children (VFC) program; only the costs for vaccine administration, which are not covered by the VFC program, are included for this age group. Vaccine administration fees were based on an average of the CMS Maximum Regional Charges for vaccine administration, multiplied by the number of doses of vaccine routinely recommended for each age group (e.g., 25 doses for children < 2 yrs; 6 doses of vaccine for adolescents).

In order to incorporate the vaccine provisions included in Patient Protection and Affordable Care Act, all routinely recommended adult vaccines were added to the IHS Core Formulary in September 2011, and costs for the purchase and administration of these adult vaccines are included in the estimated costs. In August 2014, the Advisory Committee on Immunization Practices (ACIP) for the first time recommended routine use of 13-valent pneumococcal conjugate vaccine (PCV13) among adults aged ≥65 years; the projected costs for incorporating this additional vaccine are included starting with the FY 2016 expenditures. The assumptions for all calculations are included in the table below.

Costs for monitoring of immunization coverage were also included, and represent a 1.0 percent increase over the FY 2019 estimate.

- FY 2016 Estimated Costs = FY 2015 cost plus 3.8 percent
- FY 2017 Estimated Costs = FY 2016 cost plus 3.7 percent

[1] 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.

- 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

For FY 2020, $81,449,307 is estimated for vaccine costs, and $138,579 for immunization monitoring costs, for a total of $81,587,886 estimated for all immunization expenditures. This represents a $1,110,294 decrease from FY 2019 attributable to changes in vaccine costs, redistribution in population age categories, and progress towards vaccination coverage goals aligned with Healthy People 2020 targets (i.e., as progress is made, there are fewer individuals still needing vaccination and thus reduced forecasted costs). Calculations for the costs included as part of the FY 2020 estimated immunization costs were based on the assumptions outlined in the table below:

	Estimated User Population (FY 2018)	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	39,116	80%	NA	31,293	$0.00	$21.73	25	$543.25	$16,999,814
Adolescents, 13-17 years	141,430	80%	NA	113,144	$0.00	$21.73	6	$130.38	$14,751,715
HPV Females, 19-26 yrs	112,253	60%	56%	4,490	$144.18	$21.73	3	$497.73	$2,234,867
HPV Males, 19-21 yrs	38,743	60%	42%	6,974	$144.18	$21.73	3	$497.73	$3,471,040
Tdap, 19+ yrs	1,127,641	90%	77%	146,593	$25.21	$21.73	1	$46.94	$6,881,091
Hepatitis B for diabetics, 19-59 yrs	125,983	60%	46%	17,638	$27.34	$21.73	3	$147.21	$2,596,434
Influenza, 19+ yrs	1,127,641	70%	NA	789,349	$12.31	$21.73	1	$34.04	$26,869,430
Zoster, 60 yrs$^{\alpha}$	16,151	30%	NA	4,845	$102.19	$21.73	1	$123.92	$600,430
Pneumococcal (PPSV23) 65yrs+	159,219	90%	87%	4,777	$55.27	$21.73	1	$77.00	$367,796
Pneumococcal (PCV13) 65yrs+	159,219	30%	NA	47,766	$118.05	$21.73	1	$139.78	$6,676,690
Vaccine Costs									$81,449,307
Monitoring									$138,579
Total Costs									$81,587,886

† Based on Healthy People 2020, where applicable

***** Coverage estimates based on most current coverage levels reported by IHS (https://www.ihs.gov/epi/vaccine/reports/; FY 2018 Quarter 4); beginning in the FY 2020 submission, current coverage estimates for diabetics ages 19-59 years also includes those patients immune to Hepatitis B for reasons other than immunization; HPV estimate is based on 3 dose coverage.

****** Cost per dose determined from the CDC Adult Vaccine Price List dated December 3, 2018. 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.

α ACIP recently (October 2017) preferentially recommended use of a newly approved Zoster vaccine for adults 50 years and older and requiring two doses versus one dose for the currently available vaccine. IHS will likely implement this new recommendation sometime during FY 2019 – FY 2020, increasing Zoster vaccination costs due to an expanded target population and requirement for a second dose. Estimated costs for use of the new vaccine will be included in future submissions.

Overall, the estimated costs for these immunizations are affected by:

1. Individuals outside these target groups are regular recipients of immunizations (e.g., immunization for health care workers and those at specific risk for other vaccine-preventable diseases), however, there is not 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.

Non-Budget
Discretionary

FISCAL YEAR 2020 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: To amend the Indian Health Care Improvement Act (IHCIA) to authorize the Indian Health Service to establish concurrent federal and state jurisdiction at Indian Health Service (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 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: This is a non-budget related and discretionary proposal.

Personnel Requirements: This proposal does not require additional personnel to implement.

Effective Date: Upon enactment.

Budget
Discretionary

FISCAL YEAR 2020 HHS LEGISLATIVE PROPOSAL
Indian Health Service

Provide Federal Tort Claim Act Coverage (FTCA) for persons volunteering their services at the Indian Health Service (IHS) hospitals and clinics and in authorized community settings

Proposal: To amend the Public Health Service Act (42 U.S.C. § 233) to provide FTCA coverage for persons volunteering their services at 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 can 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. 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: This is a budget related and discretionary proposal.

FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	5 Year Totals
$300K	$330K	$363K	$399K	$439K	$1.83M

The Congressional Budget Office had estimated that FTCA coverage for volunteers at Health Resources and Services Administration (HRSA) Health Centers would result in claims and lawsuits costing $6.0 million over five years for Fiscal Years 2009 – 2013. IHS claims experience currently runs less than 25 percent of the HRSA Health Center experience. Therefore, IHS estimates the cost of extending FTCA coverage to volunteers at IHS hospitals and clinics could be $1.83 million over a five-year period.

Personnel Requirements: There are no personnel requirements.

Effective Date: Upon enactment.

FISCAL YEAR 2020 HHS LEGISLATIVE PROPOSAL
Indian Health Service

Provide the Indian Health Service Discretionary Use of all Title 38 Personnel Authorities

Proposal: The 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 VA unless expressly overridden by another law or regulation. In many areas of personnel administration, the VA 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 July 1, 2014. If HHS, or an HHS Operating Division under the delegation of authority, chooses to use a Title 38 provision, the comparable authority under Title V 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 VA can offer candidates better scheduling options and annual leave accrual – particularly important benefits to providers who serve in remote areas and who may be away from their families for extended periods of time. The IHS faces specific private and public sector competition in the area of annual leave accrual. Many private organizations offer more lucrative leave for doctors and nurses – even those new to the profession. In addition, the VA provides 8 hours of annual leave accrual per biweekly pay period to all new nurses, doctors, dentists, podiatrists, optometrists, and chiropractors – regardless of their years of experience. Due to the limited scope of 5 U.S.C. § 5371, the IHS does not have this authority as it is covered by 38 U.S.C. § 7421. "Personnel Administration: in general". Thus, when a candidate with just a few years of experience is choosing between the IHS and the VA, he or she will invariably choose the organization offering 8 hours of annual accrual per pay period, as opposed to 4 or 6 hours of annual leave accrual per pay period. Supervisors report anecdotally that the IHS has lost many candidates due to this difference in accrual rates.

In addition to pursuing 8 hours of annual leave for nurses, doctors, dentists, podiatrists, optometrists, and chiropractors, the IHS is seeking access to other Title 38 authorities to increase its ability to compete with both the public and private sector and to create the best possible human resources program. This would include the potential for instituting two-year probationary periods for staff appointed under Title 38.

If the IHS is authorized to offer more competitive leave packages through the discretionary use of Title 38 authorities under Part V, Chapter 74, recruitment and retention rates could increase while vacancy rates and turnover could decrease. This would bring about a significant positive impact to the IHS healthcare system and beneficiaries. With additional staff, the IHS could provide additional services to American Indians and Alaska Natives. In addition, current services could be provided more efficiently and effectively thereby positively impacting both individual and community health.

Budget Impact: This proposal is budget neutral. The IHS will accommodate funding requirements within existing resources.

Personnel Requirements: There are no personnel requirements.

Effective Date: Upon enactment.

FISCAL YEAR 2020 HHS LEGISLATIVE PROPOSAL
Indian Health Service

Meet Loan Repayment/Scholarship Service Obligations on a Half-Time Basis

Proposal: Permit both IHS scholarship and loan repayment recipients to fulfill service obligations through half-time clinical practice, under authority similar to that now available to the National Health Service Corps (NHSC) Loan Repayment Program (LRP) and Scholarship Program.

Authority similar to Section 331(i) of the Public Health Service Act would allow IHS loan repayment and scholarship recipients 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 PHS Act (42 USC 254d(j)) defines "full-time" clinical practice as a minimum of 40 hours per week, for a minimum of 45 weeks per year. It also defines "half-time" as a minimum of 20 hours per week (not to exceed 39 hours per week), for a minimum of 45 weeks per year.

Rationale: The IHS, as a rural healthcare provider, has difficulty recruiting and retaining healthcare professionals. Recruiting physicians and other primary care clinicians has been especially challenging. We believe that having the options to permit IHS scholarship and loan repayment health professional employees to fulfill their service obligations through half-time clinical practice for double the amount of time and to offer half the loan repayment award amount in exchange for a two-year service obligation could increase the number of providers interested in serving in the Indian health system. Additional half-time direct care employees could also reduce the number and cost of Purchased/Referred Care program referrals, especially at sites that do not need full-time specialty care services. There are also a number of smaller rural IHS sites where clinicians would 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 would 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 NHSC was authorized to establish a demonstration project permitting loan repayment recipients to meet their service obligations through less than full-time clinical service in response to requests from clinicians and sites. The Affordable Care Act replaced this demonstration with permanent authority for two specific kinds of NHSC options (described above under Current Law). The IHS is equally concerned with the requests from clinicians and prospective candidates for loan repayment awards for half-time service by clinicians. Having similar authority as the NHSC would increase the ability for the IHS to recruit and retain healthcare clinicians to provide primary healthcare and specialty services (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.

Personnel Requirements: There are no personnel requirements.

Effective Date: Upon enactment.

Budget
Discretionary

FISCAL YEAR 2020 HHS LEGISLATIVE PROPOSAL
Indian Health Service

Provide Tax Exemption for IHS Health Professions Scholarship and Loan Repayment Programs

Proposal: IHS is seeking tax treatment, similar to the treatment provided to recipients of National Health Service Corps (NHSC) and Armed Forces Health Professions scholarships, to allow scholarship funds for qualified tuition and related expenses received under the Indian Health Services Health Professions Scholarships to be excluded from gross income under Section 117(c)(2) of the Internal Revenue Code (IRC) and to allow participants in the IHS Loan Repayment program to exclude from gross income 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 USC 108(f)(4) provides that funds received through the National Health Service Corps Loan Repayment Program authorized under 338B(g) of the Public Health Service Act or a state loan repayment program described in section 338I of the Public Health Service Act are permanently not subject to federal income tax.
- 26 USC 3401(a)(19) excludes NHSC loan repayment from federal employment tax.

As IHS programs are not included in the exceptions, IHS health professions scholarships and loan repayment awards are taxed under the IRC.

Rationale: The IHS, as a rural healthcare provider, has difficulty recruiting 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)[1]:

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.

Personnel Requirements: There are no the personnel requirements.

Effective Date: Upon enactment.

[1] Most recent year for which numbers are available.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2020 Performance Budget Submission to Congress

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Self Determination

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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 217 Tribes and Tribal Organizations operating 247 contracts and annual funding agreements. Under Title V, IHS is party to 101 compacts and 127 funding agreements; through which approximately $2.3 billion of the IHS budget is transferred to Tribes and Tribal organizations. Sixty-three percent of federally recognized Tribes participate in Title V.

Indian Health Service
Self-Governance Funded Compacts FY 2018
(Dollars in Thousands)

Compacts by State	IHS Services	IHS Facilities	Contract Support Costs (Direct)	Contract Support Costs (Indirect)	Total
ALABAMA	**4,500**	**170**	**152**	**259**	**5,081**
Poarch Band of Creek Indians	4,500	170	152	259	5,081
ALASKA	**432,856**	**44,797**	**52,519**	**169,630**	**699,802**
Alaska Native Tribal Health Consortium	38,494	19,911	11,610	20,980	90,995
Aleutian Pribilof Islands Association, Inc.	1,745	22	146	1,112	3,025
Arctic Slope Native Association, Ltd	23,177	2,309	3,279	6,780	35,545
Bristol Bay Area Health Corporation	20,404	982	2,205	9,213	32,804
Chickaloon Native Village	59	1	15	11	85
Chugachmiut	3,768	28	223	1,801	5,821
Copper River Native Association	5,604	402	483	2,071	8,560
Council of Athabascan Tribal Governments	1,806	128	99	1,290	3,323
Eastern Aleutian Tribes, Inc.	3,134	28	177	1,821	5,160
Kenaitze Indian Tribe, I.R.A.	11,921	1,113	395	4,315	17,744
Ketchikan Indian Community	5,270	171	548	3,327	9,316
Knik Tribal Council	73	1	10	10	94
Kodiak Area Native Association	7,028	134	454	2,599	10,215
Maniilaq Association	29,028	1,054	2,814	14,450	47,346
Metlakatla Indian Community	6,284	968	474	1,323	9,049
Mount Sanford Tribal Consortium	799	1	81	281	1,162
Native Village of Eklutna	301	2	6	43	352
Native Village of Eyak	895	26	88	238	1,247
Norton Sound Health Corporation	46,946	4,034	4,327	12,284	67,591
Seldovia Village Tribe	1,861	63	87	697	2,708
Southcentral Foundation	80,091	5,169	10,006	32,067	127,332
SouthEast Alaska Regional Health Consortium	36,048	1,796	3,559	16,615	58,018
Tanana Chiefs Conference	60,592	4,153	5,654	15,062	85,461
Yakutat Tlingit Tribe	314	3	31	131	479
Yukon-Kuskokwim Health Corporation	47,214	2,298	5,746	21,112	76,370
ARIZONA	**193,461**	**16,409**	**7,531**	**48,636**	**266,038**
Gila River Indian Community	66,902	7,956	1,764	21,018	97,640
Pascua Yaqui Tribe	15,549	232	183	2,448	18,412
Salt River Pima-Maricopa Indian Community	5,630	62	260	2,272	8,224
Tohono O'Odham Nation	40,997	3,492	2,420	6,755	53,664
Tuba City Regional Health Care Corporation	41,478	3,601	2,114	9,141	56,334
Winslow Indian Health Care Center, Inc.	22,905	1,066	790	7,003	31,764
CALIFORNIA	**76,678**	**3,148**	**3,661**	**32,316**	**115,803**
Chapa-De Indian Health Program, Inc.	6,798	193	179	3,509	10,679
Consolidated Tribal Health Project, Inc.	3,965	114	102	1,454	5,635
Feather River Tribal Health, Inc.	242	0	0	0	242
Hoopa Valley Tribe	5,305	143	262	2,293	8,003
Indian Health Council, Inc.	8,565	276	276	3,569	12,685
Lake County Tribal Health Consortium, Inc	6,602	855	166	2,596	10,219
Karuk Tribe of California	3,117	98	92	1,472	4,778
Northern Valley Indian Health, Inc.	4,260	192	112	1,226	5,790
Pinoleville Pomo Nation	61	0	2	11	73
Redding Rancheria Tribe	6,988	237	572	3,315	11,113
Riverside-San Bernardino County Indian Health, Inc.	21,667	694	865	9,245	32,471
Santa Ynez Band of Chumash Mission Indians	1,834	90	34	560	2,518
Southern Indian Health Council, Inc.	5,566	216	842	2,379	9,004
Susanville Indian Rancheria	1,709	38	158	687	2,593

Indian Health Service
Self-Governance Funded Compacts FY 2018
(Dollars in Thousands)

Compacts by State	IHS Services	IHS Facilities	Contract Support Costs (Direct)	Contract Support Costs (Indirect)	Total
CONNECTICUT	**2,479**	**85**	**0**	**762**	**3,327**
Mohegan Tribe of Indians of Connecticut	2,479	85	0	762	3,327
FLORIDA	**9,499**	**580**	**969**	**1,741**	**12,789**
Seminole Tribe of Florida	9,499	580	969	1,741	12,789
IDAHO	**16,872**	**869**	**1,862**	**5,178**	**24,781**
Coeur D'Alene Tribe	7,065	401	1,371	3,317	12,154
Kootenai Tribe of Idaho	659	30	77	155	920
Nez Perce Tribe	9,148	438	415	1,706	11,707
KANSAS	**4,782**	**157**	**21**	**1,052**	**6,012**
Prairie Band Potawatomi Nation	4,782	157	21	1,052	6,012
LOUISANA	**1,218**	**109**	**124**	**210**	**1,661**
Chitimacha Tribe of Louisiana	1,218	109	124	210	1,661
MAINE	**3,437**	**96**	**170**	**832**	**4,534**
Penobscot Indian Nation	3,437	96	170	832	4,534
MASSACHUSETTS	**716**	**31**	**218**	**0**	**965**
Wampanoag Tribe of Gay Head	716	31	218	0	965
MICHIGAN	**28,858**	**1,009**	**2,228**	**3,329**	**35,423**
Grand Traverse Band of Ottawa and Chippewa Indians	2,901	189	309	532	3,932
Keweenaw Bay Indian Community	3,449	172	811	538	4,971
Little River Band of Ottawa Indians	2,093	65	250	337	2,745
Match-E-Be-Nash-She-Wish Band of Pottawatomi	1,153	14	26	140	1,333
Nottawaseppi Huron Band Of The Potawatomi	1,782	29	53	209	2,073
Sault Ste. Marie Tribe of Chippewa Indians	17,479	540	778	1,573	20,368
MINNESOTA	**21,012**	**782**	**2,785**	**2,629**	**27,208**
Bois Forte Band of Chippewa Indians	2,684	128	390	592	3,792
Fond du Lac Band of Lake Superior Chippewa	12,293	466	1,221	909	14,888
Mille Lacs Band of Ojibwe	4,263	178	1,158	799	6,398
Shakopee Mdewakanton Sioux Community	1,773	11	17	329	2,130
MISSISSIPPI	**37,653**	**3,732**	**1,245**	**6,695**	**49,326**
Mississippi Band of Choctaw Indians	37,653	3,732	1,245	6,695	49,326
MONTANA	**35,553**	**1,488**	**1,904**	**5,904**	**44,849**
Chippewa Cree Tribe of the Rocky Boy's Reservation	10,566	593	1,088	2,378	14,625
Confederated Salish and Kootenai Tribes of the Flathead Nation	24,987	895	816	3,526	30,224
NEBRASKA	**17,742**	**827**	**3,447**	**2,101**	**24,117**
Winnebago Tribe of Nebraska	17,742	827	3,447	2,101	24,117
NEW MEXICO	**12,783**	**205**	**1,268**	**2,273**	**16,529**
Pueblo of Jemez	9,835	157	906	1,801	12,700
Pueblo of Sandia	1,992	42	151	230	2,415
Taos Pueblo	956	6	211	241	1,414
NEW YORK	**8,178**	**582**	**321**	**1,934**	**11,014**
St. Regis Mohawk Tribe	8,178	582	321	1,934	11,014
NEVADA	**28,976**	**1,191**	**2,180**	**5,880**	**38,226**
Duck Valley Shoshone-Paiute Tribes	7,094	416	772	1,863	10,145
Duckwater Shoshone Tribe	1,116	19	201	588	1,923
Ely Shoshone Tribe	1,349	15	63	417	1,845
Fort McDermitt Paiute and Shoshone Tribe	1,565	82	7	212	1,866
Las Vegas Paiute Tribe	3,470	60	120	309	3,959
Reno-Sparks Indian Colony	7,213	292	676	1,823	10,005
Washoe Tribe of Nevada and California	5,138	204	236	381	5,959
Yerington Paiute Tribe of Nevada	2,030	103	104	288	2,525
NORTH CAROLINA	**19,914**	**1,790**	**998**	**8,727**	**31,429**
Eastern Band of Cherokee Indians	19,914	1,790	998	8,727	31,429
NORTH DAKOTA	**11,689**	**479**	**1,532**	**2,035**	**15,736**
Spirit Lake Tribe	11,689	479	1,532	2,035	15,736

Indian Health Service
Self-Governance Funded Compacts FY 2018
(Dollars in Thousands)

Compacts by State	IHS Services	IHS Facilities	Contract Support Costs (Direct)	Contract Support Costs (Indirect)	Total
OKLAHOMA	**452,178**	**56,282**	**41,137**	**96,436**	**646,034**
Absentee Shawnee Tribe of Oklahoma	18,183	2,046	1,939	8,315	30,483
Cherokee Nation	141,588	16,280	13,778	23,407	195,052
Chickasaw Nation	86,147	17,698	10,155	18,772	132,772
Choctaw Nation of Oklahoma	88,601	12,720	6,383	23,718	131,422
Citizen Potawatomi Nation	22,223	1,491	1,646	9,282	34,642
Kaw Nation of Oklahoma	2,918	133	211	728	3,991
Kickapoo Tribe of Oklahoma	9,987	132	291	1,612	12,021
Modoc Tribe of Oklahoma	51	30	5	11	98
Muscogee Creek Nation	45,408	3,678	5,683	4,588	59,356
Northeastern Tribal Health System	7,596	57	154	1,175	8,983
Osage Nation	9,833	86	371	2,002	12,292
Ponca Tribe of Oklahoma	6,096	65	237	841	7,239
Quapaw Tribe of Oklahoma	159	0	29	100	289
Sac and Fox Nation of Oklahoma	9,892	114	166	837	11,010
Seminole Nation of Oklahoma	498	1,644	50	251	2,442
Wyandotte Nation	2,998	109	39	796	3,942
OREGON	**29,982**	**1,418**	**2,767**	**10,059**	**44,227**
Confederated Tribes of Grand Ronde	6,890	322	555	2,598	10,364
Confederated Tribes of Siletz Indians of Oregon	8,125	209	740	2,172	11,246
Confederated Tribes of the Coos, Lower Umpqua & Siuslaw Indians	1,847	60	289	535	2,732
Confederated Tribes of the Umatilla Reservation	7,323	436	750	2,687	11,196
Coquille Indian Tribe	2,086	206	237	1,366	3,895
Cow Creek Band of Umpqua Tribe of Indians	3,711	186	195	702	4,794
UTAH	**7,917**	**108**	**1,792**	**3,254**	**13,071**
Utah Navajo Health System, Inc.	7,917	108	1,792	3,254	13,071
WASHINGTON	**61,625**	**2,744**	**2,909**	**20,023**	**87,301**
Cowlitz Indian Tribe	7,074	111	24	1,023	8,232
Jamestown S'Klallam Indian Tribe	1,310	56	91	489	1,947
Kalispel Tribe of Indians	1,119	47	22	81	1,269
Lower Elwha Klallam Tribe	1,927	91	108	443	2,568
Lummi Indian Nation	8,295	472	267	3,653	12,687
Makah Indian Tribe	4,026	263	302	1,340	5,930
Muckleshoot Tribe	7,439	246	214	2,917	10,816
Nisqually Indian Tribe	2,370	108	115	485	3,078
Port Gamble S'Klallam Tribe	2,698	146	141	1,333	4,318
Quinault Indian Nation	5,759	406	227	1,714	8,106
Samish Indian Nation	1,165	3	99	380	1,647
Shoalwater Bay Indian Tribe	1,823	120	300	822	3,065
Skokomish Indian Tribe	2,123	96	120	502	2,840
Squaxin Island Indian Tribe	2,858	193	205	1,207	4,463
Suquamish Tribe	1,744	25	158	746	2,674
Swinomish Indian Tribal Community	2,422	88	189	1,215	3,914
Tulalip Tribes of Washington	7,473	273	329	1,673	9,748
WISCONSIN	**35,832**	**1,231**	**2,414**	**4,229**	**43,705**
Forest County Potawatomi Community	2,037	70	733	358	3,198
Ho-Chunk Nation	8,394	469	885	907	10,655
Oneida Tribe of Indians of Wisconsin	22,104	509	321	2,144	25,078
Stockbridge-Munsee Community	3,297	183	475	820	4,774
Grand Total	**1,556,390**	**140,320**	**136,155**	**436,123**	**2,268,988**

Indian Health Service
FY 2018 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	454,353	14,121	9,179	52,519	169,630	699,802
ALBUQUERQUE	11,748	884	356	1,268	2,273	16,529
BEMIDJI	85,063	1,911	1,749	7,427	10,186	106,336
BILLINGS	34,226	1,855	959	1,904	5,904	44,849
CALIFORNIA	74,201	3,065	2,560	3,661	32,316	115,803
GREAT PLAINS	29,802	714	221	4,979	4,136	39,853
NASHVILLE	90,770	2,453	1,547	4,197	21,159	120,126
NAVAJO	72,742	2,586	1,746	4,696	19,398	101,169
OKLAHOMA	489,833	11,004	12,563	41,158	97,488	652,046
PHOENIX	107,087	1,953	1,677	4,204	29,169	144,090
PORTLAND	106,684	3,931	2,895	7,538	35,260	156,308
TUCSON	56,539	2,942	789	2,603	9,203	72,076
Total, IHS	**1,613,049**	**47,420**	**36,240**	**136,155**	**436,123**	**2,268,988**

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2020 Performance Budget Submission to Congress

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Nonrecurring Expenses Fund

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Nonrecurring Expenses Fund
Budget Summary
(Dollars in Thousands)

Indian Health Service

Notification[1]	FY 2018[2]	FY 2019[3]/[4]	FY 2020[5]
IHS NEF Notification 6	$0	$185,000	TBD

Authorizing Legislation:

Authorization……..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.

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, and 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.

FY 2019 NEF funding supports IHS's work to improve patient care by enhancing capabilities of the EHR and IT Infrastructure. Significant upgrades to EHR will improve health care delivery and quality, enhance access to care, reduce medical errors, and modernize administrative functions.

Significant upgrades to IT infrastructure will replace aging equipment and provide lifecycle support to existing and emerging technologies used in IHS. IHS must enhance cybersecurity, improve IT service management, expand storage and computing capacity, and increase network bandwidth at dozens of rural locations to provide technologies that improve patient care.

[1] Pursuant to Section 223 of Division G of the Consolidated Appropriation Act, 2008, notification is required of planned use.
[2] There was no Congressional notification for the planned uses of NEF funds in FY 2018.
[3] Notification #6 submitted to the Committees on Appropriations in the House of Representatives and the Senate on December 4, 2018.
[4] Amounts notified are approximations of intended use. Amounts displayed here are current best estimates.
[5] HHS has not yet notified for FY 2020

Information Technology Related Accomplishments

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 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 Construction Program has received $143.3 million for 16 projects funded by NEF. One priority project, the Phoenix Indian Medical Center SE, Phoenix, AZ has been completed. In addition, 95 staff quarters units and one dental unit have also been completed.

The IHS Biomedical program received $70 million to replace over-age medical equipment. Area Offices held 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.

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

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[6]	**$184,947,562**

[6] Total is rounded up to $185 million in header table.